LiNEA-**R**
Retaining Nurses in the Workforce

Taking forward the career development work of the LiNEA Project

FINAL REPORT

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INTRODUCTION

Purpose of the research

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

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

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

Research background

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

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

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

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

The LiNEA research was based upon the actual experiences of new nurses, in their ward settings, so as to discover their learning needs and the challenges they perceived.

While research into such workplace learning has been surprisingly neglected in the past, it is now becoming recognised as essential to the understanding of professional development. This is evidenced in the funding of the LiNEA Project as part of the major ESRC's Teaching and Learning Research Programme, which has a significant focus on generating and disseminating research relevant to employers/users and which has wide generalisability. The research benefited from both the theoretical basis of research in this Programme and its national profile.

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

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

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

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

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

1. A 'Trust Day' for final year students: 'The Nurse as a Professional Practitioner: Preparation for Role Transition' to introduce the Trust and give examples of role progression.

2. A 'Nurturing the Novice Day' for mentors of NQNs about areas problematic to NQNs such as prioritising and delegating.

3. An 'Induction Day' for NQNs to discuss challenges and opportunities for training and development.

4. The development of Competencies was devised to clarify what their managers expected of newly qualified nurses when they started work and to give them a set of targets to aim for.

5. The development of 'Action Learning Sets' was devised to provide structured discussion sessions with peers, away from the ward, with an experienced nurse as facilitator.

6. The development of a 'Rotational Programme' for NQNs to gain a range of experience for NQNs in three 6 month placements in different nursing specialities.

LiNEA–**R**'s aims were to:

- Evaluate whether the Trust's six learning and support initiatives for newly qualified nurses were effectively enhancing nurses' development across the three hospitals, and feeding back results so that they could be acted on rapidly.

- Research into nurses' experiences in progressing from D to E grade, and the E to F and F to G grade transitions, to provide evidence of the learning development of nurses into ward manager posts and thereby assist the Trust's LiNEA Steering Group to assess how learning support could be focussed most effectively.

- Write up the total career support and development programme, in collaboration with the Steering Group, so that it was fully evidence based and could be published and disseminated.

METHODS

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

1. **A survey** of newly qualified nurses (NQNs) was carried out across the Trust hospitals in collaboration with the HR personnel who were part of the LiNEA-**R** Steering Group. The survey provided base line information that targeted the NQNs at the start of their career. 25 NQNs completed the survey.

2. **Systematic follow-up of pairs of mentors and NQNs** pursuing the learning support initiatives set up by the Trust was undertaken. This aimed to interview NQNs and their mentor, so that every pair of mentors and NQNs had attended the relevant

training days and undertook to follow through the LiNEA recommendations. The pairs were interviewed separately to see whether the learning experiences of the NQNs had been facilitated by the initiatives. 28 NQNs and 10 mentors were interviewed, including the sample obtained from the LiNEA Action Research phase of the study.

3. **Rotational Programme** Two NQNs were interviewed during their first 3-6 months, i.e. on their first placement, and one NQN at the beginning of her second placement. Two mentors of the NQNs on the Rotational Programme were also interviewed.

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

<u>Sample</u>

Senior Managers	10
Ward Managers	11
F grades	12
E grades	9
NQNs	28
Mentors	10
Total	**80**

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

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

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

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

II.

NEWLY QUALIFIED NURSES

Survey results showed that the 'typical' NQN who chose to work for the Trust was female, aged between 21-30, single, with no children, of white, British origin, was bursary funded, trained locally to receive a Diploma in adult nursing and worked full time

in either a medical or surgical ward. Reasons given for choosing the Trust were: they had trained locally; wanted to continue living locally; had been seconded by the Trust initially; the Trust's good reputation for training and development and its links to local universities; and wanted to broaden their knowledge and interest in nursing. The survey identified NQNs so that, with their agreement, they could be followed up in the research. It also contributed as a start in enabling the Trust to begin a data base of NQNs to target their support and development.

ACTION POINTS

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

Evaluation of the Trust's six initiatives

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

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

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

ACTION POINTS

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

2. 'Nurturing the Novice Day'

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

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

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

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

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

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

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

Mentorship

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

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

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

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

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

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

ACTION POINTS

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

- To continue to offer this initiative as it is essential for providing positive experiences for NQNs
- To ensure all NQNs are allocated to a mentor who has attended the Nurturing the Novice Day
- For NQNs to be self motivated and take responsibility for their own continued learning opportunities.

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

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

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

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

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

- To enforce mandatory attendance at annual mentor updates for qualified mentors as stated by the NMC (2006)
- To ensure all 'preceptors' of NQNs have attended at least a mentor preparation programme, in line with NMC guidelines (NMC 2006)
- To develop a more collegiate approach to mentorship so that 'helpful others' within the multi-disciplinary support the 'preceptors' of NQNs

- To develop a strategy to provide a mechanism for structured feedback for both mentor and mentee
- To respect the supernumerary status of all NQNs and to ensure that all clinical environments view the induction process for NQNs as building upon that which is already in place for students. It seems that not all NQNs are given the required induction when they obtain a post in a clinical area in which they have been a student as it is assumed their existing knowledge of the area is sufficient. There therefore needs to be an additional level of induction to any given clinical area: an induction that focuses on expectations of NQNs, their accountability and responsibilities and the support nurse(s) available to them.
- To make mentorship opportunities explicit for all
- To develop Action Learning Sets/clinical supervision for more senior mentors and all staff for future staff development and succession planning
- For mentors not be in charge of a shift, or if they are, they should not be allocated a patient caseload, in order that they are available to provide support to the team, as well as the NQNs
- For strategies to be in place to provide structured cover for protected time so that mentors can effectively support, teach and assess their learner's or learners' progress and competence in clinical practice
- To recognise the strain and personal 'labour' that goes into mentoring
- To develop strategies to deal with the current perceived lack of training opportunities due to financial constraints within the NHS

3. NQN Induction Day

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

ACTION POINTS

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

4. Competencies

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

ACTION POINTS

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

5. Action Learning Sets

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

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

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

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

ACTION POINTS

- Continue to offer this initiative, as it has been valuable for those who have been able to attend
- Clarify what Action Learning Sets are and their purpose
- Training for facilitators of Action Learning Sets

- Ensure that NQNs are given prior notice of the availability of Action Learning Sets
- Provide strategies to allow NQNs to leave the clinical environment so they can attend Action Learning Sets during ward time and not their own
- For the Action Learning Set facilitator to follow up issues which are raised during such Sets

6. Rotational posts

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

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

A structured induction programme: consisting of visiting areas linked to the ward and spending time with allied professionals
Education about their area of work: going through common conditions of the patient group they were caring for, being shown related Anatomy and Physiology e.g. on a model and understanding the rationale behind nursing care for various conditions
Being orientated to the area in which they were working: especially if they were new to the Trust
Support from a mentor and the nursing team: was seen by NQNs as essential
Being supervised and assessed clinically in practice
Receiving regular, constructive feedback about their capabilities.

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

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

ACTION POINTS
In relation to **mentor preparation**:

- Ensure mentors who are allocated to Rotational Post NQNs, are qualified (i.e. they have attended an NMC recognised mentor preparation module) or are supported by a qualified mentor
- Develop an in-house support programme to ensure mentors understand the paperwork and what is expected of them in their role as mentor to Rotational NQNs

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

In relation to **feedback:**

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

In relation to **assessment and competencies:**

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

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

- Expectations from new staff are higher because they are not NQNs any more – but they are still moving to a new area and so the transition needs managing

- There needs to be some form of induction to the second and third placements. This could possibly be a supernumerary shift or part shift
- An introductory booklet or welcome pack to the next placement before they get there would be helpful so they have time to prepare themselves for moving. An informal visit to that area beforehand to meet the ward manager and their mentor would be an advantage
- Have handover meetings to support the developmental focus of the Rotational Programme, e.g. between the ward managers involved in the Rotation; the NQN and the NQN's 1st placement mentor to 2nd placement mentor and then between

the NQN and the NQN's 2nd placement mentor to 3rd placement mentor, to enhance the transition phases
- Put in strategies to help the ward teams manage the loss of a valued team member at the end of 6 months.

In relation to **support:**

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

In relation to **further evaluation**:

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

III.

SENIOR NURSES

What Es and Fs Enjoyed about their role

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

Role and responsibilities of an E grade

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

Clinical: managing patient care, maintaining a safe environment for patients and staff, recognising changes in patients' conditions, dealing with difficult situations, performing link nurse duties and keeping up to date;
Managerial: coordinating the ward or a side of the ward;
Interpersonal: communicating information to staff and the multi disciplinary team, being an advocate for patients and staff;
Supportive: supervising and overseeing junior members of staff;
Educational: mentoring and teaching juniors.

Role and Responsibilities of an F grade

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

Clinical: leading the team as a clinical expert;
Quality: setting standards and following Trust policies and procedures;
Managerial: coordinating the ward and performing extended roles;
Interpersonal: communicating information to staff and other professionals, being an advocate for patients, dealing with complaints and conflict;
Supportive: supervising staff and colleagues, mediating between the ward manager and staff, an information giver and resource;
Educational: teaching, mentoring and developing junior staff, assessing staff, being used as a resource about available development opportunities;
Personnel: human resource issues such as appraisals, sickness records; off duty, manpower
Deputising for the ward manager.

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

Challenges of the E and F grade roles

The challenges of the roles related to maintaining standards of care whilst working under pressures of time and competing needs; getting through the day; having enough staff to manage the workload and maintain a safe environment, juggling patient care and the day to day management of the ward, re-prioritising on the hoof, trying to concentrate on patient care as opposed to patient throughput; managing people, situations and stress; having the time to mentor and teach juniors, to assess them in practice and give feedback, to support juniors and colleagues; dealing with the changing role of the nurse; encouraging others to be proactive; having sufficient support from medical teams; keeping themselves updated; managing personnel issues; and coping with the after-effects of reconfiguration, such as merging teams.
The challenges all appeared to relate to reacting to the current situation nurses found themselves in. Thus the response was often stressed, ad hoc, pressured and rushed. There seemed to be little time for a measured, objective, even proactive response for

dealing with situations. The workload was increasing, as was the pressure to perform. In some cases, the senior grades spoke about being in a constant state of stress, concerned about their accountability whilst looking after patients and taking charge of the ward. The pressure was constant and they had no let up or time to think and reflect on what they were doing.

Success as seen by E and F grades

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

How were they learning?

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

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

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

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

practice once they were back on the wards. The lack of follow through once seniors had attended meant it was very difficult for them to change anything.

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

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

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

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

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

Support for E and F grades to manage their roles

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

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

ACTION POINTS

- There needs to be more open and honest communication between senior management and ward staff, so actively listening to each other

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

Support for Professional Development

E grades:

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

F Grades:

None of the F grades mentioned having a mentor, although one said she would have liked one when she became an F grade. There was also the question of who was in the best position to provide feedback to seniors if they rarely worked with other seniors. The transition into the F grade role was largely unsupported by an adequate induction period. The F grades felt confident clinically but their managerial knowledge and skills were often assumed. The Fs, who were supported professionally, had been enabled to develop themselves gradually over time with support and guidance from their ward manager and other seniors on the ward. they needed to be proactive and seek out their own learning opportunities; they could not necessarily rely on a senior to do it for them. There was also the issue of the Trust being able to facilitate the development of senior F grades, since once they had reached a certain level of seniority, the only avenues open to them seemed to be a ward manager or a specialist role. There seemed to be no knowledge of how the Trust was encouraging seniors to stay on the wards and maintain their expertise.

ACTION POINTS

- For senior staff to have a yearly appraisal
- For senior staff to have regular, constructive feedback about their performance
- The purpose of appraisals needs to be clarified, so that staff know exactly what should be discussed
- There is a need to clarify who is in the best position to appraise seniors
- There is a need for seniors to work with a more experienced colleague on occasions, so as to receive feedback on their performance and enable them to improve their practice
- For senior management to develop a structured induction programme of support for those in transition, so from E to F (senior band 5 to band 6) and F to G (band 6 to band 7), ideally with a mentor, and a period of supernumerary status so as to shadow a senior and learn more about the role

- The Trust to encourage a culture whereby seniors are proactive themselves and seek out learning opportunities
- For ward managers and senior management to make explicit the learning opportunities the Trust can offer seniors in terms of progressing in their careers
- For senior management to devise strategies to encourage senior staff to stay at ward level but still develop their knowledge and skills, so as to pass on their expertise to juniors.

Contextual factors that affected E and F grade professional development

Factors that affected professional development were:

Personal motivation, being proactive and taking responsibility for developing oneself;
Family circumstances, having the time and energy to commit to a course, for example, when the Es and Fs had young children at home and/or worked part time;
Staffing levels on the ward being poor so as limit access to study time;
Being unable to study in ward time owing to inadequate staffing and busyness of the ward;
Encouragement and support from a senior to study;
Location and availability of courses, especially mandatory days which were often oversubscribed;
Current financial status of the Trust since staff education was not seen as a priority;
Access to study leave which varied from ward to ward and also in terms of funding and time allowed to study;
Lack of a structured teaching programme for all staff on the wards;
Logistical difficulties in accessing information for example, being able to contact the IT department for a computer password.
Attending E and F grade away days was also another factor. Only 3 E grades had attended an away day, but all 12 of the F grades had been to one or more F away day. The away days were perceived as useful, but attendance was becoming more difficult because of poor staffing levels on the wards. F grades felt that the nature of the away days had also changed to concentrate more on performance targets and Essence of Care issues, as opposed to everyday clinical and managerial issues that they faced and wanted to change.
E and F grade development programmes access: three E grades had heard of such a programme but none had attended. 11 of the Fs were not aware of a designated F grade development programme. One F said she had attended one day on such a programme but this 'fizzled out' after that session.
Part-time working: of the 21 E and F grades, 8 worked part-time and this was mainly because they had a young family. Those who worked part-time often had fewer responsibilities at work, which seemed to be because they had different shift patterns and worked different hours from their full time colleagues. Part-time workers often felt less involved and up to date with current ward issues which made them feel isolated at times. Working part time also had implications for establishing relationships with medical colleagues and other professionals. The overall impression was that part-time workers had come to expect less than their full-time colleagues in terms of professional development. Full-time work was perceived as equating with showing a commitment to the ward, whereas if a nurse worked part-time, it was perceived that their commitment was to their family and not the ward, and indeed the majority of part-time workers had

put their career development on hold until their children were older. But on the whole, the part-time workers were satisfied with their professional development. They felt that they had been afforded opportunities to develop if they had wanted to, and their ward managers had been flexible and supportive of them in doing so.

ACTION POINTS

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

Career Motivation and Intentions

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

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

Support from senior management for those who acted up and were then demoted was poor, as was support during the acting up period in general. It was very much left to the individual to find and develop their own support network, as opposed to a structured

support network being in place for everyone. Two of the Fs were demotivated and had lost interest in their work. What was the Trust doing to recognise this and encourage senior people with extensive knowledge and experience to stay?

ACTION POINTS

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

Support for training and development needs

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

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

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

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

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

Es and Fs would like **teaching on human resources**, such as capability and disciplinary procedures; 'tips of the trade' type sessions on for example, how to write an

off duty or coordinate the ward; people management skills, such as conflict resolution; financial planning and budgets; IT knowledge and skills and using them in practice.

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

ACTION POINTS

- For senior management to make role expectations and responsibilities more explicit, from ward level staff up to senior management
- For improved communication between ward staff and senior management
- The development of an in-house, rolling teaching programme aimed at all ward staff, and devised and constructed by in-house staff. Sessions could operate on a rotational basis so as to reach as many staff as possible. Responsibility for giving teaching sessions could be shared between ward areas so that for example, staff on one ward could teach for a month before passing on responsibility to another ward in the same division.
- For Trust policies on study leave allocation and funding to be made explicit to ward staff, so that staff know what they are entitled to. Also for senior management to operate a consistent approach to study leave allocation and funding, so that staff feel they are being treated fairly and have the same opportunities for studying on one ward as they would for example, on another. If this is not possible, then the reasons why it is not possible need to be communicated honestly and openly to ward staff.
- For senior management to be consistent in the study days and courses that it offers staff and think of contingency plans to deliver such training when in times of financial hardship. For example how can they provide training when they are over budget? Also for senior management to be honest and tell staff what is possible to achieve and what is not possible. Maybe asking for help from staff as to what they can do would create a sense of unity in trying to solve the problem.
- For awareness of E and F grade away days to be promoted, especially for E grades as their knowledge of such days was patchy. For Es and Fs to have more of an input into the away day structure and agenda, so as to promote ownership of the days. Fs would like the away days to discuss more day to day clinical issues, as opposed to focussing solely on performance targets, so for example, how they could change and improve practices in their ward area. Fs would also like those who run away days, to follow through issues raised with actions, so that for example, they provide practical support for changing ward practices.
- Senior management need to develop new ways of delivering study sessions so as to limit the time that staff spend away from the ward. For example, ward based, mandatory update sessions during the handover period or amalgamating mandatory training sessions so that 3 updates could be achieved in one day
- For senior management to develop theoretical and practical study sessions on issues relevant to everyday practice such as human resource issues, writing the off duty, coordinating the ward, managing people and conflict, financial planning and budgets, developing IT skills
- Senior management to devise ways to help wards deal with their administrative pressures, so as to free up nurses' time to deliver patient care

- For senior management to help ward managers and their teams to think about how they organise their time and structure their shifts, so they can make changes to improve their working lives. For example, enabling seniors to make time to meet and discuss practice issues together
- For senior management to develop a structured induction programme of support for those in transition, so from E to F (senior band 5 to band 6) and F to G (band 6 to band 7)
- For senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that career progression is less fragmented and seen as more of a continuous process.

IV.

WARD MANAGERS

The Managers' Perspective on support and development

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

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

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

Relationship with senior management: ward managers wanted to see more of their senior managers to improve communication and understand each others' point of view. Decisions made by seniors resulted in actions at ward level which the ward manager was then responsible for but may not have approved. Senior managers who listened were seen as supportive, but ward managers felt there was a lack of positive feedback. Ward managers also felt that they would have more respect for senior management if they were more honest and upfront with them about the reasons behind some of their actions. There was a perceived blurring of management roles and responsibilities. Ward managers thought they had less authority now but more was expected of them on performance targets. They were saddened by the impersonal relationship with senior managers with the prevalence of communication by email.

Development: most ward managers started their roles without specific training, relying on informal advice from peers and trial and error. They would have liked help on how to read and understand budgets, personnel issues and monitoring sickness rates. Some

had subsequently been to training sessions but not others; they gave their staff priority for course attendance. The RCN course on leadership had enabled some to develop support networks. Staff appraisal was patchy or non-existent. Appraisal was seen as focussed on meeting targets and not personal development. Some found support was there if they asked questions; others felt isolated and out on a limb. The G grade away days could be good for networking but sometimes were seen as overly critical and negative. Administrative help would ease workload.

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

ACTION POINTS

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

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

The Senior Managers' Perspectives on support and development

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

Succession planning was key to preparing staff for their next roles. However senior managers were aware that development programmes needed to be put in place for

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

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

Support for Ward Managers to aid learning

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

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

ACTION POINTS

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

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

V.

CONCLUSIONS

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

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

1. Development within a role

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

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

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

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

2. Succession Planning

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

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

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

3. Feedback and support in higher grade roles

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

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

Support should be a cascade effect in that the G supports the Fs, the Fs support the Es etc., and senior management within the Trust should facilitate this. However the pressures of work have contributed to a reduction in people's ability to contribute to their collective responsibility, perhaps as a form of protection against further stress. How can stress be best managed within the Trust? There is sometimes a cultural resistance in nursing to acknowledging stress formally where nurses feel they must show that they are coping. There is a need to promote self awareness and teach practical ways to handle

stress, as well as addressing some of the factors that are causing it. For example, staff felt that more and franker communication with senior managers would help them to understand the reasons for decisions more clearly. This may seem counter intuitive to some senior managers given the amount that those on the wards are already having to deal with and the difficulty of some decisions being made. Other contributors to reducing stress, such as recreational facilities and space for staff to relax might be one way of showing staff that they are valued.

4. Clinical expertise, leadership skills and management skills

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

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

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

Conclusion
The research findings have confirmed the view of the LiNEA Steering Group that there is a need to consider staff development for nurses as a more continuous and supported process. Since the inception of the research, competition for stretched resources has increased even further in NHS Trusts, with a serious impact on available posts, particularly for recently qualified nurses. In these circumstances, it is more than ever vital to develop the skills of staff rapidly and effectively and to retain them in the Service. The data have shown what staff themselves, from newly qualified to senior managers, see from their experience would make the difference to their development. The career planning and support in order to move to the next stages of learning and progression to

management roles have been found to be non-existent at worst and haphazard and fragmented in many cases. This is of concern at all levels: to nurses, who need to be more forward looking and proactive about what they want to do and in seeking development opportunities; to their managers in making sure staff have equal access to development opportunities and have involved their team in learning with succession planning in mind; and to senior managers, who were aware of many of the difficulties and development needs faced by staff, although this did not necessarily communicate itself to those staff.

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

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

SECTION I

RESEARCH BACKGROUND

Introduction

The aim of the research described in this report was to examine the learning, support and development needs of nurses, from those who are newly qualified, to those in ward management roles. The research evidence was grounded in the work place experiences of nurses and has built upon a previous project, Learning in Nursing, Engineering and Accountancy (the LiNEA Project), carried out by the Universities of Sussex and Brighton, which studied learning in newly qualified nurses. The present research:
:

1) Evaluates initiatives to support newly qualified nurses (NQNs), which were developed by the BSUH Trust, based on findings from the LiNEA Project.

2) Extends research into the learning and support needs of nurses as they progress to higher grades E and F[1].

3) Examines the support and development needs of ward managers.

4) Identifies the key aspects of support and development to enhance retention and development of nurses, further satisfaction with existing roles and to facilitate transition to management roles.

This report is in five Sections.
Section I:
The background to the research and the LiNEA Project on which it is founded;
The Trust's development of the findings of the LiNEA Interim Report;
Establishment of the LiNEA-**R** Project and the methods used to conduct further research to extend the findings.

Section II:
The survey of newly qualified nurses
The evaluation of the Trust initiatives for newly qualified nurses.

Section III:
Support and development issues for senior nurses.

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[1] Nurses in the research sample refer to these grades. They have now been replaced by the banding system following implementation of the Department of Health's *Agenda for Change.* Senior Es are now 'senior band 5'; Fs -junior and senior are 'band 6' and Gs and Hs are 'band 7'.

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Section IV:
Support and development needs of ward managers.

Section V
Discussion and overview.

To provide concise overviews of data, 'Summary Points' are given within Sections III and IV. 'Action Points', to indicate areas relevant to a development programme, are given within sections II, III and IV.

Background

> 'Clinical effectiveness and cost efficiency are attributable in no small part to the way in which nurses are organised, deployed and practice'.
> *Towards a Strategy for Nursing Research and Development: proposals for Action* Department of Health, 2000, p.1.

For many years the NHS has experienced substantial difficulties in recruiting into the nursing profession and in retaining existing nursing staff. During 2005-6, the employment situation has changed nationally, with a sharp decrease in available posts for clinical staff resulting from the budget deficits in a number of NHS Trusts. This can be seen as increasing the need to support and develop existing staff to meet the current challenges.

Newly qualified nurses

The impetus for the present research was the lack of evidence about learning in the workplace and particularly about how newly qualified staff make the transition from being a student and progress their learning to adapt to the demands of work. There is evidence that attrition rates are highest among newly qualified nurses (Gardner 1992; Shields & Ward 2001). A number of research studies have shown that the early stages of a nurse's career are often the most difficult and that the change from student to staff nurse creates professional and personal conflicts and role stress (Kramer 1974; Kelly 1991; Maben & Macleod Clark 1998). In recognition of the problems that newly qualified nurses face, the UKCC (1999) recommended that they should have a period of induction and preceptorship when they start work. However the nature and provision of such support schemes has been shown to be variable (Bick 2000) and the efficacy of preceptorship programmes contradictory and inconsistent (Bain 1996). Given the well documented acute shortage of trained nursing staff (e.g. Shields & Ward 2001) it is essential that newly qualified nurses learn to practice efficiently as soon as possible. The time of experienced staff to support them is also constrained and it becomes even more important to focus that time effectively on the key learning needs of new recruits. However, the learning experiences of newly qualified nurses have been largely neglected in the literature in favour of studies of students. This is somewhat surprising given that the nature of induction into the clinical environment has far reaching implications for the retention and rate of development of newly qualified nurses. Furthermore, facilitating the progress of these nurses towards nursing team management and increased responsibilities is part of their development. The revision of the former grading structure into the new banding system as part of the Department of Health's *Agenda for Change* (1999), contains commitments to planned staff

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development. This makes the need for a longer term, research based understanding of the learning needs of nurses imperative if they are to be retained and appropriately supported in their development. This was confirmed by a large scale study of nurses' job satisfaction on intentions to quit the profession:

> 'Satisfaction with respect to 13 aspects of their job, shows that demoralisation linked to poor career advancement opportunities, increased workload, pay and workplace relations are all important in determining quitting outcomes, but that *dissatisfaction with career advancement opportunities has the largest quantitative effect* [our emphasis].' Shields M and Ward M (2001) p.697

The transition into more senior management roles

The literature concerning the support and development needs of nurses as they move into management roles is patchy. What is available, centres mainly on G grade, ward manager level as opposed to senior E and F grade roles. However two recent studies have looked at the preparation for management of F grade nurses and ward managers. Cooper (1996) found that F grade nurses were primarily managers and givers of patient care and that they performed their managerial function by working alongside, supervising and guiding junior nurses. However when they became F grades, they were not prepared for ward management despite being able to perform competently in their clinical role. In terms of the training needs of clinical nurse managers, Gould *et al* (2001) found similarities to the study mentioned above. For example nurse managers appeared to feel clinically competent but generally experienced lack of confidence when dealing with human resource issues, managing budgets, deputising for senior colleagues across the trust and using information technology skills in everyday practice.

Recently, there has been a great deal of investment to develop leadership in the NHS, in order to fulfil the aims of the NHS Plan (DoH 2000a). The RCN Clinical Leadership Programme that runs over an 18 month period was set up in 1994, to help nurses in leadership positions improve the quality of patient care. In a recent evaluation of this programme, Cunningham and Kitson (2000a, b) found there was a need for more clinical leadership development for nurses in the areas of managing self, managing the team, patient centred care, networking, and becoming more politically aware. The LEO (Leading Empowered Organisations) programme is another course aimed at developing leadership capability in the NHS. This is a 3 day course designed for health care professionals from all disciplines and with differing levels of experience and expertise (Hewison and Griffiths 2004). The programme aims to improve relationship management and develop problem solving and risk taking skills, to help staff examine what works and what does not work in their leadership behaviours with other staff (Tremblay and Dunn 2002). A regional evaluation of the LEO course, carried out by Werrett et al (2002) in the West Midlands, found that participants viewed the programme as useful, but few were able to report a specific example of the impact the programme had on their delivery of clinical care. A national evaluation of LEO, found that the programme was popular with participants because they enjoyed the time out from work and the opportunity to network with staff from a wide variety of disciplines; however the impact of attending the course on their practice was not so evident (Faugier and Woolnough 2003). When staff were asked their perceptions of their own organisation's approach to leadership development, the majority described their organisations as 'machines' in which leadership felt driven by senior management to establish order and control and staff felt like 'cogs in a wheel'.

The challenges of adapting to the workplace and of learning to take on more responsibilities, are faced by novice staff in many settings in service and commercial industries. However, the particular contexts can determine how the challenges are experienced and therefore the best ways to support and develop staff. This was why the LiNEA research, described below, focused on gaining an understanding of how staff experienced their work and saw them in their practice environments. From this, evidence emerged of their learning on the job and how this might be made more effective.

Learning in Nursing, Engineering and Accountancy (LiNEA) Project

This Project was the foundation for the current research and from which the Trust developed various initiatives. The research was carried out by Brighton and Sussex Universities, funded by the Economic and Social Research Council, as part of a large national programme which aims to have high impact and clear user involvement. The LiNEA Project focussed specifically on learning in the workplace. It studied samples of newly qualified nurses, newly graduated engineers and trainee accountants, and their managers/mentors. The employers collaborating in the Nursing sector were local Trusts, amongst whom were the former Brighton Health Care and Mid Downs Trusts, now Brighton and Sussex University Hospitals NHS Trust.

The aims of the whole project were: to identify what was being learned in the workplace, how it was being learned, the factors affecting the level and direction of learning, as well as the use and extension of prior knowledge and generic skills brought into employment from higher education and other life experience.

The objectives were to contribute to evidence-based practice in the management and support of newly qualified employees; to further knowledge of learning in practice in the workplace; and to develop understanding of the transition from higher education into employment.

The research involved:
1. Observation of newly qualified nurses at work in the wards and interviews with them, their managers and preceptors/mentors. There were four workplace visits to each nurse over a three-year period. (Similar studies of the trainee accountants and newly graduated engineers were also done, but this summary refers only to the nursing sector).

   40 newly qualified nurses were observed and interviewed in their workplace. The visits during the first 2 years of the newly qualified nurses' employment led to an Interim Report, which was sent to our partner NHS Trusts for discussion. The Report recommended areas where support for novices could be improved and the Project team offered to evaluate any changes in such learning support systems that a Trust wanted to take forward as action research.

2. An action research project was implemented in the 3rd and 4th years of the study, in collaboration with employers, building on the findings of the fieldwork. This stage

involved visiting a new sample of novices who were going through the changes resulting from the action research.

Theory and Methodology

Eraut *et al*'s (1998) study of mid-career professionals, including nurses, provided a conceptual and methodological platform for this research. The project's methodology addressed the problems of accessing information on what people need to know at work. Chief among these problems are:

- Only knowledge acquired in formal educational settings is easily brought to mind, articulated and discussed;
- Tacit, personal knowledge and the skills essential for work performance tend to be taken for granted and omitted from accounts;
- Often the most important workplace tasks and problems require an integrated use of several different kinds of knowledge, and the integration of those components is itself a tacit process.

These constraints affect people's awareness of learning and their ability to recognise and articulate their personal knowledge and understanding which enables them to think and perform at work. Therefore, the more researchers are able to ground conversations with informants in the actuality of daily working life (tasks, relationships, situational understandings, implicit theories etc), the greater the chance of eliciting information about the full range of what is being learned, how it is learnt, and the factors which affect learning, especially the informal learning of key skills such as team working (Miller *et al.*2001).

Summary of Findings

The findings were detailed in the Interim Report and sent to our partner Trusts, of which the following are the main headings from which recommendations were derived:

1. **The transition from student to staff nurse** was typically seen by newly qualified nurses as being 'massive'. At the start of their ward experience they recounted four main areas of concern: striving to achieve tasks, such as technical tasks like drug rounds; being accountable and responsible; 'doing everything'; and getting to know new people and equipment.

2. **Induction processes and support** varied enormously: at ward level, in staff development programme provision, allocation of supernumerary status, use of competency booklets, allocation of preceptor/mentor and feedback on performance. How well the newly qualified nurses settled into their role was largely dependent on how supported they felt.

3. **Key elements of the Preceptor/Mentor role**, which enabled the novice to settle in more quickly were identified.

4. **Feedback on performance** was essential in influencing how well supported novices felt.

5. **Learning to prioritise** is a key aspect of nursing activity and managers agreed on its importance, yet it was a skill that few NQNs seemed to have on qualifying and was an important part of their further development.

6. **Delegation** had to be learned by novices who start by feeling that they should be 'doing everything' and completing all of the tasks that they see have to be done.

7. **Learning skills** adopted by novices included asking questions, practising skills, using trial and error, demonstration, teaching others such as students, reflecting, and attending study days and courses.

8. **Being given appropriately challenging work** also determined how the novices learned.

9. **Being actively encouraged to question practice** enabled the novices to develop their confidence and use their own clinical judgement in situations.

10. **Doubting their abilities and a crisis of confidence** occurred in a significant proportion of novices at between four to six months into their first post.

The findings were presented to employers as an Interim Report for each sector. Provision was made in the research programme for a further 'action research' element in which any developments introduced for newly qualified staff as a result of the research findings could be evaluated as part of the research. The Interim Report was enthusiastically received by the BSUH Trust and they collaborated in the following further stage of development and research.

The Trust's Developments of the Research Findings

The Director of Nursing invited a senior practice nurse, Caroline Davies, to act on the research findings and the Trust LiNEA Steering Group was formed in response. This collaboration between the Trust and the Project team resulted in six initiatives being implemented to improve learning support systems for newly qualified nurses. The Action Research Phase then started[2], which involved interviewing a new pilot sample of newly qualified nurses, who were experiencing the changes resulting from the implementation of the 6 initiatives. The 6 initiatives were:

1. **'The Nurse as a Professional Practitioner: Preparation for Role Transition': A 'Trust Day' for student nurses** - The Trust had linked with the University to develop a day specifically designed to support the transition of third year students into work, which took place during their final module prior to qualification. This included an overview of: the LiNEA Project; the Nursing and Midwifery Strategy for the Trust; career opportunities for nurses and job availability within the Trust; training and development opportunities; Personnel support; career journeys – senior nurses describing their experiences of role

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[2] Catherine Caballero was recruited to the research team and she and Claire Blackman carried out the interviews.

progression; Directorate workshops and a placement learning pathway for Placement 8 (Management Placement).

2. **A 'Nurturing the Novice Day'** – this was a study day aimed specifically at supporting the mentors of newly qualified nurses. The day included an overview of the LiNEA Project; teaching specific skills found to be problematic to novices i.e. delegation and prioritising; initial experiences of newly qualified nurses – a group of novices shared with the mentors their experiences of being new; how learning could be facilitated in practice; and how mentors would like to be perceived.

3. **An 'Induction Day' for newly qualified nurses** – this was devised for novices to meet each other and address some of the issues in the LiNEA Project. The day consisted of: an overview of the LiNEA Project; the challenges facing newly qualified nurses; delegating and prioritising skills; opportunities for training and development; career journeys and mentorship.

4. **The development of Competencies** – was devised to clarify what their managers expect of newly qualified nurses when they start work and to give them a set of targets to work towards. These were devised in line with *Agenda for Change* and were to be discussed and reviewed by mentors.

5. **The development of 'Action Learning Sets'** – was devised to provide structured discussion sessions, away from the ward, with an experienced nurse as facilitator for newly qualified nurses to discuss their experiences with their peers. This followed the research finding that such groups were helpful.

6. **The development of a 'Rotational Programme' for NQNs** – was instigated following feedback from local nursing students that this would benefit their development. The aim was to develop clinically skilled, experienced and flexible practitioners who, at the end of their Programme, would be sufficiently competent and confident to take on a more senior role within the workforce. The pilot Rotational Programme was started with 3 NQNs in June 2005 and was made up of three separate placements of 6 months. Each placement was of a different nursing speciality i.e. medical, surgical and specialist environments with the third placement including a management component, to aid in the preparation of NQNs for promotion.

The action research to evaluate these programmes during the final part of the LiNEA Project (2004-5) showed some very positive results in terms of improved provision for NQNs. But some of the initiatives were still evolving, e.g. the competencies and the Rotational Programme, while others were still bedding in and needed further evaluation with a larger sample size. Furthermore, the Steering Group saw the potential for a longer-term programme of support and development for nurses from newly qualified status towards more responsibility (progression from D-E-F-G grades). The LiNEA Project had shown that there was further evolution in learning as the nurses became responsible for teams and wider roles in ward management. They wished to take this forward, but further research and evaluation were beyond the end date of the LiNEA Project of June 2005. A research proposal was therefore submitted for a BSUH Medical School Research and Development grant by the researchers at Brighton University involved in the nursing sector of the LiNEA Project, in consultation with the Steering Group. The aim of this research was to enable the Steering Group to continue collaboration with the nursing research team so as to gain more data about:

1) the effectiveness of their six initiatives on the experiences of newly qualified nurses;
2) the learning challenges experienced by nurses as they take on management roles.

This would provide evidence for the Trust to develop an evidence-based, long term, career support programme to enable staff to develop their roles effectively and confidently. The methods for this are discussed below. The funding was for one year and the project entitled LiNEA-**R,** to indicate its derivation from LiNEA and with the 'R' signifying the purpose of enhancing **r**etention of nurses.

Methods

The research had four stages, each of which produced new data to contribute to a generalisable career development programme for nurse progression.

1. **A survey** of newly qualified nurses was carried out across the Trust hospitals. At present the Trust is not able to track NQNs (in common with many other Trusts, as the LiNEA research showed). The survey provided base line information that targeted the NQNs at the start of their career. This enabled a sample of NQNs to be identified for the next stage of the research. The content of the questionnaire was produced in collaboration with the HR personnel who were part of the LiNEA-**R** Steering Group. Base line information covered aspects such as NQNs' nurse training qualification (degree/diploma) and branch (adult/child/mental health/learning disabilities), their nurse training institute/college/university, the date they qualified, why they chose to work at this particular Trust, current place of work and length of time in the new post. HR personnel posted the survey, along with their contract of employment, to NQNs before they started work. 14 NQNs (out of the 22 attending) completed the survey at an NQN Induction Day and another 11 returned the survey via Personnel. This gave a total of 25 NQNs who completed and returned the survey.

2. **Systematic follow-up of pairs of mentors and NQNs** pursuing the learning support initiatives set up by the Trust was undertaken. This aimed to interview NQNs and their mentor, the idea being that pairs would be matched, so that every pair of mentors and NQNs had attended the relevant training days and undertook to follow through the LiNEA recommendations. The pairs were interviewed separately to see whether the learning experiences of the NQNs had been facilitated by the initiatives.

   The sample of NQNs for this stage of the research came from those who had completed the survey. The names of 2 NQNs who had not attended the NQN Induction Day were also given by their ward manager. NQNs were contacted via telephone and invited for interview. A total of 17 NQNs were interviewed, which included all 3 NQNs on the Rotational Programme. The sample of NQNs obtained from the LiNEA Action Research phase of the study (interviewed in 2004) was also added to give a total sample of 28 NQNs. The total number of mentors interviewed for the evaluation, including those from the Action Research phase, was 10. We thought it useful to include the data from the Action Research phase of the LiNEA evaluation, so as to compare the experiences of NQNs and mentors at 2 different time points.

3. **Monitoring of the Rotational Programme** with the 3 NQNs on the Programme was carried out by interviewing them about their experiences. Two were

interviewed during their first placement and 1 at the beginning of their second placement. Two of the NQNs' mentors were also interviewed about their experiences of being mentors on the Programme.

4. **Data about the learning needs of nurses progressing into management positions.** This involved interviewing and observing in practice senior nurses who were moving from E to F grade (or senior band 5 to junior band 6) and from F to G grade (or senior band 6 to junior band 7). The aim was to recruit 10 nurses at E to F grade and 10 nurses from F to G grade. We also wanted to interview ward managers, modern matrons, care centre managers and general managers about their roles in relation to supporting and developing senior nursing staff. A sample of nurses at these transition points was selected from the Medical and Surgical Directorates in wards across the Trust's hospitals. These Directorates were chosen because they tend to provide a higher turnover of staff and therefore a likely sample at these grades; and secondly, because these Directorates (as opposed to specialist areas) are the most generalisable across other NHS trusts for the dissemination phase of the research.

Letters of introduction were sent to ward managers and senior managers, inviting them to take part in the research. These were followed up with a telephone conversation to answer any questions about the research and to ask whether any nurses at E to F and F to G grade were employed there whom we could invite to take part. Letters were then sent out to these senior nurses inviting them for interview. The sample of nurses who agreed to participate were interviewed about their learning in the context of the new expectations placed on them by the further development of their roles and the learning involved, and how this was being, or could be facilitated. These topics included what they enjoyed about their role and its responsibilities; the knowledge and skills required to do their jobs properly; the challenges of their roles; the support they received in their roles and also in terms of professional development; what made someone successful at their level; formal training they had undertaken for their roles, plus any informal learning opportunities; their thoughts on promotion to the next grade/band and their career intentions.

In total, 9 senior E grade nurses, 12 F grades, 11 ward managers and 10 senior managers were interviewed.

Of the 21 E to F and F to G grade nurses, 19 were also shadowed for half a shift. This was to observe the nature of their roles and to triangulate the data from the interviews. This method had been tried and tested in the LiNEA Project and had proved to work well.

Participants Interviewed

Senior Nurses & Managers		NQNs & Mentors	
Senior Managers		*NQNs*	
General Managers	3	Rotational	3
Care Centre Managers	3	Non-Rotational	14
Modern Matrons	4	From LiNEA Action Research	11

Total	**10**	**Total**	**28**
Ward Managers		**Mentors**	
H grades	2	From LiNEA-R	6
Senior G grades	7	From LiNEA Action Research	4
Junior G grades	2		
Total	**11**	**Total**	**10**
F grades			
Senior F grades	7		
Junior F grades	5		
Total	**12**		
E grades			
Senior E grades	9		
Total	**9**		
Total Participants	**42**	**Total Participants**	**38**

Data Analysis

The data were analysed using the qualitative analysis package NVivo. Interviews were transcribed and coded into categories that reflected the learning experiences and stages of the nurses' learning. From this data the learning needs were derived. For example, in the previous research, NQNs expressed their concerns in the interviews about the difficulties they had in prioritising care for their patients, and this was verified in the observations. Help and support could then be focussed on addressing prioritisation needs so that nurses could move forward more rapidly and confidently. For the NQN and mentor pairs, the expectations of mentors and their understandings about NQNs' progress were also analysed in the context of their having attended the Trust's training days and the nature of the ensuing mentor support.

The data categories derived from the interviews at the transition points from E to F and from F to G grades were supplemented by the observations of senior nurses in practice. Together they highlight the specific learning challenges as seen by the nurses as they took on new responsibilities.

Ethical Approval

The research capitalised on the work that was already done in gaining Multi- centre Research Ethics Committee (MREC) ethical approval for the LiNEA Project, as the methods were the same. An application was made for a new sample of nurses as an addition to the original proposal. This request was met by MREC and meant that the research got underway speedily so as to take full advantage of the year's funding.

All data were anonymised, given a code name and stored securely. Participants were assured that no-one would be identified in reporting the findings.

SECTION II

NEWLY QUALIFIED NURSES

This Section is in two parts. It discusses the findings from 1) the survey of newly qualified nurses (NQNs) and 2) the evaluation of the six initiatives put in place by the Trust to support NQNs and mentors.

The NQN Survey

As noted in the Methods section of this report, the original LiNEA research identified that the Trust, in common with many others, was not equipped to track NQNs as they progressed. Thus accurate information as to where NQNs were working was not routinely collected and so NQNs could potentially slip through the system. As the first 6 months of a NQN's career is often the hardest, it would be prudent therefore, for trusts to monitor their progress and support needs. Hence the aim of conducting the survey was:

1. To collect basic demographic information about NQNs so as to establish an accurate database of all NQNs who start work for the Trust;
2. To show NQNs that the Trust, as their employer, was interested in their professional development;
3. To help the Trust keep track of NQNs' progress, so as to identify whether their support and development needs were being met; and
4. To identify where changes could be made to improve the support that NQNs receive.

The research team also aimed to follow up the survey a few months after it had been completed, with a face-to-face interview so as to see how the NQNs were progressing in their new jobs. Due to time constraints the whole sample of NQNs who completed the survey could not be followed up, so a sample was selected and interviewed about their experiences so far.

Participants Surveyed

	Number of Participants		Number of Participants
Gender		*Ethnicity*	
Male	**3**	White British	**22**
Female	**22**	White Other	**2**
Age		Black British/African	**1**
21-30	**15**	*Nursing Course*	
31-40	**6**	Local University	**15**
41-50	**4**	Other University	**10**
Marital Status		*Branch*	
Single	**12**	Adult	**23**

Married	4	Child	1
Living with partner	6	Midwifery	1
Living with partner/Divorced	2	*Nursing Qualification*	
Widowed	1	Diploma	22
Children		Degree	3
None	20	*Training Funded*	
0-4yrs old	1	Seconded	6
5-11yrs old	3	Bursary funded	18
12-18yrs old	3	Self funded	1
Current Workplace		*Hours Working*	
Surgical ward	9	Full time 37.5	22
Medical ward	9	Part time 22.5	1
Bank/agency work	2	Variable	2
Other	5		

The sample data give an idea of the 'typical' NQN who chooses to work for the Trust. As can be seen, this is typically a female, aged between 21-30, single, with no children, of white, British origin, and who was bursary funded, trained locally to receive a Diploma in adult nursing and who works full time in either a medical or surgical ward.

The NQNs were also asked in the survey why they had chosen the Trust as an employer. Ten of the NQNs said that their choice was because they had trained in the local area and university:

> '*I studied in [name of local area] and liked it*'

> '*I like [name of local area] and feel familiar with the Trust*'

Five NQNs had been seconded by the Trust which is why they returned to work there:

> '*I'm contracted to go back for a year*'

> '*I felt obliged to return and give something back to the Trust*'

Eight of the NQNs said that the Trust was close to home or they enjoyed living in the local area:

> '*It's close to where I live*'

> '*I just wanted to stay living in [name of local area] for a while longer*'

Other reasons given related to 'broadening knowledge' and a 'personal interest in the field of nursing' they had chosen. The reputation of the wards and the Trust was also a factor:

> '*The ward has a good reputation for training and development*'

> '*To work for a Trust that has a good reputation and is linked to a Uni that offers good educational opportunities*'.

Conclusions from the survey

The survey was useful in identifying:
- Demographic characteristics of NQNs attracted to working for the Trust; and
- A sample of NQNs that could be followed up for the interview phase of the research.

But in order for the Trust to establish an accurate database of NQNs who start work for the Trust, this type of survey needs to be targeted at and include all NQNs, as opposed to a self- selected sample of NQNs. This survey was voluntary and so only those NQNs who chose to fill in the survey did so. This meant that the data collected was biased towards those who were interested in taking part in the research. But what about those NQNs who were missed, who did not want to fill in the survey? We have no demographic information about these NQNs and their support and development needs.

There is also a need to follow up those NQNs who completed the survey but because of time constraints within the research project, were not interviewed. Were they left wondering what happened to that initial interest that the Trust showed in them when they first started work?

As we have said, one of the aims of the survey was to show NQNs that the Trust, as their employer, was interested in their professional development. However we have no evidence to suggest that this is how the survey was perceived by NQNs. Certainly those who completed the survey did so willingly and seemed happy to be interviewed at a later date. Anecdotal data implies that the NQNs felt that taking part in the LiNEA-**R** Project was useful, as one NQN on the Rotational Programme said when she was interviewed after completing the survey:

> '...I actually feel quite special...I don't mind doing it and it's quite helpful I think...'

Yet those who did not take part may have seen the survey as just another piece of paper to fill in, especially as the NQNs had already provided demographic information on their job application forms.

There is no doubt that the Trust needs to collect data such as this about their employees routinely, but the question is whether a separate survey is the most efficient and appropriate method of achieving this. In order for the Trust to track their workforce accurately, the response rate to such a survey needs to be 100%, so that all NQNs are included in the evaluation of their support and development needs.

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

Evaluation of the Six Initiatives for NQNs

As described in Section I, six initiatives were developed by the Trust in order to support NQNs in practice. As noted in the Methods section, 11 NQNs and 4 mentors were interviewed for the Action Research phase of the LiNEA Project in 2004, and 17 NQNs and 6 mentors were interviewed during 2005-6 in this LiNEA-**R** Project. The findings for each initiative will be discussed in turn.

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

The content of this Day for final year students was evaluated as a rolling programme by members of the LiNEA Steering Group, and therefore the following refers only to the impact of this Day in relation to our interview data. There is limited data because not all of our sample remembered the Day and in addition, not all were trained at the Trust and therefore would not have been exposed to the Day as student nurses.

Overall the 'Trust Day' was found to be of value as the students had the opportunity to listen to senior nurses in the Trust describe how they had developed their careers in nursing. The soon to be qualified students were also given advice on how to gain as much general experience as they could at the outset of their careers. This especially rang true for N11[3] as following this advice, she had opted to work in a medical assessment unit for six months before specialising in her area of interest.

The students also valued the chance to hear about other agencies that support patients whilst they are in hospital, such as the chaplaincy and patient support services. However N10 said that, although the talk about career progression from the senior nurses was inspiring, the Trust representatives then went on to say that there were few vacancies. This left her rather disheartened. N10 felt that this could have been better presented rather than painting a picture of "*doom and gloom*".

2. 'Nurturing the Novice Day'

As with the Trust Day for final year students, the 'Nurturing the Novice Day' content has been evaluated separately as a rolling programme by members of the LiNEA Steering Group, and the following discusses the impact of this day in relation to our interview data. The Day was for the support and development of mentors and a number of issues were raised about mentoring from both NQNs and mentors, some of which were positive and others which required improvement. Some of the NQNs (n=7) interviewed, discussed how they were not always allocated mentors, and that if they were, they rarely worked with them. In addition to this they seldom received feedback on their performance. Out of the 10 mentors interviewed, 6 had attended a 'Nurturing the Novice Day'.

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[3] The sample was coded such that each newly qualified nurse was given a number and those contributing to this part of the research were given the letter N. Mentors were also given a number, plus the letter M.

<u>Positive outcomes of the 'Nurturing the Novice Day'</u>

Points 1 and 2 below begin to highlight the importance of structured, facilitated mentorship as a means of assisting in the development of confidence and competence amongst NQNs, whilst points 3 and 4 emphasise how vital constructive feedback is to the development of NQNs.

1. In general the mentors now recognised the importance of ensuring that NQNs had time to discuss their progress. Whereas before they felt they did not have enough time to go through the NQNs' learning needs, they now ensured that time was set aside to enable this to happen. For example: M3 working on a gynaecological ward, said that staff on the ward were now more aware of the need for NQNs to spend protected time with their mentors and that they facilitated this by setting aside half an hour a month for the NQNs and mentors to discuss progress. Although this was minimal, it was an improvement on what NQNs were getting previously. This new understanding led the team to reshape the way in which members worked as, not only did they recognise the need for time out for the NQN, but also for similar time for all team members. The team leader no longer had responsibility for a patient caseload and therefore, if staff needed time out, the team leader had the capacity to care for their patients. This made it possible to interview this particular nurse, as the team leader cared for her patients whilst she was being interviewed.

2. N3 noted how having a structured period of supernumerary status helped her to develop and gain confidence in her area of practice. She started her time in the operating room for the first month by circulating and by being the runner for the scrub nurse. As she became more familiar and comfortable, she then scrubbed for her first case. This was facilitated and supervised by her mentor, and they initiated on the minor cases before progressing her onto the larger more complex surgery. By the end of her second month she was starting to be part of the on call team. This again was facilitated by her mentor who did the 'off duty' and ensured that N3 was allocated to her, not only for the on call shifts but also most shifts. N3 also had two mentors, one who was very experienced in operating room nursing and one who had undergone specific mentorship training.

3. One NQN (N10) discussed how the mentors on her ward who had been on the 'Nurturing the Novice Day' had recognised when she had a 'wobble' (crisis of confidence) at four months in line with expectations, as this was a finding of the main LiNEA Project. As a result, they also supported her through this period of self-doubt.

4. Overall, mentors who had attended the 'Nurturing the Novice Day' did report that as a result they recognised the importance of feedback. Following this, M3 now ensured there was time for NQNs to meet with their mentors for structured feedback sessions. Feedback was identified as being really important to the NQNs, even if they were performing badly; they still needed to have feedback. They found it difficult to judge how they were doing for themselves. Some felt that just a cursory "How are you doing?" or "Ask if you need anything" was not always sufficient. They wanted *structured* feedback so that they knew where they were and what they needed to improve upon. Some said it would be nice if

now and again people would say, "Oh you did that well" or "Well done today, you have really worked hard and you managed it really well". This kind of feedback boosted NQNs' confidence and morale and increased their chance of staying in post, and as such was central to the way in which the NQNs developed confidence in practice.

Structured feedback needed to be seen on a longer term basis too. M8 discussed how monitoring NQNs' progress was very 'hit and miss', and although they had competencies to achieve at various stages of their first year, no one documented their achievements, not even the NQNs themselves. M8 suggested that mentors of NQNs should meet with their NQNs in the first 3 months, then 6 months and at 1 year to discuss progress and competency acquisition, but that this unfortunately did not happen. Therefore feedback, as identified in the original LiNEA Research Project, was generally informal and unstructured, with consequences for the development and confidence of NQNs.

Negative Outcomes of 'Nurturing the Novice Day'

1. A few of the mentors interviewed who had been on the 'Nurturing the Novice Day' felt that, although they carried out some mentoring activities, they did not see themselves as 'real' mentors as they did not possess the mentorship qualification. Therefore, they felt that it was a senior nurse's responsibility to oversee a NQN's progress and not theirs. One mentor interviewed was a key member of staff in relation to mentorship provision on her ward, and yet, she had only just completed the mentorship course. As she had not received her piece of paper to say she had passed this course, she did not class herself as a mentor, but only an associate mentor i.e. one who supports the mentor in practice:

   > 'I still haven't been an actual mentor because I still felt that I shouldn't until I got my results I'm not going to take on extra responsibility …and I feel that until I've actually officially passed then I'm not going to take that role on.' M4

   Nurses' self-perception of whether they were a 'real' mentor or not influenced how seriously they took the 'Nurturing the Novice Day', which had implications for supporting NQNs.

2. The interviews from the LiNEA Action Research showed that mentors and NQNs were not being matched and unfortunately this was also the case in the more recent interviews. Mentors were either not attending the relevant training days, or were attending the 'Nurturing the Novice Day' but not being matched to NQNs. The impact of this was evident when the NQNs discussed their experiences. N14 had such a bad experience of poor mentorship, that she only lasted 3 months in post, as she felt completely unsupported. The problem of lack of support extended into night duty and weekends. NQNs reported, in some instances, good mentor support from Monday to Friday, but when it came to nights and weekends, they were effectively on their own:

   > 'If you're working Monday to Friday in the day you've got hundreds of people you can ask…but with regards to working

nights and weekends you're a bit on your own...there's just no-one else you can speak to ...weekends I find horrible really' N15

<u>Implications of not attending 'Nurturing the Novice Day'</u>

A number of the points raised were negative, but they were not specifically about the 'Nurturing the Novice Day', but were rather a consequence of mentors not attending this training. These comments, which related to supernumerary status and feedback, have been collated below.

1. As identified in the main LiNEA Project, there was still a disparity of mentorship provision. Some NQNs reported that they worked with their mentors all the time, whereas others hardly saw them at all. Supernumerary status was often not in line with Nursing and Midwifery Council (NMC) recommendations as it varied greatly from as little as one day to a maximum of six months. It was often reported that, if the NQN had been on the ward as a student, they did not need an induction period including supernumerary status. Many were expected to take full caseloads and responsibilities almost from the outset. This has implications for the development of NQNs' confidence in practice and their ability to remain in the job:

    'I took over my first lot of patients after 3 days, the F grade allocated them to me and I said..."I haven't really done a drug round on my own" and she handed me the keys and came round with me for a couple of patients and that was it. I was very nervous thinking "Oh my goodness what do I do?"...' N14

2. As identified in the main LiNEA Project, NQNs, (such as N1) had typically never received any feedback on her progress and felt unsure of how others perceived her ability. It so happened that on the day the interview was carried out, she had just submitted her notice to leave, and this she attributed to lack of feedback:

    'I've never been told up until today that I was even a good member of staff, so I did not know, I thought I was terrible' N1

3. NQN Induction Day

Meeting others: Most (n=12) of the newly qualified nurses who attended the NQN 'Induction Day' said how useful it was to meet other newly qualified nurses in the Trust. N12 for example:

    'It was quite reassuring and good to network' N12

N9 also recognised the importance of networking with other NQNs, but found the Day disappointing, as she was having only good experiences in her specialist area whereas the majority of NQNs were having difficulties. She felt unable to share her positive experiences since she felt uncomfortable and 'different'. Therefore the Induction Day had limited value for her:

'I just felt very different from the other nurses because their experiences are from the ward and were very different from mine, most of them seemed to have a lot of problems being left alone…and I just don't have that…' N9

Timing: some NQNs felt that the Day was scheduled too late after they started work for them to benefit from it. For example, N24 had her Induction Day when she had been working for some 6 months:

'it was good that they ran it but I think I did it a bit late though…it was 6 months too late for me… it's good that they are aware it's needed…' N24

N17 suggested that although the NQN Day was a good time to discuss anxieties it would be useful to follow them up some 6 months later with another NQN day to see how they were getting on.

Introduction of competencies: N4, N5 and N20 felt that the Day was beneficial because they were given the D grade (junior band 5) competencies. However, they had anxieties about the number of competencies they had to achieve and how they would be completed, especially when they were coupled with speciality specific ones.

Nursing information: N24 felt the NQN Day was good in relation to giving tips on how to organise time as an NQN. However, she felt it sad that the nurses who had come to tell them about their career progression were no longer at the patient's bedside and had all gone into management. She would have preferred to have heard from a senior nurse who was still in regular contact with patients:

'It was good but it could have been better…there was one bit when the people running it told us about their career history and that was very interesting, it's just a shame though that all 4 of them had actually left the actual nursing floor though and were all in normal clothes and at management level, I thought it quite a shame that they couldn't have had another nurse…' N24

As a paediatric nurse, N20 felt that the Day was biased towards adult nursing and as such, raised limited issues in relation to her speciality. However, she acknowledged that it was good to hear that all NQNs have the same general issues even if they trained in another trust.

Value of reflection: N12 noted that the reflection part of the day was useful in enabling the NQNs to take a step back and look at things objectively, in an attempt to find solutions to challenges they faced in daily clinical practice, rather than there just being an opportunity to 'winge'.

Some NQNs who did not attend the Induction Day, gave the following reasons:
    They were unaware of the Induction Day
    They found out about it too late to attend

They were not allowed to attend, as they could not be spared from the clinical environment (N15 & 16).

4. Competencies

1. Statements of competencies were also viewed by the NQNs as extremely valuable. As a result of being provided with a list of competencies, staff who worked in the operating room changed the way in which they facilitated NQNs. In the past, the NQN was given a competency booklet which they worked through at their own pace. This was never looked at by their mentors and no evaluation took place. Since attending the 'Nurturing the Novice Day', M2 now recognised how important it was to have someone to facilitate the NQNs' competency acquisition and to evaluate it at the end of their supernumerary status. This was now recognised by the staff and if competencies were not completed by the end of the supernumerary status, this was extended until they were.

   However there was still evidence that NQNs failed to see the point of undertaking competencies when they were never looked at or signed:

   > 'I don't see the point of them [competencies] …I just don't know how they would ever get filled in really…' N15

   Where competencies were made use of, and effectively facilitated with the mentor, they helped the NQNs to develop confidence in their decision-making and the NQNs also felt that they were achieving something:

   > 'I suppose it's going to give me confidence [completing the competencies] to know that I've cleared that hurdle and that's it, done now, and I know that I can do it, so in that way yeah it's good' N23

2. Access to, and information about, the competency booklet were not consistent. Some NQNs were sent the booklet by HR when they started working for the Trust, whereas others received theirs at the NQN Induction Day. Some were sent the booklet through the internal post and others got theirs via a senior colleague. It was often difficult for their mentors to spend the necessary time with the NQN to go through the competencies, owing to time constraints and lack of information about the purpose of the competency booklet. Mentors who did go through the competencies with their NQNs did so usually in their own time away from the clinical area.

3. Competencies seemed to work best when they were either specific to the area of nursing or were being used along side a Work Based Learning programme (Structured learning on the job). On such a programme, mentors who were familiar with the competencies had been assigned to NQNs. Development and completion of these were seen as integral to the NQN's development.

5. Action Learning Sets

Action Learning Sets were set up to give the NQNs a forum in which to discuss issues that they faced in practice. The Set was facilitated by a senior nurse to help and guide discussion.

The NQNs interviewed in 2004 had attended these forums and they had found them to be beneficial. However of the NQNs interviewed more recently, only those on the Rotational Programme had attended.

<u>Positive views</u>
1. NQNs were reassured that they were not alone in having to deal with the same challenges as other NQNs.

2. N5 in particular felt reassured that senior management were listening to the NQNs' issues during these Action Learning Sets by valuing their contributions and suggestions for changes in practice. However, (N1), although favourable in her comments about Action Learning Sets, noted the lack of follow up in relation to issues raised. This left her feeling that no one was listening to or acting on her comments. This raises the following questions:

   - Is there a need for better clarification of the purpose and function of Action Learning Sets and the responsibility of those involved in them?
   - Do facilitators, although experienced nurses, require further training and support in acting on these kinds of issues?

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

<u>Challenges</u>
1. Some NQNs were unaware of the Action Learning Sets (N12 and N13) or did not really know what an Action Learning Set was, so had not accessed them since qualifying:

   ' What were they, I know we did them once [as a student] but it was just us sitting around a table chatting about our weekends as I recall' N12

2. NQNs also had to attend Action Learning Sets in their own time as they were not built in to the structure of the ward.

6. Rotational posts

Rotational posts were introduced in the Trust to develop clinically skilled, experienced and flexible practitioners who, at the end of their Rotational Programme, would be sufficiently competent and confident to take on a more senior role within the workforce. The pilot Rotational Programme was started with 3 NQNs in June 2005 and was made up of three separate placements, each of 6 months duration, completing in 18 months.

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

1. **A structured induction programme**: consisting of visiting areas linked to the ward and spending time with allied professionals
2. **Education about their area of work**: going through common conditions of the patient group they were caring for, being shown related Anatomy and Physiology e.g. on a model and understanding the rationale behind nursing care for various conditions
3. **Being orientated to the area in which they were working**: especially if they were new to the Trust
4. **Support from a mentor and the nursing team:** was seen by NQNs as essential
5. **Being supervised and assessed clinically in practice**
6. **Receiving regular, constructive feedback** about their capabilities.

Overall, the Rotational Programme received a positive evaluation from all 3 NQNs. Participation in the Programme seemed to ensure the continuation of the learning and training process after qualification, as well as the enhancement of, and/or gaining of competencies. It provided a clearly defined structure for professional development in the initial period of work. One of its major benefits was to instil in its participants an appreciation of the importance of continued lifelong learning and that training is not something that comes to an abrupt end upon qualifying[4].

Mentorship

There were a number of general issues raised about mentorship in the interview data obtained from the mentors of NQNs and discussed below.

Mentorship training

1. A number of the mentors had not undergone any formal training, i.e. the mentor preparation course, in order to become mentors and consequently were under the impression that attendance at an annual update was all that was necessary

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[4] For a more detailed evaluation of the Rotational Programme, please refer to the separate report entitled 'LiNEA Evaluation of the BSUH Pilot Rotational Programme', August 2006, submitted to the Trust's LiNEA Steering Group.

to mentor both students and NQNs. It is a mandatory requirement from the NMC that all mentors will have attended a recognised course, and that following this, they will attend an annual update to ensure they are kept familiar with the training and assessment processes of student nurses/midwives in clinical practice. In their latest circular, the NMC (2006) has named those who provide support for NQNs as 'preceptors' and recognised that, whilst there are no formal qualifications associated with being a preceptor, individuals will need preparation for the role. Therefore nurses who are on the same part of the register and have at least 12 months experience within the same area of practice as the NQN can be preceptors. However the NMC still expect those who undertake the role of preceptor to have completed a mentor or practice teacher programme (or equivalent).

The NMC also strongly recommend that all NQNs have a period of structured support on starting employment. To facilitate this, the NMC suggest that NQNs should have learning time protected in their first year of qualified practice and have access to a preceptor with whom regular meetings are held. This support can be offered by a 'named' preceptor who will facilitate these outcomes, but NQNs can also be supported by the rest of the multi-disciplinary team i.e. 'helpful others'.

2. Those mentors who had never undergone any training were very keen to get some, but were often thwarted by their managers who were unwilling or unable to relieve them from the ward/department due to staff shortages, sickness or a perceived cost implication. The general advice given by the mentors was for them to apply for the course themselves, as no–one was going to do it for them. This encouraged a culture of mentors being more proactive in identifying their own learning needs so as to access training for themselves; yet when senior colleagues were unable to share information about courses, this became difficult.

3. Those who had attended training courses were able to articulate the ways in which it had helped them to understand the implications of the need to fail students who had not met the recommended standard. In addition, attendance on the Mentor Preparation Module highlighted the need to carry out robust assessment to ensure the students could meet the recommended standard upon qualifying. Those mentors who have undergone mentor preparation training, are therefore in a better position to assess NQNs competencies, thus raising the confidence of NQNs and their standard of clinical practice. .

Barriers to Effective Mentorship

1. The overall barrier to effective mentorship was reported to be not having enough time to support the NQNs. Most of the mentors were either senior nurses who would generally be in charge of the ward/department each shift or they were very junior nurses who had had little experience of mentoring or mentorship training. This made it very difficult for senior nurses, as they were meant to be in charge managing the patients' needs and therefore the time spent with the NQN was very limited. For junior inexperienced staff, they were having enough trouble managing their own patient caseload, let alone supporting other learners.

The issue of time was exacerbated by having several learners together. If a mentor was experienced, and had the necessary qualifications, they seemed to be inundated not only with the NQNs, but also with allocated pre-registration students and return to practice students within their clinical environment. Most of the mentors discussed the fact that they had more than one learner at a time and one of the qualified mentors said that they had up to four learners at once and how difficult it was to meet their different needs. The NMC (2006) states that no mentor should support more than three learners in practice at any one time. The aforementioned mentors found managing such a large number had a detrimental effect on their ability to provide adequate support. One mentor (M6) discussed how she coped with this by sharing her learners with other members of the ward team when she could, and by giving the learners days out to other related units/departments to provide different learning opportunities as well as to give her space and time to focus on the patients' needs. This again draws on the 'helpful other' as identified in the main LiNEA Research Project.

2. Mentors identified that effective teaching in clinical practice needed time to organise, research, prepare and deliver. Therefore most teaching was done on an ad hoc basis or was not as structured as it could be for maximum effectiveness. For those who did manage to 'grab' a bit of time, there were constant interruptions, which made any meaningful discussion impossible:

> '...you are just trying to grab time where you can...you never know what the ward is going to be like…if you are together you might have a really busy shift and then...you still won't get to see each other…' M7

3. Another barrier identified was that of mentors not working with NQNs. The 'off duty' can be compiled by nurses other than the mentors themselves, who may well have a different agenda, and consequently mentors and the NQNs for whom they are responsible can be put on different shifts. This process should be easier with students because of their supernumerary status compared with the NQNs, who have a limited period of supernumerary status. However, the ideal for student nurses should be held up as a norm for NQNs as well. There seemed to be a lack of understanding from the rest of the multidisciplinary team about the 'labour' of mentorship and the need for the mentor to spend meaningful time with the mentee to enable effective mentorship to occur. Again, this would imply a need to develop a collegiate approach to mentoring.

Improving the Role of Mentorship in Clinical Practice

Most mentors discussed the need to employ more staff to free them up so that they could spend more time with their learners. However, in the current NHS climate, this is rather unlikely and so it would seem that another solution must be sought. The following were suggested solutions offered by the mentors:

- There was a need to increase the orientation programme, as it was felt that most of this time (usually two weeks supernumerary) was spent visiting other associated wards, departments and specialist colleagues, rather than in the environment in which they were to be staff nurses for the first time. One particular mentor (M8) added that, once these two weeks were up, 'they're expected to get on with it…sink or swim'. Hence the two weeks supernumerary was seen as insufficient for NQNs as they still did not get any real support in undertaking their new role.

- If protected time was introduced to provide time to support NQNs, then this needed to be structured in a manner that prevented interruptions, such as having the nurse in charge take care of patients whilst the mentor and mentee meet.

Support for Mentorship

1. Most mentors identified the need for structured support for themselves, such as protected time for their own development.

2. Even an experienced mentor such as M8 expressed the need for support, especially when dealing with difficult or underachieving students. Most mentors identified that there was little or no structured support for their role and the only type of support they received was either if one of their colleagues occasionally took a student or NQN for them or if they asked for help, in which case they generally got it. However, on a day-to-day basis, the mentors were expected to survive on their own, with little constructive support from managers.

3. Difficulty in obtaining release for mentorship training has already been discussed. Some mentors were not informed of the training opportunities available to them:

    'We don't get a lot [of study days]…we should have a training board where everything that comes through, [the manager] should stick it up there…but [the manager] won't because everything comes out of the budget doesn't it' M5

4. Rarely did mentors have opportunities to discuss their performance as a mentor with others, and this could have an effect on the confidence of the mentor and their continued ability to support NQNs in clinical practice. One mentor (M8) discussed the issue that, as a senior nurse, she could talk to other mentors during F and G grade meetings and through the student link group that happened every 3 months. Yet it was clear that the overwhelming experience of mentors was that there was little support for them in carrying out their role in clinical practice.

Conclusion

It is clear that most of the initiatives have had a positive effect on the experiences of NQN's, however, there still remains a lot of work to be done in relation to ensuring that

both mentors and NQNs are given time to implement these initiatives. As has been outlined the responsibility for all these recommendations lies within the four groups concerned: the NQNs themselves; the mentors; the clinical environments; and the NHS Trusts. The areas for attention are summarised below.

ACTION POINTS

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

Nurturing the Novice Day
In relation to **NQNs**, there is a need:
- To continue to offer this initiative as it is essential for providing positive experiences for NQNs
- To ensure all NQNs are allocated to a mentor who has attended the 'Nurturing the Novice Day'
- For NQNs to be self motivated and take responsibility for their own continued learning opportunities

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

In relation to **clinical environments**, there is a need**:**
- To map the 'off duty' of NQNs with that of their mentors so that NQNs work with mentors as much as possible, including making certain that mentor support is fully available at night and during weekends
- To ensure that not only is collegiate support available when the demands of the clinical environments are reduced, but also to recognise that NQNs need more support in line with pressures resulting from the increased needs of patients
- To identify specific individuals who want to be qualified mentors, rather than them feeling 'forced'; as motivated enthusiastic mentors equal good mentors

- For NQNs to only be allocated mentors who fully understand the need for structured and constructive feedback and the consequence of this on an individual's performance.
- To have strategies in place to support students and NQNs in the absence of their mentor
- To make use of staff appraisal systems to offer regular structured feedback to both NQNs and more experienced colleagues

In relation to **NHS trusts**, there is a need:
- To enforce mandatory attendance at annual mentor updates for qualified mentors as stated by the NMC (2006)
- To ensure all 'preceptors' of NQNs have attended at least a mentor preparation programme, in line with NMC guidelines (NMC 2006)
- To develop a more collegiate approach to mentorship so that 'helpful others' within the multi-disciplinary support the 'preceptors' of NQNs
- To develop a strategy to provide a mechanism for structured feedback for both mentor and mentee
- To respect the supernumerary status of all NQNs and to ensure that all clinical environments view the induction process for NQNs as building upon that which is already in place for students. It seems that not all NQNs are given the required induction when they obtain a post in a clinical area in which they have been a student as it is assumed their existing knowledge of the area is sufficient. There therefore needs to be an additional level of induction to any given clinical area: an induction that focuses on expectations of NQNs, their accountability and responsibilities and the support nurse(s) available to them.
- To make mentorship opportunities explicit for all
- To develop Action Learning Sets/clinical supervision for more senior mentors and all staff for future staff development and succession planning
- For mentors not be in charge of a shift, or if they are, they should not be allocated a patient caseload, in order that they are available to provide support to the team, as well as the NQNs and students
- For strategies to be in place to provide structured cover for protected time so that mentors can effectively support, teach and assess their learner's or learners' progress and competence in clinical practice
- To recognise the strain and personal 'labour' that goes into mentoring
- To develop strategies to deal with the current perceived lack of training opportunities due to financial constraints within the NHS

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

- Reflection needs to be facilitated for NQNs' experiences in order that they might find solutions to problems that may have arisen since they started their post..

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

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

Rotational posts
(For a fuller account of the background to the action points, these should be read in conjunction with the report previously cited: *'LiNEA Evaluation of the BSUH Pilot Rotational Programme'* August 2006).

In relation to **mentor** preparation**:**

- Ensure mentors who are allocated to Rotational Post NQNs, are qualified (i.e. they have attended an NMC recognised mentor preparation module) or are supported by a qualified mentor
- Develop an in-house support programme to ensure mentors understand the paperwork and what is expected of them in their role as mentor to Rotational NQNs
- Ensure mentors who have attended the 'Nurturing the Novice Day' are matched to the NQNs, as only 1 mentor seemed to have been on this day
- Allocate mentors in terms of seniority i.e. senior band 5 or junior band 6, as the more experienced nurse appeared to manage their time more effectively in order

to mentor. Allocating more than 1 mentor with different levels of seniority would help to ensure adequate support for the NQN. However this needs to be done by ensuring each mentor has clearly defined responsibilities to avoid the 'I thought she was doing it' problem

- Having only 1 mentor working part-time has implications for supporting NQNs, they need either 1 full time mentor or more than 1 part-time mentor, but again with clear discussion about sharing responsibilities
- There needs to be a clarification of the expectations of the NQNs and the expectations of the mentors at the start of each placement to avoid unrealistic expectations of both NQN and mentor

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

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

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

In relation to **support:**

- The time spent waiting for the NQN's PIN number to come through from the NMC must be structured in a way that the golden opportunities for learning the role of a staff nurse are not lost in performing only care assistant duties. Supernumerary status should commence once the PIN number is through

- The multi-disciplinary team need to recognise that NQNs do not always feel confident to ask for help when required. Therefore it would be beneficial for them to offer regular support even if the NQN has not asked for it

- The Non-Rotational NQNs need to be supported in a way which complements that received by Rotational NQNs (assuming that not all NQNs will be offered or will take up the offer of the Rotational Programme). This parity may mitigate the current perception that Rotational NQNs receive more support

In relation to **further evaluation:**

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

SECTION III

SENIOR NURSES

This Section refers to nurses at senior E and F grades (subsequently incorporated within bands 5 and 6). The data covers their characteristics, perceptions of their role and responsibilities, their views of the challenges in the role and the successes. These points are interspersed with comments from ward managers as to what they expected of the nurses in their roles. A selection of observations has also been interwoven to give context. This is followed by discussion of how they were learning and their support and professional development.

Characteristics of the sample of E and F grade Nurses

The data described here were derived from interviews with the 9 E and 12 F grade nurses, and observations of 19 of these nurses working in practice.

Senior E grade

	Number of Participants (n=9)		Number of Participants (n=9)
Gender		*Current Workplace*	
Female	8	Medical ward	4
Male	1	Surgical ward	5
Age Group		*Working Hours*	
21-30		Full time	5
31-40	6	Part time	4
41-50	3	*Years in Nursing*	
51-60		≤10years	2
Marital Status		10-15years	5
Single	3	20years+	2
Married	6		
Children		*Years as an E grade*	2.5 -11 years
None	2	Average	6 years
0-10yrs old	3		
12-18yrs/grown up	4		
Ethnicity			
White British	9		

F grade

	Number of Participants (n=12)		Number of Participants (n=12)
Gender		*Current Workplace*	
Female	11	Medical ward	6
Male	1	Surgical ward	6
Age Group		*Working Hours*	
21-30		Full time	8
31-40	5	Part time	4
41-50	5	*Years in Nursing*	
51-60	2	<10years	1
Marital Status		10-15years	5
Single	5	20years+	6
Married	7		
Children		*Years as an F grade*	9 mths -14 years
None	5	Junior F (<2yrs)	5
0-10yrs old	4	Senior F (>2yrs)	7
12-18yrs/grown up	2		
Ethnicity			
White British	11		
Black British	1		

As can be seen from the data, the majority of participants were female (n=19), in the age group 31-40 (n=11), were of white, British origin (n=20) and were married (n=13) with children (n=13). Ten worked in medical wards, 11 in surgical wards and the majority worked full time (n=13), with 10 having been in nursing between 10-15 years.

What Es and Fs Enjoyed about their role

SUMMARY POINTS:

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

The E and F grade nurses cited similar things that they enjoyed about their roles and their responses have been presented together. They enjoyed:

Caring for patients was the thing that E and F grades enjoyed the most about their roles:

> '...I think my main thing is the direct patient care, I think I enjoy that most...' F4[5]

> '...patient contact and the chat, so that's what's kept me because I love it really...' E4

And trying to give the best standard of care they could:

> '...and everyone trying to give the best standard really I suppose of care...' E9

Working within a team and the interaction they had with their colleagues:

> 'I enjoy my interaction I enjoy coming to work; I enjoy colleagues y'know I get on well with colleagues at work...' E7

> 'I enjoy being part of a team and it changing all the time...' E9

Variety of the work and the 'buzz':

> 'I do really enjoy the adrenalin rush of a really busy medical ward...what do I enjoy about it, the patient contact is the most enjoyable and the whole atmosphere, the whole busy atmosphere, there's so much going on, there's so much to take on board, that kind of thing, it's a bit like a juggler keeping balls in the air...' F9

They felt that when things worked out how they should, and they were able to do their job properly, then they were satisfied with their work:

> 'I enjoy patient contact, I enjoy giving good care, when things work out, to some extent I guess I do enjoy tackling the issues that crop up in the day to day life, I enjoy working in a team with other people, and when the team work well it's great, we have a good day...but ultimately for me it's around making sure that people are comfortable, well cared for, that they get what they expect from the system...' E5

But it was often the case that the things they enjoyed doing were the things that felt they were prevented from doing properly:

> 'the things that I enjoy are then limited by other pressures, I mean having students I enjoy but I feel I'm pressured or that it's not always the best experience for them because we're so busy and I enjoy teaching, I enjoy doing everything that I can to the best of my ability for my patients, but I feel that other pressures mean I can't always do

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[5] The nurses have been given a number and coded in accordance with their grade, E or F. Ward managers were coded as WM with a number.

that so...the things I enjoy the most are the things that I feel I fail in because I can't do it to the best of my ability...' E2

Supervising, supporting and developing colleagues were also mentioned:

'...it's around teaching people, learning and supporting people...' E5

Influencing patient care and the working lives of colleagues was also important:

'I do like the way I can come onto a shift and I can control it, I can have an influence over how that shift is going to go...and I do like the way most people like to work with me because they know it's going to be a lot less stressful...' F6

Making a difference:

'I can actually see where I make a difference...' F8

Being respected and consulted for their opinion was also satisfying:

'...they all know me by my name, all the consultants call me [by name], you're suddenly not...a pleb...they actually come and talk to you, pull you out...and they listen to you and take your opinion, even the consultants that aren't even based here, they still know me so...that's quite nice...' F8

Roles and Responsibilities of an E grade

SUMMARY POINTS:

> The role and responsibilities of an E grade were discussed in relation to **clinical:** managing patient care; maintaining a safe environment for patients and staff, recognising changes in patients' conditions, dealing with difficult situations, performing link nurse duties and keeping up to date; **managerial**: coordinating the ward; **interpersonal**: communicating information and being an advocate for patients; **supportive:** supervising colleagues and **educational**: mentoring and teaching juniors. The knowledge and skills required to perform the roles and manage the responsibilities are highlighted at the end of each section.

The E grades discussed their role in terms of 5 main categories:
1. Clinical: managing patient care;
2. Managerial: coordinating the ward or a side of the ward;
3. Interpersonal: communicating information to staff and the multi disciplinary team, being an advocate for patients and staff;
4. Supportive: supervising and overseeing junior members of staff;
5. Educational: mentoring and teaching juniors.

1. *Clinical: patient care*

Managing patient care and coordinating involved knowing:

> '...what's going on with the patients and also the staff, making sure that they're doing safe practice and that patients are looked after 100%...' E1

Maintaining a safe environment and ensuring that patients received the highest standard of care possible was paramount. This involved providing strong leadership on the ward:

> 'you do need a strong leadership figure on the ward, somebody who puts an ethos across, that upholds standards and that reflects then on your care... I think it's by being here and being consistent here, being reliable, I think its about having answers for people or at least finding out for them if you don't have the answers...just understanding if people are having difficulties, to understand what those difficulties are and try and offer support...' E5

This also involved being able to **recognise changes in patient conditions** and act accordingly, as well as ensuring that other staff were doing the same:

> '...but also my role is to make sure I can identify very sick patients...or potentially sick patients...' E9

> '...checking that people are looking for the right things in people...' E9

Dealing with difficult situations

E1 spoke about having to cancel patients for operations if there were no available beds. The social side of the role was also seen as difficult in terms of arranging social care packages and timely discharges for patients.

Performing link nurse roles

Those mentioned included manual handling, or stoma care, as well as being able to perform advanced skills such as venepuncture and cannulation.

Keeping up to date

> '...to be well updated on the area that you're working in, your speciality...it's quite important also for the updating on any of the new policies and protocols really...' E4

The following were cited as key elements for managing patient care:

Knowledge and Skills required for managing patient care:

- A breadth and depth of experience
- A sound knowledge base in your clinical field
- Excellent clinical skills and extended skills e.g. venepuncture and cannulation
- Able to give a high standard of nursing care
- Being able to trouble shoot and recognise deteriorations in patient conditions
- Keeping calm and cool in a crisis
- Keep up to date with new practices and protocols
- Knowing what resources are available to patients

2. Managerial: coordinating

Coordinating included maintaining efficiency, in terms of patient flow through the ward:

> '...making sure the ward is running correctly, that patients go to theatre on time, being discharged and getting admissions in within a reasonable time, just make sure that the wheels, the cogs are running smoothly...' E1

> '...and also a fair understanding of the system, how things work...' E5

Having a group of patients to care for when they were coordinating the ward, or a side of the ward, was common, but difficult to manage at times, especially if one of their patients deteriorated:

> '...you can feel quite pulled if you are coordinating and you've got a group of patients and then one becomes ill and you can't pull yourself in all directions, that's quite hard, like if one of them had become ill I wouldn't have been able to do all the other checks and things...' E9

The E grades did not coordinate every time they were on shift; it was mainly when they were the most senior on duty. Some were given the option of coordinating if there were other seniors on duty too. One senior E did not coordinate because of the hours they worked, as they started work an hour later than the rest of the team.

Knowledge and Skills required for coordinating:

- Being able to organise yourself as well as others
- Being able to delegate appropriately
- Thinking on the hoof and reprioritising
- Keeping calm and cool in a crisis
- Being able to lead staff
- An understanding of how things get done, of how the 'system' works
- Being able to trouble shoot and deal with difficult situations e.g. cancelling patients' operations

- Making use of resources

3. Interpersonal: Communication of information and being an advocate

Communication was seen as essential and passing on information to keep staff, patients, members of the multi disciplinary team and relatives updated and informed:

> '...as a ward nurse in charge it is around managing y'know doctors, making sure things are happening timely for these patients...it is about making sure that we're meeting patient targets, getting investigations done, a lot is around communication, a lot is around explaining why certain tests haven't happened because the hospital is just so busy, there's so much of a back log in terms of appointments, as in house...' E5

> '...certainly basic understanding of patient conditions and therefore also being able to put that into a communication that the patient can understand so it's not about having text book answers it's about being able to relay that to a patient and communicate that...' E5

Questioning practice on the patient's behalf, so for example voicing concerns during doctors' rounds, was also a big part of the role:

> '...being an advocate for the patients and questioning what their treatment is and making sure that they're informed, making sure that the relatives are informed and updated...and I think a lot of the time that's a lot of stuff that you've got in your head, just knowing your patients well enough to be able to answer any questions or queries and when the doctors come round and do the ward round, knowing your patients obs or any particular change in their health...' E2

Knowledge and Skills required for communicating information:
- Excellent interpersonal and people management skills
- Be assertive
- Being confident with your own knowledge and skills
- Being able to communicate to a variety of audiences e.g. other staff, patients, relatives, doctors
- Confidently liaise with other professionals e.g. social workers, physios, doctors

4. Supportive: supervising colleagues

Supporting their colleagues was about making sure they were keeping on top of their workload as well as ensuring they were taking breaks:

> '...to be there for the staff first and then the patients really I would say because if you look after the staff they'll look after the patients...' E9

As a senior E grade, if they were not coordinating then they were a major support for team leaders as well as for juniors:

> '...also I feel that it's my responsibility to support the junior members of staff and I try and take that on as much as I can because I know it's a very stressful ward and sometimes if you are junior it can be quite overwhelming so to work as a team I think is really important and to make sure that everybody is looked after because sometimes people are struggling, they don't say anything, so you need to watch out for people...' E8

Knowledge and Skills required for supervising and supporting others:
- Be approachable
- Actively listen
- Be understanding and empathic
- Keeping calm and cool in a difficult situation

5. Educational: mentoring and teaching

All 9 E grades said that they enjoyed mentoring students and teaching staff, and this was a major aspect of their role:

> 'I personally like it, I like to have students with me, I find it boosts me in terms of I make sure I know what I'm talking about...if me and the student don't know together, we'll look it up and find the information so...and I generally feel it's good to get people enthused about being a nurse, caring for people, get the priorities right, which is the patient at the end of the day...' E5

Mentoring students day in, day out was tiring but still enjoyable:

> '...I find a lot of my time is spent with student nurses, an awful lot of time, because I seem to have one student leave and another one is there straightaway so it's virtually all the time, I've got a student with me everyday really, so there's an awful lot of mentorship and teaching...
> I: How do you find that?
> E4: Quite exhausting sometimes... and some days you just feel like it would be nice just to actually do your day's work and not have to explain everything or show everything and maybe get it done a bit quicker sometimes...but I quite enjoy it as well...' E4

However, the general feeling was that mentoring was undervalued in terms of how much time and energy it takes to do well:

> 'I really enjoy it, I don't feel again that the role is always recognised in how much pressure it puts in your day and y'know some people think that if you've got a student then you've got another pair of hands, but

I actually find that sometimes you need to spend more time with the student...but I think it's an important role to do properly and it challenges me when people ask me 'Oh why are you doing that?' or questioning me, it's always good to keep thinking...' E2

Supporting staff by enabling them to come to solutions was also mentioned:

'If people come up to you and say 'Oh I don't know what to put on this wound' going and having a look at the wound and letting them decide what to do with it, like the drain on that lady in the side room is leaking everywhere so make sure it's asked on the round...'What shall we do with it because we can't manage it the way it is' that kind of thing...but without taking over from people, letting them do it really...' E9

Knowledge and Skills required for mentoring and teaching:
- A sound knowledge base
- Act as a resource for others
- Being able to adjusting your style of teaching to suit individuals
- Working knowledge of documentation required for mentoring students and staff in practice
- Understanding and experience of the assessment process and of giving feedback
- Acknowledge limitations
- Being an enabler of staff, giving advice and supervising but allowing them to have a go in a safe environment

Such knowledge and skills are shown in the **Observational Vignette of E4 mentoring a student in practice**, in Appendix 1.

Role and Responsibilities of an F grade

SUMMARY POINTS:

The role and responsibilities of an F grade were discussed in relation to **clinical**: leading the team as a clinical expert; **quality**: setting standards and following Trust policies and procedures; **manageria**l: coordinating the ward and performing extended roles; **interpersonal**: communicating information to staff and other professionals, being an advocate for patients, dealing with complaints and conflict; **supportive**: supervising staff and colleagues, mediating between the ward manager and staff; **educational**: teaching, mentoring and developing junior staff, assessing staff, being used as a resource; **personnel**: human resource issues such as appraisals; and **deputising** for the ward manager. The knowledge and skills required to perform the roles and manage the responsibilities are highlighted at the end of each section. What was noticeable was the variation in terms of responsibilities that the F grades had, with some having fewer responsibilities than others, yet all presumably working to the same job description. For example some were only responsible for running a shift when they were on duty, whereas others did the off duty, performed appraisals and were involved in capability

procedures. Some also took patients when they were in charge, whereas others were supernumerary and acted more as a resource to the staff.

The F grades discussed their role in terms of 8 main categories:
1. **Clinical**: leading the team as an expert in their field of practice;
2. **Quality**: being responsible for setting standards in practice and ensuring Trust policies and protocols were followed;
3. **Managerial**: coordinating the day to day running of the ward, performing extended roles such as holding the bleep for the medical wards;
4. **Interpersona**l: communicating information to staff and the multi disciplinary team, being an advocate for patients and staff, dealing with complaints, diffusing difficult situations; conflict resolution, disseminating Trust information to staff
5. **Supportive**: supervising junior staff and supporting colleagues in the multi-disciplinary team. Acting as an intermediary between the staff and ward manager, an information giver and resource;
6. **Educational**: teaching, mentoring and developing junior staff, assessing staff capabilities, acting as a resource to help them know what professional development is available to them e.g. courses. Also encouraging staff to be proactive and seek out learning opportunities;
7. **Personnel**: interviewing, monitoring sickness records and manpower figures, being involved in capability procedures and disciplinaries, staff appraisals, writing the off duty;
8. **Deputising** for their ward manager.

1. Clinical: leading the team as a clinical expert
Ward managers expected the F grades to be responsible:

> *'for day to day clinical management decisions'* WM7

The F grades were expected to lead the team by example and were considered to be experts in their particular field of nursing:

> *'As a senior staff nurse, I'm meant to be the clinical person with expertise in the field...someone to give advice and run the ward basically and to take charge...to show juniors...take a lead and show them what to do and how to do it...'* F8

> *'I see my role primarily as I'm taking a group of patients as any other nurse would, but I've also got a role in terms of maintaining standards, maintaining the flow of patients...ensuring that the nurse allocation to patients is appropriate, so I need to have a reasonable understanding of what else is going on with the patients on the rest of the ward...'* F9

Taking a lead clinically also meant helping staff to recognise changes in patients' conditions and to enable them to act on such changes, so as to prevent patients deteriorating, or acting promptly so as to minimise the effects.

'...making sure they're aware of changes in patients and that they're recognising and that together as a team they're acting on any changes that happen, to make sure that patients, obviously some patients do deteriorate but to try and prevent that from happening, to recognise signs and call the appropriate teams and take the appropriate actions...' F2

Knowledge and Skills required for leading the team as a clinical expert:

- A breadth and depth of clinical experience
- An excellent knowledge base in your clinical field plus extended knowledge of a range of patient conditions, procedures etc
- An excellent nurse who set the standard for patient care, is an example to staff and acts as a role model
- Excellent clinical skills and extended skills e.g. venepuncture and cannulation
- A trouble-shooter of clinical situations, so recognising changes in patient conditions promptly and acting accordingly
- Being able to make clinical decisions based on sound understanding of the situation at hand and justifying that decision to others
- Being able to question practice and challenge clinical decisions
- Leadership skills – being able to lead and motivate the team
  A professional who instils authority and discipline on the ward
- Able to stay calm in a crisis and create a relaxed working atmosphere
- Keeping up to date with new practices and protocols and sharing that information with colleagues
- Knowing what resources are available to patients

2. Quality: setting standards and following Trust policies and protocols

This was about being responsible for setting standards for patient care and again, leading by example, to maintain those high standards of care in practice. Ward managers expected the F grades to take the lead in the Essence of Care benchmarks on the ward, so as to monitor quality and help improve patient care. This work involved carrying out audits and analysing the recorded data to feedback to the ward staff and the Trust as a whole, in the form of a report. Essence of Care issues were also discussed at F grade away days. However the Essence of Care work was contentious because Fs had little time to do it:

'...there is the Essence of Care, which the F grades are leads in, but to be quite honest I never get the time to do anything for it because...in actually nearly a year now, I've had 2 mufti days, so the first mufti I did do some work on the Essence of Care, the second mufti day, unfortunately one of my kids was sick so I've had in effect 1 mufti day in a year...' F6

Maintaining quality was also about ensuring staff understood Trust policies and procedures and were following them in practice.

'...I need to be aware of the initiatives, thinking of things like Essence of Care, which are going on, and what the priorities of the Trust are...' F9

The Fs were also responsible for performing link nurse duties, and this involved attending meetings on a particular aspect of nursing and feeding back any updates or changes to the rest of the ward staff. For example, F2 was involved in the introduction of the MUST Nutrition Tool on her ward:

'I've been doing the MUST tool (Malnutrition Universal Screening Tool) for the ward, which I found that interesting to do, WM1 partly does it and I think she's pushed it onto me as well to do it, so we lead it on the ward...and I probably push it that little bit more because I'm a bit more interested in it...' F2

Knowledge and Skills required for maintaining quality care:
- A commitment to providing and maintaining high standards of patient care
- A working knowledge of the Essence of Care benchmarks and taking a lead in that work for others to follow
- An understanding of the audit process, so how to set standards, implement and monitor and evaluate them, as well as reporting back information
- Knowledge of Trust policies and protocols and ensuring others are aware of and follow them
- Being able to challenge poor practice
- Taking a lead in new initiatives designed to improve patient care e.g. MUST Tool

3. Managerial: coordinating a ward

'...I expect that the ward is run safely and efficiently...' WM10

The F grades were responsible for managing the ward in an efficient way, so ensuring that admissions and discharges ran smoothly, that patients went to theatre or for procedures on time and that staff allocation, staffing levels and skill mix were appropriate. They spoke about ensuring efficient patient flow through the system and making sure that the staff were happy with their workload:

'I see my role as obviously managing the ward and managing it effectively, making sure that staff are happy and are confident with their work and their workload...' F7

Ward managers also expected Fs to be efficient with resources too, which most were aware of:

'...when you're a staff nurse you think "I don't care how many wipes I use, it's not my problem, I don't care how many bars of soap just get chucked in the bin by mistake...it's not my problem, I don't care" because that's how you think "I'm here for the patient" once you become more managerial and you start looking at your budget

statements and you realise that a box of wipes is £25 and...you go round and you see that a nurse has actually got…half the packet and slung it into a bowl just for a face and hands wash, you think "Hang on a minute, you only need 2" you start thinking in...pound signs...' F7

Knowledge of resources that could be called on was also important:

'...knowing who to call when you need help as an F grade because everybody looks to you and if you don't know the answer, who do you go to next...' F6

The majority of the Fs coordinated when they were on shift; but this was not always the case. For example since moving ward areas after a phase of reconfiguration, F5 had fewer responsibilities and rarely managed the ward. F5 also found that her role was very different in her new ward area too:

'the F grades here work very differently than they do in Hospital B...what I couldn't get used to was they're very desk orientated, they're very paperwork orientated, they tend to do all the discharges, they've taken that away from the junior nurses here, not taken away, that's how it's always been so but where I've worked before if you're looking after a patient, you do the whole thing for that patient...' F5

In some cases, the Fs were also responsible for performing extended roles, for example F11 had started holding the bleep for the medical wards in her area. This involved giving advice to other ward staff, sorting out staffing problems, giving IVs and responding to emergencies. Five of the Fs said they took patients when they were in charge of the ward. And although they enjoyed the patient care aspect of their role, they often found it difficult to balance the care they were giving with coordinating. A few Fs were actually supernumerary when they were on duty, so they did not take a patient load, but were available for staff as a resource:

'...my role tends to be more supervisory but at the same time, if something needs doing I will get in there and do it, or if somebody needs advice, I will go and help them and as I said this morning, the only way you're going to know what's going on with the patients is by getting in there, y'know knowing who they are, knowing a little bit about their background, knowing what they're going through...' F4

Being supernumerary was seen as the ideal by the Fs and a luxury because staffing levels militated against that happening on every ward. It was particularly difficult for those who were the only Fs on a ward as they felt torn between all their other responsibilities:

'...I'd like to have more of a supernumerary role, because...I've got other things that I need to do at the back of my mind, that when I'm a number, everybody else sees me as a number, so "Why haven't you done your washes?...why haven't you done so and so, what are you doing in the office, you're not doing anything" the usual y'know..."Why

are you answering that phone, why are you looking at the off duty?...why haven't we got any staff...did you make the request?" "Yes" "Are you sure, we've got no staff"...' F8

Knowledge and Skills required for coordinating:
- Excellent organisational and time management skills
- Able to organise yourself as well as motivate others
- Being able to delegate appropriately – but not delegating anything you would not do yourself ethos
- Being able to lead staff and inspire confidence
- Planning ahead, thinking on the hoof and reprioritising
- Able to stay calm in a crisis and create a relaxed working atmosphere
- Is self aware and able to manage their own stress well
- An understanding of how things get done, of routine procedures for example, of how the 'system' works for organising discharges, social care packages etc
- Being able to trouble shoot and deal with difficult situations e.g. cancelling patients operations
- Being able to make managerial decisions based on a sound understanding of the situation at hand and justifying that decision to others
- Being able to challenge managerial decisions
- Making use of resources, knowing who to contact if need help

4. Interpersonal

Communicating information to staff and the multi disciplinary team was essential:

'...I think you also need to have a good understanding of team dynamics...whether or not you manage the team, it's more the dynamics that can happen within the team, and you've got to be able to learn to sort out and diffuse situations either between relatives and patients or between staff on the ward...' F1

Tailoring the information depending on the professional they were dealing with was also important, as was being an advocate for patients and staff, so challenging treatment or behaviour. Dealing with complaints, conflict and being able to diffuse difficult situations were common to the role. Ward managers and experienced Fs felt it was important to try to pre-empt potential problem situations, so as to avoid them getting out of hand. Ward managers felt this approach required Fs to be self aware and have insight into their own behaviour as well as that of others (e.g. WM5):

'...you spend a lot of time listening to a complaint and trying to resolve it before you have a situation and before it becomes a [formal] complaint, if you try and resolve it and you say to people "What can I do to help you?" because once you get the complaint in, it takes ages to go through all the paperwork, fill in the forms, make a response and then go back and look at what happened and what didn't happen and could this have been avoided...trying to be proactive rather than reactive to situations...' F4

Disseminating and understanding Trust information and filtering information to staff was also part of the role:

> '...you also need to know what's going on in the Trust, what are [the] Trust priorities...so that you can explain things when they arise, for example, at the moment there's a ban on agency staff so you need to understand why that is, so you need to understand why extra beds are being put on the wards inappropriately, thinking of privacy and dignity in the essence of care, y'know if you've got a patient in the middle of the ward or by the entrance...so those kind of things broadly...' F9

Knowledge and Skills required for communicating information:

- Excellent interpersonal and people management skills
- Experience in a range of situations requiring interpersonal and people management skills
- Being able to trouble shoot and successfully deal with difficult situations e.g. handling conflict
- An understanding of team dynamics and the individuals that you work with in that team
- Being assertive and able to get your point across to a wide range of audiences, for example junior and senior doctors, other professionals, patients and relatives
- Being confident with your own knowledge and skills to challenge practice and justifying your position
- Being able to communicate on a daily basis with a variety of people e.g. other staff, patients, relatives, doctors
- Being able to confidently liaise with other professionals e.g. social workers, physios, doctors
- Being politically aware, having an awareness of the Trust's priorities as well as wider government led initiatives and their impact and disseminating that information to staff
- IT skills –how to communicate using email, download information off the intranet/internet, write reports and documents, use spreadsheets

5. Personnel

Personnel issues included elements such as monitoring sickness records and manpower figures, the ward budget, being involved in capability procedures and staff appraisals and writing the off duty. Some had also been involved in disciplinary procedures (F8) and interviewing new staff (F1):

> '...I deal with everybody's salary returns at the end of the month, I deal with all the sickness, all the annual leave records and I write all the off duty for everybody up here...and we've just gone through a big recruitment drive and so I've been involved with all the interviewing...' F1

'...I do things for interviews, away days, I'm going to do appraisals, budget meetings, organising stock, organising staff, sorting any problems out but also basic nursing as well, attending meetings, anything really...' F11

'...need to be aware of budgets and financial control, need to be making decisions...generally about managing the ward on a day to day basis and be aware of where things are going wrong, so I can flag things up and which staff are comfortable in their job and those who aren't...' F9

People skills, being approachable, and knowing the capabilities and limitations of the staff were skills that ward managers said were essential in dealing with Personnel issues.

Knowledge and Skills required for dealing with Personnel issues:

- Experience of managing people
- Some experience of Personnel issues e.g. staff appraisals, monitoring sickness records, writing the off duty
- Knowledge of the Trust's Personnel policies and procedures e.g. capability
- Being fair and objective in difficult situations
- Being open and honest with people
- Being able to take control of and diffuse difficult situations
- Being calm and handling stress well
- Knowing the team of people you work with, as a team but also as individuals, so knowledge of team dynamics – this was seen to help with writing the off duty in particular
- Budgetary and financial awareness
- IT skills – how to communicate using email, download information off the intranet/internet, write reports and documents, use spreadsheets

Such knowledge and skills are shown in the **Observational Vignette of F10 dealing with a difficult discharge** in Appendix 2.

6. Supporting staff, acting as a resource and intermediary

F grades thought that a major part of their role was to support staff, junior as well as senior and with both personal as well as professional issues:

'...supporting people, a big part of our role I think is helping people who are having difficult times, whether it be at work, outside of work and just being supportive of people y'know everyone has bad stuff going on at times in their lives...tea and tissues...and just being a resource really...' F12

Ward managers felt that F grades should be a support for them too, especially in relation to the rest of the ward staff:

> '...I expect F9 to support me and particularly in front of other staff, which F9 does, even if we were to disagree on something I think any disagreement between the F and the G should not be seen by other staff because I think we need to present a united front because otherwise people use that, divide and rule and they will use it...' WM6

Supporting other professionals in the multi-disciplinary team was also part of their role. They were also intermediaries between the staff and the ward manager, an information giver and a resource:

> '...to lead them and to be someone that they can turn to and feel that they can get the information from that they need, or I can find the information that they need and also for other health professionals, as you've seen today, to try and help those because especially as it is, a lot of them you seem to deal with don't know, it's all new to them, so to try and steer them in the right direction as well, so you can have people coming at you from all sides...' F2

> Knowledge and Skills required for supervising and supporting others:
- Be approachable
- Actively listen
- Be understanding and empathic
- Keeping calm in difficult situations
- Being able to handle your own stress and diffuse that of others

7. Educational

Teaching and mentoring was another aspect of their role, which ward managers expected:

> 'I think they need to be good teachers, they need their mentorship or are undertaking it because even if they're not involved with a student, you're got lots of trained staff who need tuition as well...' WM1

The Fs felt it was their responsibility to help develop junior staff, to act as a resource in terms of knowledge and skills, as well as to encourage them to be proactive and seek out learning opportunities for themselves. They were responsible for assessing staff competencies and giving feedback and appraising their capabilities:

> '...to provide mentorship to the junior staff, give them support as well in what they're doing and if I can't support them, then see if I can find someone higher up or someone alongside who can give them that support and answer those queries, to provide them with a knowledge base as well and to pass on any skills that I possess that they may not have…to help with their time management skills…' F10

> Knowledge and Skills required for mentoring and teaching:
- An excellent knowledge base

- Passing on your expert knowledge to others
- Seen to be developing yourself so leading by example, encouraging others to follow
- Act as a resource for others
- Being able to adjust your style of teaching to suit different audiences and individuals
- Working knowledge of documentation required for mentoring students and staff in practice
- Understanding and experience of the assessment process and of giving feedback
- Acknowledge limitations
- Being an enabler of staff, giving advice and supervising but allowing them to 'have a go' in a safe environment

8. Deputising for the ward manager

In the absence of their ward manager, F grades acted as their deputy, or shared responsibility for this with their fellow F grade colleagues. This meant attending ward meetings on their ward manager's behalf, for example:

> '…in charge of both wards, in charge of staff, I work as WM13's deputy when he's off, that's about it really, running of the ward, organising bits and pieces, anything really…' F11

However, there was a lack of consistency in what the F grades were responsible for and what their ward manager expected them to do. Four (F7, F8, F9, F11) were more involved in managerial issues, such as the budget and manpower figures, than the other Fs, and only 6 Fs wrote the off duty. Some ward managers were actively thinking about succession planning:

> '…somebody once said to me "The sign of a good manager is when you can go away and come back and everything's ticking along still, because you've let the reins up, you've given the reins up, you've let them have some ownership" and that's what I try to indoctrinate into them, that they're actually grooming for my job or someone else's G grade job…and they're very good…' WM1

Whereas other ward managers limited seniors' involvement in certain aspects of the job and so were not actively thinking about succession planning:

> '…I do deal with things that are left by my manager but because there's an F grade who's full time and of course a manager who is full time, they deal a lot with the actual manpower figures, management, budget, although I have said I'd like to know how it's done because for my own development…' F3

F6, who had acted up as a ward manager for 9 months before coming back down to an F grade, was only responsible for coordinating a shift when she was on duty. This meant

that she was not using the managerial skills that she had acquired in her ward manager's role:

> '...I've got no responsibilities, apart from running the shift, I suppose I'm link tutor for the students but that's just pointless because I'm never given students because I only work part-time and I can never go to the meetings because they're never on days that I can make it, I've asked to be taken off that but I was told "Oh no you may as well stay on that" so I'm still staying on it doing absolutely nothing...' F6

Knowledge and Skills required for acting up as ward manager:
- Knowledge of what is involved in a ward manager's role
- Being able to lead and motivate the team
- Getting the best out of staff by nurturing their strengths and weaknesses
- Be professional, command respect, act as an authority figure

ACTION POINTS
- Senior management and ward managers need to clarify the responsibilities and expectations of the F grade role, so that those in this position are working more consistently and fairly across the Trust
- Senior management and ward managers need to start actively thinking about their approach to succession planning, so as to provide a means of passing on their expert knowledge

Challenges of the E and F grade roles

SUMMARY POINTS:

The challenges of the roles related to maintaining standards of care whilst working under pressures of time and competing needs; getting through the day; having enough staff to manage the workload and maintain a safe environment, juggling patient care and the day to day management of the ward, re-prioritising on the hoof, trying to concentrate on patient care as opposed to patient throughput; managing people, situations and stress; having the time to mentor and teach juniors, to assess them in practice and give feedback; to support juniors and colleagues, dealing with the changing role of the nurse; encouraging others to be proactive; having sufficient support from medical teams; keeping themselves updated; managing personnel issues, and coping with the after-effects of reconfiguration, such as merging teams. The challenges all seemed to relate to reacting to the current situation the nurses found themselves in. Thus the response was often stressed, ad hoc, pressured and rushed. There seemed to be little time for a measured, objective, even proactive response for dealing with situations. The workload was increasing, as was the pressure to perform. In some cases, the senior grades spoke about being in a constant state of stress, concerned about their accountability whilst looking after patients and taking charge of the ward. The pressure was constant and they had no let up or time to think and reflect on what they were doing.

- **Maintaining standards** and trying to give holistic care, under pressures of time, competing needs and workload were highlighted by both E and F grades:

    'Getting the work completed I mean because it's so busy at times...I think everyday is a challenge trying to get through the day really and offer the best care you can...' E7

    '...to be able to deliver the level of care that I want to with being up against the pressures...it's time pressures and...that I feel challenges my ability to deliver the level of care that I would like to...' E2

- **Getting through the day** - with little thought to anything else because of the pressures of time and workload. Only having the time to be reactive, and not proactive:

    'At the moment it just seems to be surviving from day to day really with regard to the pressures that the hospital are imposing on everybody with regard to staffing, sickness, shortages and the bed pressures within the hospital, because there seems to be no let up, whereas a little while ago if you had an empty bed you might have an empty bed for the day...now the pressures are harder...' F1

    'I think at the moment it's just a fire fighting exercise y'know you're dealing with the problems as they arise, so re-assessing your priorities and working out what is most important...' F9

- **Having enough staff** on duty to manage the workload and maintain a safe environment:

    'I think the biggest challenges are having enough staff and enough time...it's always the big thing with nursing and it has been for years now I think...' E4

- **Juggling patient care and the day to day management** of the ward, so deciding what the priorities were e.g. having 2 discharges and a possible 10 patients needing that bed – juggling admissions and discharges, as well as ensuring current inpatients received a high standard of care. Juggling was more difficult when Es and Fs were managing a group of patients *and* being in charge:

    '...if you have lots of things going on like unhappy relatives, patients absconding, you have additional paperwork on top of looking after your patients, I think going to a role where you have somebody floating in charge would be better because that way you won't have all of that and you can literally manage the ward but not have the additional patient care aspects, you're just overseeing patient care, you're not actually physically doing it...' E5

'...everybody seems to want something from you during the course of the day and a prime example this morning, I'm getting pressure from a consultant to get a patient into a bed for an operation and yet I've social work teams coming round doing a trawl of all delayed discharges and they all want you at the same time, and you can't do that and you have to decide whether your priority is sitting down and having a chin wag for 20 minutes talking about which patient is causing what delay or you can get on and deal with those who can be discharged and putting more people in the beds…and that sometimes can be very challenging, just everybody arriving on your doorstep at like 11 o'clock in the morning…' F1

- **Trying not to lose focus** when you feel the emphasis is on beds and not patient care, and dealing with the competition this creates between wards in terms of patient throughput:

  '...2 wards came here with similar staff...and we're very much compared on our turnover and...it's almost like a competition, how many beds they can make basically and they're actually not performing well at all, so there's actually talk of moving sisters to try and get the [turnover increased]...it's quite horrible...everything's performance managed...it's almost got to the point where you stop looking at the illness, "You've been here 10 days, why aren't you going home?"...IV antibiotics, you've had 4 days, even though you think they could do with an extra, you stop thinking about that "You've been here 3 days, why can't that be oral, time to go home" social services, you don't look at the actual care anymore, well I don't…it's got to the point where you're just like beds, beds, beds, you saw earlier, beds, beds, beds, beds, beds, that's all they think about...' F8

- **People management** – staff, patients, relatives, other professionals. Handling difficult situations and conflict, dealing with sensitive issues such as the off duty, having to cancel operations if there were no beds, being able to pre-empt potentially difficult situations:

  'I think dealing with people is probably the toughest part of the job but it's there everyday of the week y'know, whether it's patients, relatives, starters...' E5

  '...confronting, in a difficult situation I'm one of these ones that will just sort of brush it under the carpet and say "It's okay" whereas actually I'd probably be thinking "Well no I should be standing up for this person"...' E6

'...the off duty is a very sensitive thing and it does cause a lot of stick if I can't give people what they've asked for...' F9

'...another part of the job that's very difficult is having to ring people in the evening and cancel them for the following day...having to cancel them over the phone, I don't always agree that it's a nurses' job to cancel patients that they're probably going to be looking after again in a week or sos time when they finally do come in...the average comment you get is "I know it's not your fault but"...' F1

- **Managing the stresses of the job** and your own stress. Some F grades spoke about being in a constant state of stress, having so much to do that they worried about missing something that might cost them their registration:

  'Finding a balance I think...between patient care and dealing with the day to day ward management problems, I look after a group of patients as well as managing the ward on a shift...sometimes I've gone home and I've been thinking "I've not done as well with my patient care as I should have done" simply because I got tied up with some management issue so sometimes I feel as though I am neglecting my patients...and it's scary because I'm thinking "Am I going to lose my registration at some point because of something basic I've forgotten to do or haven't done"...' F9

- **Having the time to educate and mentor students and juniors** properly, especially when managing a group of patients and being in charge, having the time to develop juniors through teaching sessions and update the team in general:

  '...the difficulty here is that I can mentor a junior D grade but the reality is if I'm dealing with patient care and being in charge and the mentee that you're looking after is up the other end of the ward, how much support can you give that individual, it's limited and I think that's the problem where people struggle here is when they're a newly qualified D and it's a busy environment and they don't get the mentorship they need just because of the fact that you haven't got the time to mentor them properly...' E5

  'I think one challenge is to develop the staff further...to try and develop some teaching programme...so that people will learn more while they're here, like we have the link nurses, but we rarely get a chance to even get feedback from them really, so it's not totally working, so it would have to be having the numbers of staff, but to try and encourage that, better communication, spreading of information and trying to get people to learn a bit more and develop themselves more...and

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to get them to do more competencies, I would like to do that, to be part of that...I think it's just not being able to take yourself away and as we said, maybe work alongside a nurse and be able to encourage them and give them feedback, develop them further that's missing, yeah we're just working and getting through the shifts really...' F2

- **Assessing juniors** and giving feedback – being confident enough to give negative feedback if necessary:

  '...someone can pass an assessment on another ward for example and I actually see them and I'm not happy with their level or standard...it's usually around safety issues and good practices, you have to address it while they're with you but yes you do wonder how some people get through the system without being pulled up on certain things...and I think nurses do find it very difficult to stand up and say "Actually you don't fit the grade" y'know it requires an element of conflict, it requires you to stand your ground and say "Actually I'm not happy with that"...' E5

  '...it's trying to I suppose enforce and educate other people under you...which I suppose I'm finding a little bit difficult at the mo...because I'm worried about being a bully or pushing people too far and it's a case of finding the fine line and saying "Okay you need to concentrate on this because you're lagging behind, or you need to do X, Y and Z" it's just trying to get the word play across again...' F10

- **Having time to support juniors**:

  '...a lot of the junior staff need a lot of support because it is that kind of heavy high dependent ward so...that's quite challenging...' E9

- **The changing role of the nurse** - taking on more responsibilities from other professions:

  'The challenge of this role I think really is changing the way we work with the doctors' hours and everything else, if I think about what we were doing 2 or 3 years ago compared to now, a lot of us are being more trained to do a lot of clinical skills like taking blood, cannulation, IVs, there's a lot of change with that, I think we're taking on more responsibility...' E8

- **Encouraging nurses to be proactive** in changing their working practices – updating and moving away from ritualistic nursing:

'I think it's trying to get people around to being proactive, all the nurses know it should be done, but does it get done and we've got to get people around a different approach to working and I think that's a big challenge for the health service at the moment...years ago it was very much like ritualistic almost, ritualistic working in nursing, you came on, you stripped the beds, every bed had to be stripped regardless or not, now that's all old hat because if somebody's going home, why are you wasting your energy stripping that bed and it's getting people out of their old ways and getting to work in new ways...' F4

- **Having enough support from doctors** when patients become very sick and being assertive enough to say 'No':

    '...it's always busy up here and we always have high dependent patients and it's very easy for I think medical staff to expect us to look after people who shouldn't be on this ward...and do things that we shouldn't do like they'll try and push giving potassium in a 100 mils "No we don't do that, that's got to be as per Government policy, it's got to be given on an Intensive Care Unit" y'know things like that so you just have to know where your limitations are really...so it can be quite stressful having to tell somebody quite senior "No we can't do that here doctor sorry"...' E9

- **Keeping updated** and trying to improve patient care:

    'I think one of my challenges is constantly trying to improve my practice, trying to be more efficient, trying to give my patients better care, manage everything effectively...' E8

- **Managing appraisals**, **interviews**, attending budget meetings, more so if they had no experience of these aspects before

- **Dealing with the 'after-effects' of reconfiguration** – e.g. F5 had to get used to a different acuity of patient care, and was finding it difficult to maintain an interest in the work now that it had changed:

    'One of the main challenges for me at the moment is keeping interested to be honest because of the type of patients that we're getting...some days are better than others...we need variety, it's all very samey at the moment...' F5

As well as dealing with the effects of merging 2 teams of nurses, educating and assessing 'problem' staff inherited from other teams and different specialities without adequate support to do so:

    '...because we've been performing well so we've been taking other members of staff etc whose performance has been quite

poor so they've been sent here for us to sort out...other wards' problems...and they're just one of the numbers as well...y'know there's nobody to actually supervise them as in somebody to take over their role and see what they're doing...it's hard...' F8

ACTION POINTS
- For senior management in the Trust to acknowledge the challenges of the E and F grade roles.
- For senior management to devise a proactive approach to working with the challenges as mentioned above to combat a reactive approach.

Success as seen by E and F grades

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

The E and F grades identified success at their level with someone who was:
- Experienced
- Knowledgeable

> '...I think it's knowledge really...I think I respect people more if they seem to have sound knowledge...' E2

> 'I think being successful at my level you need to have a good knowledge base clinically because you would need that to install confidence in your staff so if your staff came and said to you "I have a problem I don't know what to do" then you say to them "Well actually this is how we do it, come on I'll show you, we'll do it together" it means they have confidence when they're on...' F7

- Efficient
- Organised
- Competent
- Confident
- Honest
- Acknowledged their own limitations

> *'I think somebody who is confident in their job, knows what they're doing, is understanding and sympathetic, I think knowing what you're doing is the important thing because I think if you pretend to know what you're doing then you do get caught out…' E1*

- A good team worker
- A good team leader
- Credible in practice

> *'…you have to work well within the team and be a good leader, you have to ensure that you deliver very high standards of patient care so that you're a good role model for other people, you need to be there for other staff and be able to support them really as well, mentor students, mentor junior staff…' E3*

- Professional
- Approachable
- Caring

Success was also about:
- Maintaining high standards of care
- Commanding respect – F grades spoke about commanding respect by being involved in hands on patient care, and not delegating anything they would not do themselves:

> *'I think respect is another thing that is important in somebody who is in charge of a ward and I think again that's something that's earned…and I mean I'm prepared to get in there and muck out with the girls if I have to, I'm not prepared to just sit there and say "Well you do this, you do that" and watch somebody struggle when you can get up and…help out…' F4*

- Supporting juniors, personally as well as professionally

> *'…it's to make sure that you're supervising your junior staff and that you've got confidence to be able to liaise with the multi-disciplinary team, you've got the confidence to maybe question care that's given because sometimes junior doctors will maybe ask for something that you may feel in your own experience is inappropriate and I think so to challenge things as well…someone who is very good at stress management,*

because again that's very important, if you can't cope with your own stress then you're not going to make a very good leader as it were...' E8

- Being an excellent communicator in a variety of audiences
- Challenging practice and/or behaviour
- Enabling others

> *'...trying to support people so it is around enabling other people to do what they want to do, it's around enabling patients, it's around enabling doctors to achieve what they want to achieve, it's following instructions, it's really around being a global person...I think you've got to be pretty much acceptable to a wide range of people, you have to be able to communicate with different types of people, different backgrounds… ' E5*

- Being able to diffuse difficult situations and deal with confrontation. F grades also spoke about being able to pre-empt potential disaster situations – e.g. preventing complaints from happening by diffusing situations early on – both with patients and staff
- Troubleshooting clinical situations - recognising changes in patient conditions promptly and acting on them appropriately
- Actively listening to and having time for others, showing an interest
- Having a strong sense of self, being a calming influence and handling stress

> *'...good management skills and people skills...how you approach people really because it is a stressful job and you've just got to show that you're not stressed and ask them if they are stressed and what you can do to help it really...' E9*

In terms of leadership, F grades associated success with someone who was able to:

- Support their ward manager and act in their absence
- Instil discipline on the ward and act as a figure of authority
- Support the team and act as a resource for them – answering questions or pointing them in the right direction
- Make confident and competent decisions without necessarily consulting their ward manager first – and being able to justify their decision making process
- Be objective – able to step back from a situation and assess it fairly, not jumping in before they had all the facts
- Disseminate a clear plan of action to staff – be decisive and clear about what they were asking of staff and follow it through
- Be fair and not show favouritism
- Act consistently in a professional manner – set boundaries so staff knew where they stood:

> *'…being consistent with what you're doing and the standards that you have and I think being a role model, so they look at you and I think if they think that you're working hard then they*

should be working hard as well and work to the same standard…being decisive and clear with what you're telling them to do…' F2

- Exhibit excellent interpersonal skills
- Act as a role model - work hard so that others followed suit – lead by example
- Acknowledge limitations and be honest
- Know the team as individuals as well as a team – what their strengths and weaknesses are, who works well together and who does not
- Build an effective, happy, relaxed team

  '…be able to build a good team and achieve good standards…' F9

- Manage stress so that it does not filter down to staff – be a calming influence

  'You've got to be a real people person I think...because you can be really, really mad and stressed and you've still got to…come across as being fair and cool, you can't go off and slam the phone [down], you've got to be able to manage people very well, be a good communicator...and even in really tricky situations, you have to come across as fair...' F8

- Keep updated - develop themselves so as to set a good example for others to follow
- Act as an intermediary between the ward manager and the team and act as an advocate for the staff in trying to improve working lives:

  '…somebody who is aware of what's happening with the team, to support the team, but who also can feed that back to the ward manager, who may not necessarily be aware of what's going on, and to liaise between the two really, very much an intermediate role...' F6

- Meet Trust targets e.g. turnover (said very tongue in cheek)

How were they learning?

SUMMARY POINTS:

The E and F grades learnt aspects of their roles through a mixture of informal and formal learning, although the majority of knowledge and skills were learnt on an informal basis. **Managing patient care** and being a clinical expert were mainly learnt through experience, practice, demonstration by and supervision of a senior, asking questions, learning from role models, studying and attending courses or study days. Courses related to updating mandatory skills and developing clinical skills and knowledge e.g. specialist nursing courses like HDU, cardiac, or extending skills such as venepuncture

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

Communication was learnt through experience, practice and from role models, trial and error, picking it up as they went along, reflection and establishing relationships with staff over time. Very few had attended people management study days to inform their practice. **Personnel issues** were learnt through exposure to them and discussion with their ward manager. A few had attended study days on interviewing and appraisals and one had been to an in-house course on finance. Trial and error was the norm with Personnel issues, so learning how to deal with them as and when they occurred. **Supervising and supporting others** were learnt through experience, practice, and reflection mainly, as well as discussing issues with peers and colleagues. Role models and watching others communicate were also cited, as was acting up into the next grade. **Teaching and mentoring** were learnt through studying and reflecting on their own experiences as students. **Deputising for the ward manager** was learnt from role models, having the opportunity to shadow their ward manager, acting up under the supervision of a senior, attending management meetings with or on behalf of their ward manager and attending leadership skills courses such as LEO.

1. Managing patient care and being a clinical expert
- Experience
- Practice, demonstration and supervision:

    '*…often you'd be with a doctor and they'd say "Well you come and feel this" so and then obviously more senior nurse managers and nursing sisters would say "Well you come and feel this" and I think it's that, y'know they've shown you, let you try, feel, discover…'* E4

- Asking questions of colleagues or other professionals:

    '*Colleagues, looking at books, looking at notes and asking questions…and looking at A&P books…'* E1

    '*I learn a lot of things probably from two of the senior, two of the E grades on here really, who've done the cardiology pathway, or the ENB equivalent and from asking the doctors and just questioning what they're doing and they're very approachable if I ask them why they've done something or why*

they've prescribed something...they're usually quite happy to answer my questions, and other stuff, from self-guided study really...' E2

- Role models:

  '...she was actually a sister, but she worked on the ward an awful lot, but she was very efficient, she was always very caring with patients, she was very skilled she managed things very well...just somebody you could look at and say yes she's a very capable person, and people had a lot of respect for her...' E3

  '...also there's experienced nurses on the ward which is extremely useful, an individual who's been a ward sister, who's moved down, so useful, so knowledgeable, she knocks spots off me in terms of her knowledge, y'know it's superb having her on the ward...' F9

- Ethos on the ward:

  '...they're very good up here, a lot of people who come here having worked elsewhere think it's threatening, another nurse coming in to look at their patients when actually what they're doing is they're just doing their job, to look at the patients but I think in nursing you have the ethos that "They're my patients, I'm responsible for them, I'm responsible for my professional development" whereas on ward 5 we were always there to help each other and y'know some people knew more about other things than other people do and we used to have teaching [sessions] about different subjects that we'd get people in with and we've got quite a few resource files here, so you just learn as you go along really and also from the doctors, they're quite good at letting you know "Oh that NG is still draining green bile, no, we'll leave it, it'll get lighter" that kind of thing...' E9

- Studying:
  - Mandatory study days e. g. BLS, manual handling, fire, blood glucose monitoring;
  - Clinical skills study days or 'mini' sessions e.g. venepuncture and cannulation, ALERT, diabetes, swallowing assessment, discharge planning, male catheterisation, MEWS, blood gas analysis;

E9 developed her clinical knowledge through attending the HDU course:

'...little tricks of the trade like if someone's got a sputum plug and they're desaturating and you can't get them to cough it up because they've got no energy, to use the Ambu bag to force some oxygen down, just little things like that that I have used since and they've been really good and like going through renal again, y'know being

specialised in one area you forget about all the other areas really don't you and we have had the odd renal patient with dialysis and it's nice to know what you should be doing with them...' E9

- o Courses e.g. ALS, HDU, coronary care, neuro, respiratory, diabetes, depending on speciality working in
- o Higher education e.g. degree

- Other resources e.g. intranet site, internet, reading books and manuals:

> *'...if I'm not sure I'll ask a colleague or I've even phoned the ward, the speciality ward so and we've got a good intranet here as well, so you can always look up if you're not sure on the computer...there's actually a book...you can log into it and it will tell you, say if you want to look at tracheostomies, what sort of equipment you need and how to look after the patient and doing blue dye tests and what not, and the same with urology, if someone's got a suprapubic catheter, and you want to know how to look after them, so it's all quite interesting but obviously if what you want there isn't there, you'd speak to the speciality ward...' E1*

- Being seconded to another ward area e.g. an ITU placement on the HDU course.

2. Quality: Maintaining and setting standards

- Leading the Essence of Care audit work
- From role models e.g. ward manager:

> *'...she has high standards herself and as I said she's a fantastic nurse herself and if you see her with patients...whatever she's doing she just will give them one hundred per cent of her attention and that's a really hard thing to do when you know you've got all this other work going on, so as a nurse in herself, and I think because of that people respect her and she's been here a long time, she knows the Trust very well, a lot of people know her very well and she works very, hard, in her time she works very hard...and she expects her nurses to have standards so I think that's what makes her a good manager...' E8*

- From the F grade away days

3. Managerial responsibilities e.g. coordinating, leading the team, the off duty, etc.

- Observing seniors at work, seeing how they practice and drawing on that:

> *'I haven't been on any management courses really as such, I suppose it's just through working with your senior staff and*

practice…you watch other people as well and you see how things work well and how things don't work so well...' E3

'I really just picked that up as I was going along to be honest, I've learnt from watching other people who coordinate...' F12

- Being shown by a senior:

  'My previous ward manager…when I first got my F grade, for the first couple of weeks, she was very good at delegating and...she'd write me down for a management day knowing that she'd be around and she'd give me a list of things to do and then what I couldn't do, she'd show me where I was…and then she showed me how she wrote the off duty…' F1

- Asking questions from colleagues and other professionals e.g. F2 on how she learnt about social services and discharge information:

  '...I think we're just picking it up from each other and little bits of information that you do get fed, say from the discharge planning nurse, who obviously knows a lot more about it than we do, but...I've not been on a formal day to learn about it...' F2

  Talking to other F grades on the F grade away days was also useful:

  '...certainly on F away days, talking to other F grades, and learning how they deal with problems and being aware that they're faced with similar problems and have the same difficulties of overcoming them that I have...so it's just kind of by networking that you get the benefit of other's experiences...' F9

- Role models

  '...she has got the all round knowledge of having run her own ward so she's got the experience so she makes suggestions about how to approach things, how to deal with things and she's very good at maintaining standards…she's an inspiration...' F9

  '...F7 is also quite a good role model, managerial wise...she'll just go in, get things done and say why, questioning in a nice way but blunt and to the point...I suppose she's a hammer, I'm a sponge (laughter) because she just goes in, gets things done I think "Yeah that's cool" I can take elements of that for myself and I like that, but also you have to have the kind of knowledge...to get that level of respect and be known for quite a while...' F10

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- Shadowing seniors before taking on the role
- Having a go under supervision from seniors:

  'I worked alongside other E grades, or I was put in charge with another E grade working so if there were any questions I could ask...' E6

- Trial and error
- Picking it up as you go along e.g. the off duty:

  '...I was just given the job to do it and I suppose the person that was acting up at the time, she actually went through it with me...and then it was sort of hit and miss at first and then you just get on with it I suppose...' F5

- Practice
- Experience
- Reflection
- Having an opportunity to coordinate and develop another field of nursing e.g. setting up a pre-op assessment clinic:

  '...we watched the nurses in their practice running the clinic and then we had to set up our own clinic here...we kind of started the ball rolling, we got some literature from Hospital A that they'd already set up, we added some of our own in and a lot of it was trial and error with timings about how long we needed for patients, whether we had extra help, things like that just the logistics of it, so I was involved in really setting up the clinic as well and then we kind of found our own way...' E8

- Attending courses e.g. LEO: Leading an Empowered Organisation. Six F grades and 1 E grade said they had been on the LEO course, when they were a ward manager. The general feeling was that LEO was useful because it made them more aware of their own leadership style and skills:

  '...it was a very good course and it...examines different types of leadership skills and that's a good thing to know really and then maybe you can change or adjust accordingly to how you actually want to be perceived...' F7

It was also useful for exploring practical techniques about how to respond to staff behaviour:

  '...the LEO course was good...in how you word things "How I expect this of you, why haven't you?" y'know closed questioning and it's a case of putting the onus back onto that person...instead of rollicking someone for being late, say "Don't you feel you've let the team down by coming in that late?" instantly puts someone on a guilt trip and in most cases they'll make a bit more of an effort and it's a case of you haven't done

anything and you haven't cracked the whip and I think that's nice, that's the kind of practical skills I'm glad I took away...'
F10

But it did not enable them to affect changes in practice:

'...it's fantastic while you're there and then you come back and reality hits and actually it's really a lot harder to change things...' F6

'...the reality is when you try and transfer some of the skills into a busy environment, you can't always transfer them because you don't have the time to transfer, I think that's the problem...' E5

E5 had also been on the RCN Leadership Course when she was a ward manager. She gained more from this course than LEO because it was over a longer period of time, had 360 degree evaluation, study sets, and discussions of challenging problems. None of the F grades had been on this course:

'I think apart from the peer support you got from that group, I think you did learn basically how you were as a leader and what areas you needed to concentrate on...' E5

4. Communication

- Experience:

  '...I think some people have just got a personality that gets on well with people, but I think you develop over the years as well, I think you become calmer around situations and you put peoples' minds at rest and I think it's something with experience and then age as well, maybe...y'know being in the same job a long time I suppose if you're relaxed and confident in what you do it sort of reflects...' E4

  '...it's just got to do with interpersonal skills I suppose and it comes with experience...and to be honest you've got to be aware of when it's best not to say anything and let the patient take the lead...' F5

- Practice
- Role models:

  'Experience really and role models, people that you aspire to be like as well I think, if you've got good nurses then you look at how they maybe deal with situations…' E8

- Trial and error:

'I think I've learned by watching and I've also learned by making mistakes...whereas years ago I might have told somebody to do something, now I think the best approach is to ask people...that's one thing I have learnt, because people can make one's life very difficult because if you don't treat people properly they will rebel in their own way, like for example if you want people to do something and they always find that they're too busy to do that thing...' F4

- Picking it up as you go along:

  '...you pick up on tips for dealing with them…' E6

- Reflection:

  '...nothing really can teach you, you can't be taught how to deal with a situation; you have to just deal with situations and learn from them...' F1

  '...and also your own experience, you reflect on what's worked and what hasn't worked...' F9

- Building up relationships with people over time:

  '...I have good relations with most people and because I've been here a long time I know a lot of the multi-disciplinary team and so I tend to get quite a lot from them, the stoma nurses I've worked with so I've got good skills with that...' E8

- People management study days - only 4 Es said they had attended a people management skills study day, such as breaking bad news, assertiveness training and bullying and harassment. And one of these had been a ward manager in the past and so had studied people management issues in that role. The trouble was that even though study days were available, staff rarely got the chance to attend them:

  '...I'm trying to think of the courses that are available, we've got handling bad news, dealing with aggressive behaviour I think, which might come into it...but I've never been on those, they are available but...' F10

5. Personnel

- Experience of personnel situations
- Discussing personnel issues with their ward manager:

  '...he talked me through budget meetings and yeah, I don't think he's done appraisals either so we'll do that

together…interviewing yeah, he talked me through, we had a list of questions, what to ask and bits and pieces like that…' F11

F6 spoke to other professionals as well when she was acting up as a G grade:

'I had a lot of meetings with the accountant to go through things so that I understood them, I did have meetings with an occupational health nurse over there so I could find out about their role, I met up with [name of personnel person] from Personnel so I could find out about her role...I spent a lot of time talking to other sisters and care centre managers and just making sure that I was keeping on top of things...' F6

- Study days and courses e.g. appraisals, interview skills, budgets

'...there's so many courses that you can go to, there's loads of them, communication workshops, dealing with relatives, how to do appraisals, there's a huge folder…' F11

When E5 was a ward manager she attended an in-house financial study day called 'Making nursing count'. She found this very beneficial. None of the Fs interviewed mentioned having been on this course or one similar to it:

'...we had "Making nursing count" which covered how to budget, how to do off duty, because they did recognise in the Trust that G grades weren't familiar with how to work an establishment out, or how your budget came from that, what whole time equivalents that gives then and then off duty from that...expenditures...how...budgets are driven so yes there was a 5 day course which I did around those sorts of issues...' E5

- Trial and error, for example when dealing with aspects such as manpower figures:

'I've learnt it through trial and error really because somebody will phone up and say "Can I have this?" and I'll say to them "I don't know what you're talking about...how do I find out about that?" and then...M10 was actually very supportive here, he was the modern matron for medicine, so I used to phone him up and say to him "I don't know what this is talking about, can you show me" and he'd come down and say "Oh I've got that" and then he would email it to me, and then come down and show me how it worked and then I'd be up and running...' F7

6. Supervising and supporting others

- Experience
- Practice
- Reflection

- Discussing issues with colleagues or seniors

  '...I've got a good relationship with WM6, we can talk to each other so I get a lot of information from her and I can understand where she's coming from and I get the opportunity to say what I think...' F9

- Watching others communicate:

  '...it's not always a good idea to go off on a tangent, as I say, I've got quite an even keeled temperament but there's some people who haven't…other staff, they deal with situations differently to maybe how I would, they may get a bit hot-headed whereas I try to keep cool…and also when patients are upset I try and be as sympathetic as possible, again it's experience over the years you learn it, and nursing is a lot of common sense and knowing how to react at the right time…' E1

- Role models:

  '...she's caring, understanding, thorough, fair...and I think she's all of those things, she listens...approachable...' E7

  'I think the skills are around somebody actively listening to somebody, being supportive, having a fair understanding of where that person is coming from even if you're not in their position so a lot around empathy and appreciating peoples' differences probably, whether that's cultural or different perspectives and understanding where you come from and I think understanding your self a bit helps...' E5

- Being given more responsibility e.g. acting up into the next grade up.

7. Mentoring and teaching

- Studying – attending courses such as teaching and assessing in practice, or mentorship updates. Only 4 of the 9 E grades said they had been on a mentorship training course.
- Reflecting on their own experiences as students and drawing on them to influence their own teaching style:

  '...when I was a student some of my experiences of mentors were very poor and really I was a bit clueless about lots of things because people didn't take the time to explain things or didn't show me how to do things properly, so for me its about standards, that I can show students how to have best practice

and to give them a rationale about that, but not just giving them knowledge but to give them understanding as well because that's how you learn properly, I never had that as a student so that's what I want to try and give to my students...' E8

E8 explained how she supervised her students, which was about allowing them to practice in a safe environment and helping them to realise their strengths:

'I try not to smother them but I'll give them things that maybe they don't feel they're capable of but I feel that they're capable of, so for example I had a mature student who had 4 children...and I gave her a group of patients and because she hadn't done that before she didn't feel that she was able to cope yet even her being a parent gave her lots of skills that she didn't realise she could bring to the workplace for organisation and everything else, so it's about saying "I think you're able to" but also you have to make sure that they feel they're supervised and you're not leaving them, so it's about letting them try and do things on their own, giving them some respect as capable people without leaving them vulnerable as it were, so it's getting the balance right really…' E8

8. Deputising for ward manager

- Role models
- Opportunity to shadow ward manager to gain insight into their role
- Acting up opportunity as an F grade under supervision of senior
- Attending management meetings with or on behalf of ward manager
- Attending leadership skills courses such as LEO

Support for E and F grades to manage their roles

SUMMARY POINTS:

Support to manage their responsibilities and meet the challenges of their roles, came mainly from their colleagues, peers and ward manager. The number of F grades per ward varied from 1 to 7, which affected how supported the F grades felt. Those areas where more than one F grade was working at any one time, were felt to be more supportive, since Fs felt the benefit of working with experienced colleagues as they were able to draw on their breadth of knowledge and skill if required. The Fs who worked part time found it difficult to meet up with their senior colleagues to discuss ward issues because they usually worked opposite shifts. Ward managers were perceived as being most supportive if they treated staff well, got directly involved with patient care and led by example. Other sources of support were F grade away days and talking to specialist nurses. Only 1 E grade had attended a clinical supervision session and there was

confusion amongst some seniors as to its purpose and benefit. Senior management above ward manager level were not seen as supportive. The general feeling was that senior managers were not visible enough on the wards and so were 'faceless' to the staff. Seniors implied that senior management did not actively listen to them and did not acknowledge the pressures that staff worked under. Conflict within the team as a result of reconfiguration was also an issue since the tension this caused often militated against support.

Both E and F grades received support on a day to day level from:
- Their colleagues in the nursing team:

> '...whilst we're on duty, we're all there for each other, we do support each other, we do work as a team...and if somebody is having a problem then somebody else will try and step in and help or try and sort out what's going on, give some advice or help out, take over, whatever's going on...' E3

- Their fellow E and F grades:

> '...I think there's a nice skill mix there and we bounce off each other...' F10

> 'I think I'm quite cosseted here even as an E grade I'm cosseted because I've always got an F grade to go to and even on nights you've always got a site manager...there's always someone you can go to...' E9

The Fs felt they supported each other well, especially if their fellow Fs were more experienced in terms of their knowledge and expertise. The number of Fs per ward varied from 1 to 7, which arguably, depended on the number of beds per ward and also patient acuity. But this was not consistent within the Trust because for example, medical wards such as Ward 7, had a similar number of beds to Ward 16 and also a comparable workload, however Ward 7 had fewer F grades than Ward 16.

How many Fs per ward?

Ward Code	Ward Type	Number of Fs	Full Time	Part Time
Ward 1	Surgical	3	1	2
Ward 2	Surgical	7	3	4
Ward 3	Surgical	4	1	3
Ward 5	Surgical	2	2	0
Ward 7	Medical	1	1	0
Ward 8	Medical	1	1	0
Ward 11	Surgical	1	0	2
Ward 16	Medical	3	3	0
Ward 20	Medical	3	1	2
Ward 21	Medical	1	1	0

F12 felt that the diversity of experience of the Fs on her ward meant that there was always someone on duty whom she could ask if she was unsure of anything. Even if she was coordinating, there was usually another F grade working on the ward, which she found immensely supportive. F2 and F6 also felt supported by their fellow Fs, but working part time meant that they never worked with each other as they were usually rostered on to cover opposite shifts. They rarely got the chance to meet up as a group and discuss each others' perspective on ward or professional issues:

> '...we're like ships that pass in the night really; we don't see each other much...' F2

> '...we never ever work together, we always pass, so we see each other probably about 2 hours a week if that...we never talk about where we want to go with things, what needs improving, or anything like that...' F6

They felt it would be very beneficial for them and the ward if they were able to meet up with their fellow Fs and their ward manager at least once a month:

> '...I think if we did have those meetings like once a month I think that would be supportive for us...because we don't get chance to really sit down and talk about things...and like I said I don't see one of the sisters that often at all and it would be nice to know her opinions on things...I think you're just in the dark sometimes of what each other's thinking and really we're supposed to be a united front on things, a team...' F2

- Their ward manager:

> 'I think most of the support I get is from my immediate manager...if there was an issue, then we would sit down and discuss it formally, but mainly informally, we just say..."Can I have a word" or..."I'd like to run something by you, what do you think, this has happened" or "This is what I did" or "I haven't done anything, I wanted to discuss it with you first"...' F4

The ward managers who were perceived as being most supportive were those who treated staff well and strove to improve patient care. F12 said that her ward manager supported the staff so that they could do a good job – working on the understanding that if she looked after her staff then they would look after the patients:

> 'She [ward manager] is very supportive, she's always around and...even when you know that you've done something wrong you know you're not going to get a hard time for it, she'll go through it and...when you don't do things well it's not treated as "Oh you've done this wrong" it's "How could you have done that

better?" it's almost flipped over onto its other side and she brings out the best in people because people want to do the best for WM2 and they want to do the best care for the ward...' F12

Both F10 and F7 felt that their ward manager could be more supportive but understood that it was difficult for her to support everyone. Only F6 felt that her ward manager was not supportive because she seemed out of touch with the ward and the staff:

> *'...[ward manager]'s not very good at seeing the obvious, she would be distraught if she realised the effect it has on people with some of the blinkered things that she doesn't say...off duty is always a big issue because certain people work nearly every weekend and other people don't and those things really wind people up...some people get requests and other people don't...but the staff tell me that y'know they get fed up because she doesn't come out on the ward, she doesn't have any patients, she doesn't come into handover so she doesn't know anything about any of the patients so that causes tension because she used to be very hands on and have her own patients and since coming up to this ward, she's definitely more office based, which is what y'know the line managers want really, but the staff have found that very difficult to understand...'* F6

Attending clinical supervision sessions was not the norm, mainly because they were not built in to seniors' working hours and so had to be organised in their own time. Only 1 E grade said she had been to a supervision session, which she found beneficial, but again, it was in her own time. Some did not really know what clinical supervision was or what it would achieve either and felt that they reflected themselves or chatted to their colleagues after a busy day.

F11 found the F grade away days (see section on professional development) supportive because it was a chance to share experiences with other Fs. Senior nurses in specialist positions were also a source of support, for example, clinical nurse specialists, consultant nurses and site coordinators around the Trust:

> *'The site managers are usually fantastic...if you've got a problem, you can ring them up, straight off the cuff and that applies to any member of staff, ring them up for support and they're there...'* F10

Both E and F grades felt that support from senior management, managers above ward manager level, on a day to day basis was poor. The overall feeling was that senior managers were not visible enough on the wards to have a presence and so remained 'faceless'. Only 1 E and 2 F grades said that their care centre manager was supportive:

'Support from the team I think 95% of the time is brilliant, outside of that, this is where...I feel it's not there, there's no support at all I don't think...above Ward Sister grade I think the focus is on the Trust's priorities, in other words at this moment the financial situation and Department of Health initiatives such as trolley waits...and in a kind of blinkered way, these are being driven forward by the managers, regardless of what happens, y'know what pressures are caused elsewhere...and coupled with the modern matrons, who I see as not adding real value to patient care, if that makes sense, y'know just sort of nagging and pushing "This is what you should be doing" that kind of thing, I don't see...that as being supportive because although I'm quite sure they're aware of the pressure of work that there is...rather than actually looking to resolve the problems that are there, such as asking themselves questions..."What could I do to make things easier on the wards?" there doesn't seem to be any of that going on, so I think there's very little support there from the more senior managers...which I'm sure comes over as extremely negative but this is how I feel and I know colleagues feel...' F9

'...any management beyond the ward, no I don't think so, you seem to be just be told of things that have to be done and changed...one incident...a modern matron level person...we were really short staffed and there was an awful lot of surgery and we knew it wasn't going to be manageable and she came on the ward...and...said "How are you E4?" and I said "Well not very happy, it's going to be impossible" and she said "Oh well just all pull together" and walked off...and as she went I said "We always pull together"...but today that's not enough...y'know why not just listen even if she couldn't actually physically change anything...I mean if they listened and said "This is the reason why it's like this...it is a budget issue, but if it's that bad well you can do this or"...it's just talking really isn't it...' E4

It seemed that support in terms of actively listening was what staff needed, not necessarily actual solutions to problems. It was acknowledgment from senior managers that people were working in difficult circumstances and under a lot of pressure, and the communication of that awareness that seemed to make a difference to staff.

Conflict within the team was noted in some instances, for example merging two different teams as a result of reconfiguration. This was reported as being difficult and a real source of tension amongst staff. F8 felt there was no real support offered from senior management in terms of educating staff inherited from other ward areas, especially if their competency had been called into question. There was perceived to be a lack of awareness from senior management of the stresses that merging teams created and the energy required to merge them.

ACTION POINTS

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

Support for Professional Development

SUMMARY POINTS:

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

None of the F grades mentioned having a mentor, although one said she would have liked one when she became an F grade. There was also the question of who was in the best position to provide feedback to seniors if they rarely worked with other seniors. The transition into the F grade role was largely unsupported by an adequate induction period. The F grades felt confident clinically but their managerial knowledge and skills were often assumed. The Fs, who were supported professionally, had been enabled to develop themselves gradually over time with support and guidance from their ward manager and other seniors on the ward. But they needed to be proactive and seek out their own learning opportunities too; they could not necessarily rely on a senior to do it for them. There was also the issue of the Trust being able to facilitate the development of senior F grades, since once they had reached a certain level of seniority, the only avenues open to them seemed to be a ward manager or a specialist role. There seemed to be no knowledge of how the Trust was encouraging seniors to stay on the wards and maintain their expertise.

Support for E grades

Professional Development Support	Number of participants (n=9)
Mentor assigned	1
Recent Appraisal (in last year or so)	6
Feedback about their capabilities	2

E9 was the only E grade who said she had a mentor, with whom she discussed developmental issues:

> '...she works 4 days a week, so if I haven't seen her for a few weeks she'll come up and say "Oh we must have a cup of tea together, shall we make that time?" and she'll bring me in and say "How's it going, have you been watching that, have you been doing that?" y'know and we'll chat about that kind of thing, so she's very good at making sure I'm happy...about what courses I want to do and things like that...' E9

The other 8 E grades said they could talk to their colleagues or ward manager if they had a problem and so were not sure how useful a mentor would be. E3 recently applied for an F grade post on her current ward and said that it would be good to have a mentor to guide her through the transition if she was successful.

Only 2 of the 9 E grades received constructive feedback about their capabilities and as such felt that someone senior, who happened to be their ward manager, was interested in their development. The other 7 Fs said that feedback when they received it was either about something they had done wrong or fairly non-specific for example 'Thanks for working hard'. They assumed they were doing okay if they had not heard anything different:

> '...sometimes the manager or whoever will say "Thank you" or "Well done" or "That's very good" or but I'm sure it would be more that if there was a problem you'd definitely get feedback then...' E3

> '...it would be nice to have some feedback on how you're doing on the ward...I suppose all the time you hear nothing you assume you're doing alright...which...is not right really...' E4

Appraisals had only really got going in the past year or so on some wards (e.g. E4, E6), whereas in others (e.g. E8, E9) it had been part of the developmental process for a number of years. E4 explained that appraisals were not the norm for a long time, but that had now been addressed:

> '...that's been jumped on and they're doing it now, but they've only really just got organised and started doing them recently...so that's quite good because you have a little bit of guidance as to where you're heading to...' E4

> 'I've been here 10 years and I've had 2 [appraisals] but last year was the first year that everyone had one...' E6

In other areas, appraisals had not been addressed at all:

> '...I haven't had an IPR for ages and that…I think is quite important because it gives you an idea of [how you are doing], because you may feel that you're doing really well...hopefully…somebody would have identified problems if there had been any, or you might be thinking

you're not doing so well but in actual fact people think you're [doing okay]...so it would be nice to have that a bit more regularly really...'
E3

But there seemed to be fundamental differences in terms of what should be discussed in the appraisal process. E4 thought her appraisal was useful for talking about further study or training issues, but there was no discussion as such about her capabilities and developmental needs on a more personal level:

'...but there again you don't really get...what they feel about your progress, it's just about what study you're doing...so they don't give you much personal [feedback]...maybe it's because they work with you...because different sisters are allocated different staff members so maybe it's because they work with you on a daily basis, they might feel a bit uncomfortable doing it...' E4

The general feeling amongst the E grades was that they had to be proactive about their own development and seek out learning opportunities. They could not necessarily rely on a senior to assess their capabilities and point them in any kind of direction:

'It has to come from you...' E4

'...I think you do have to proactively seek it for yourself if you're not getting the support you need, or needing further training, I make sure I keep myself up to date and therefore I can tell my manager that's what I'm doing, I'm quite proactive in my own appraisal system and making sure I keep that up to date...' E5

Support for F grades

Professional Development Support	Number of participants (n=12)
Mentor	0
Recent Appraisal (in last year or so)	5
Feedback about their capabilities	5

None of the F grades interviewed mentioned having mentors. Two considered their ward managers to be their 'unofficial' mentors but this was not a formal arrangement. F7 would have liked to have had a mentor when she first became an F grade, for guidance and direction mainly:

'I would have liked somebody to bounce ideas off, and obviously tell me where I was going wrong if I was going wrong and what I could do to improve...going through things blind is quite hard really when you've got nobody actually saying to you "Well yes you're doing that really well but let's look at this, let's see if we can work on that area"...' F7

Moving up to an F grade was seen as being more of a transition than moving up into an E grade role. This seemed to be because it was a step more in the direction of management and meant more responsibility. There appeared to be a lack of structured support during the transition into the F grade role, for the junior Fs especially. For example, F10 had a couple of weeks shadowing the ward manager when they first started but this was not enough and a lot of what they needed to know was 'learnt on the fly':

> '...so I had to pick things up on the fly and ask which also in a way undermined my authority because you're still like a fish out of water and it's like "Well I don't know the ins and outs" you don't want to look stupid...' F10

F10 would have liked to have spent a month working with seniors in practice before being left in charge. It took about 6 months to settle in, but up to a year before F10 felt totally comfortable in their role:

> '...I don't think I picked up as much as I probably could have done or maybe asked the right questions because I don't think you see in that time what's going to be expected of you and what's going to come through the door and what you will need...' F10

F12 was also unsupported during her transition into her first F grade role. The ward manager left just after she was promoted, leaving her as a brand new F grade to manage a very busy surgical ward. She received little help from those above ward manager level and the amount of stress she encountered in this role eventually made her leave. This experience put her off applying for an F grade position for a second time but on a different ward. It took a lot of encouragement and support from her current ward manager to make her realise that she was capable of doing the job and was in fact already performing the duties of an F grade as an E grade. F12 had been an F grade for 9 months when interviewed and her experience of being an F now was totally different from what it was the first time round. She had learnt from her first experience and was now in a more supportive, cohesive working environment where responsibilities were developed gradually and with guidance, as opposed to being thrown in the deep end and left to get on with it.

F3 found that knowledge was assumed when she went into the F grade role, that because she had been a sister years before that she would pick up where she left off, so to speak. And yes she was able to draw on her experience but she would have liked more of a structured introduction to the role:

> '...when I got this role as a sister I think it was assumed I knew what to do because I'd been a sister before even though there was like a 10 year gap in between...' F3

Along the same lines, F7 was very experienced when she became an F grade, so she felt confident in her clinical skills and knowledge but there was no acknowledgement of the transition:

> '...I didn't have any qualms about actually managing the ward in a clinical sense, professionally there is obviously a big transition between a staff nurse and a sister...and I did find that quite difficult, for the simple reason that everybody actually wants you, once you change from light blue into navy blue, I didn't realise how, y'know people actually want to speak to you, doctors immediately see navy blue, they expect you to know everything about what's going on with every single patient, relatives particularly "Is the sister on?" y'know you might have not been on for 2 or 3 days but you're still expected to know and sort of gen up quickly...' F7

And F7 did not receive any kind of formal induction or training for the role:

> 'I learnt just by doing what I was doing really, I did what I thought I should be doing, yes that's basically it...but no there was no preparation, there was no feedback, apart from criticism...and there was no real support...' F7

In terms of performance review, 5 of the F grades had had recent appraisals, but again, as with the E grades, there seemed to be concerns that the appraisal process was not actually focusing on individual capabilities and providing honest feedback:

> '...the trouble with appraisals is that in some ways they're appraising you rather than sometimes giving you honest feedback and the trouble is I mean WM1 would do mine and yet...y'know if I'm in charge then she's not usually on the shift with me, I mean she might get feedback from other people, which she would tell me, I know she would tell me but...' F2

There seemed to be an issue about the Trust being able to facilitate some senior nurses' development. For example, F3 was advised to leave her current position because the Trust did not have the means to develop her any further. She was not encouraged to stay and share her expertise but was advised to seek a specialist post:

> 'They couldn't do anything more for me...as far as I see they're concerned, I'm two a penny; they can always get somebody lower and bring them up into that slot...' F3

F6 had not received a recent appraisal:

> 'Not done any, not had one...I mean I've been working for this Trust for 9 years and I've had 2 appraisals in the whole of that time...' F6

And no feedback either:

> 'No I don't...not at all, not even negative which worries me because I don't think I'm perfect and the fact that I don't get any negative feedback makes me worry because there must be things I need to improve on but I don't get told about...' F6

Yet she did have a senior with whom she was able to discuss developmental issues:

> '*Probably the person I go to most for advice is the [name] because she was the sister who employed me onto the unit and each step along the way, she's given me loads of advice about how to go for the F grade, what things I need to look at when I went for the acting G grade, she was very supportive in helping me with what I needed to keep an eye on, how to deal with things and also she was the one who made sure I was okay once the merger happened and I went back down to an F so...*' F6

As with the E grades, feedback for F grades was not forthcoming. When F1 acted up as a ward manager, she rarely received feedback unless she had done something wrong:

> '*...people don't come up to you and praise you and pat you on the back and say "Thank you, you're doing a good job", you don't get told those sorts of things, people are very quick to tell you when you're not doing something right...and that's why I think it's always important if people do achieve something or they actually do something that they should be doing that they should be praised and acknowledged for the work that you do...when I was doing that job no-one actually came in and said "Look you are going in the right track" they're quite happy to come and say "What the hell are you doing?" but people don't regularly come and praise you because it's not in peoples' nature to do that...*' F1

Because it was rare for senior grades to work together clinically as well, there was a question as to who was in an appropriate position *to* give them feedback. In most cases, the senior nurses worked in isolation, they were rostered to work opposite shifts, and so rarely worked alongside another senior. If they did, then they never had time to actually observe what each other was doing. So who was looking at their development and giving them feedback on how they could improve their practice?

> '*sometimes I'd like more feedback I think of how well you're doing with things, as to whether you're approaching things right or wrong because I think if you're the one left in charge, you're left to your own devices really and own style of doing things and you don't always recognise if you're doing something wrong or if someone else is doing something in a better way, you don't always get that feedback from people...*' F2

But there were instances where a ward manager was good at pointing their seniors in the right direction:

> '*...if there's something that involves my job that I'm lacking, WM13 will suggest somewhere to go, like the clinical incident forms, I don't know how to do them so that will be another course that I shall go on to do them...*' F11

ACTION POINTS

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

Contextual factors that affected E and F grade professional development

SUMMARY POINTS:

Factors that affected professional development were **personal motivation**, being proactive and taking responsibility for developing oneself; **family circumstances**, having the time and energy to commit to a course, for example, when the Es and Fs had young children at home and/or worked part time; **staffing levels** on the ward being poor so limiting access to study time; **being unable to study in ward time** owing to inadequate staffing and busyness of the ward area; **encouragement and support from a senior** to study; the **location and availability of courses**, especially mandatory days which were often oversubscribed; the current **financial status of the Trust** since staff education was not seen as a priority; **access to study leave** varied from ward to ward and also in terms of funding and time allowed to study; **lack of a structured teaching programme** on the wards; **logistical difficulties in accessing information** for example, being able to contact the IT department for a computer password. **Attending E and F grade away days** was also another factor. Only 3 E grades had attended an away day, but all 12 of the F grades had been to one or more F away day. The away days were perceived as useful but attendance was becoming more difficult because of poor staffing levels on the wards. F grades felt that the nature of the away days had also changed to concentrate more on performance targets and Essence of Care issues, as opposed to everyday clinical and managerial issues that they faced and wanted to change. There was also confusion as to the existence of **E and F grade development programmes**. Three E grades had heard of such a programme but none had attended.

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

The overall feeling was that staff had to be proactive in order to develop and educate themselves. Some were prepared to study in their own time but again this depended on their individual circumstances. Some felt it was almost a luxury to be given both study time and funding and that both were not possible.

- **Personal motivation** – being proactive and taking responsibility for self development:

  'I think it's up to each individual, as I said my development and my degree was done in my own time and I don't think people are prepared to put that commitment in anymore, they want to do a study day, they want time off to do it, they want time off the ward, they want time off for this, that and the other and I don't think that's realistic anymore...' F4

  '...its very much left to the individual these days to get on with their professional development, nobody's pushed to do anything but you know you need to be doing something...' F5

- **Family circumstances** - going on a course was seen as a big commitment of time and energy, and some nurses with young families did not feel able to take on such commitments, especially if they were working part-time too:

  '...I'm interested in expanding that knowledge, given child commitments and everything else at the moment that hasn't been possible and won't be possible really until [my child] is a bit more stable and a little older because I don't think I can sit down and give my solid attention to a long course at the minute and I think that would be unfair for me to go to when someone else could take the place...' F10

- **Staffing levels** on the ward being so poor that staff could not be spared to attend sessions:

  > 'It would be nice to go on more study days, but I can understand the reason why it doesn't happen as much as we'd like it to because we don't have time, nurses have to go off the ward to do study days or do it in their own time, and I think people need their own time to themselves, maybe if study days were made more available…I think people would be more prepared to go...' E1

- **Being able to study in ward time** – was becoming more and more difficult to achieve because of staffing levels and busyness of ward areas. Some staff came in for study sessions in their own time whereas for others, such as those who worked part-time and had young children, and had to organise childcare, this was not possible:

  > '...I very often come in for meetings and we had a short hours session on the MEWS score a little while ago, which I did in my own time and any extras seem to be done in my own time, because I don't feel that I can ask for the study days, again maybe that's a problem with me not being able to ask for the time but I generally feel as though it's not particularly encouraged...' E2

  > '...There are all sorts of study days that we can do, dealing with difficult patients and stuff, I haven't actually been on one of those but there are, the trouble is they sort of come and go and then you won't have one for months and months and then suddenly you think "Oh I should have done that study day"...' E6

- **Encouragement to study and support from a senior** - E2 left her higher degree course because she was expected to do it in her own time and thus felt unsupported in her studies:

  > 'I would just liked to have had more support doing my [higher degree], I was told that I could do it half in my time and half in work time and I ended up having to do it in my annual leave which I was quite upset about, particularly when...there was somebody else on the cardiac pathway at the time, who was given the time...if they'd said from the outset that they couldn't give me the time then that's fair enough but to say one thing and then do another, I actually felt very unsupported because of that...' E2

  Support from the ward manager was also essential in terms of educating seniors about what training was available to them and also in giving advice about the logistics of studying, so for example, how much study leave they could take and

how it would fit in with their working hours. In the majority of cases the ward manager was supportive of giving study leave and good at advising staff what was available to them. If the course was relevant for the area in which they were working then the course was supported. If it was more of a personal interest and not related to the field of work, then such courses were funded by individuals themselves and done in their own time.

- **Location of courses** – the distance between hospitals within the Trust and the difficulties with travelling and parking, meant that attendance was problematic at some study sessions:

  '...the only problem is, a lot of them [away days] are at Hospital B which we go to and I feel the nurses at Hospital A are very good at going there but the nurses there aren't good at coming here and the last one was cancelled because none of them would come...that's disappointing then that they don't come here and yet we're expected to go down there...' F2

  '...there's some study sessions that I should do and they're an hour each, I mean I don't want to come in for an hour because it will take me longer to get here and get home and park…' F11

- **Availability of courses or study days** - this was an issue because in some cases, the mandatory training days were oversubscribed and/or not run very often, which made it difficult for all staff to attend:

  'The amount of mandatory courses they expect you to do is rather a lot and to try and fit all of those in as well as running a home and being a mum, it is difficult to try and get all that time...it would be nice if they could maybe run one day doing your BLS, your fire, your mandatory stuff try and all 3 of them in one day…then at least you're killing them all in one day...but then it's various different departments and when can they do it' E7

  '...because we've got so many mandatory days...we've got 12 mandatory study days we have to do a year but we're only paid for 3...' F3

- **Current financial state of the Trust** – the perception was that staff development and education was not a priority in the current financial crisis:

  '...they're just interested in that you do your job really, educational issues, even your statutory training is very difficult to get on, a) to get time away from the ward and that goes for all grades downwards, to b) getting on a course in the first place, for example basic life support, there'd only be set dates for last year and it didn't matter whether you got on them or not, there was no extra, even though there's a huge amount of

staff, there's only a certain amount of training for each, so they might pay the lecturers or whoever does it at [name of nearby hospitals], so it's a bit daft really...' F8

'...we're all expected to be updated and we're all expected to be using evidence based practice...but y'know if it's not encouraged it's very difficult to, yet it's a requirement that you have to fulfil...' E2

- **Access to study leave** – this varied depending on ward area and ward manager. For example, when F5 worked at Hospital B part time, her study leave allowance was always included in her working hours, whereas now, having moved to Hospital A, this was no longer the case:

    '...in Hospital B it was very much that your study leave was part of your hours and it's a very different picture here...you're expected to do it sometimes in your own time which can be a bit annoying sometimes...' F5

In another case, an F grade in a surgical area in Hospital A, started a specialist course relevant to patient care on her ward, and her ward manager expected her to do it in her own time. Yet the ward manager on the equivalent ward at hospital B funded the course and gave the nurses study leave for it:

    '...I really enjoyed...being on that course, but it was hard work because WM1 had said to me you can do the course but at first she said I had to do it as extra but I spoke to someone because the rest were doing it within their hours…
    I: The ones down at ward 2…
    F2: Yeah the whole course, and she was making me do it in my own time and…I spoke to someone there and she said "No that's not right, you should have it out of your hours" so she did change it, but the only thing was I had to go round to ITU, I was paid for it but it was on top of my hours, so it was quite hard...' F2

Yet other Fs in Hospital A had positive experiences of getting study leave:

    '...I have to say the Trust is very good with study leave, this particular Trust when you go on study days and you discuss study leave with other members that are there...they have to do it in their annual leave or in their own time and...I think this Trust is very good, we do get study leave...and it's paid for I mean I don't think you can ask for much more really...' F7

- **The lack of a structured teaching programme for all staff on wards** -

    '...we don't have a big teaching programme here and it is through lack of time...' F2

Only 1 E and 1 F grade said that they had teaching sessions on their wards:

> *'we've had one of our sisters doing a degree, so she's been doing an awful lot of teaching sessions recently which has been nice...' E4*

- **Difficulties in accessing information** – for example, E6 had been trying to obtain a password for the computer system:

> *'...I'm having a nightmare getting a password for the computer…for weeks and months I've been trying to get one and every time I ring up they say "Oh it's all reset" and I try and oh, I mean I find that absolutely frustrating because I know how to discharge and admit and I can't actually get on the bloody thing [computer] so...whereas before you'd ring an extension in this hospital and somebody would be on the end of the phone and answer it...now it all goes through Hospital B and it's like "Try this extension and that extension" so that does frustrate me somewhat because everything is down at Hospital B now, it's not like you can nip down and say "Look help me out here"…it's not very accessible…' E6*

- **Attending E and F grade away days** – there was no consistency in terms of attending such away days and awareness of their existence was limited. Only 3 (E3 E5 E7) of the 9 E grades had attended an E grade study day and that was just the once. Of the other 6 (E1 E2 E6 E4 E8 E9) one was aware of the days and wanted to attend, but the other 5 did not know about them or were aware but had not been on any:

> *'There might be [away days] but I'm not aware of them...' E2*

> *'…I haven't been on anything like that, only the mandatory ones...' E6*

> *'I know that E grades have away study days but I've never had any so I don't really know what they are to be honest with you, so and that's the thing I want to try and get more involved as an E grade in that role…' E8*

E3 attended an away day a couple of years ago that covered fluid balance and electrolytes. She found this useful and would like to '*go on more of those really'*. E7 has been on an away day more recently but did not find it that helpful:

> *'I've only had one but I think there's another one coming up that I'm put down for but I haven't a clue what it's about...to be honest I suppose I found it a bit boring, it was all harping on about clinical governance quite a bit...' E7*

All 12 F grades had been on one or more away day, which were generally perceived to be useful, especially for sharing experiences with colleagues:

> '...they are beneficial and it does let you meet people...' F2

> '...it's good because it's a good way of talking to your colleagues on other wards and seeing what they doing and seeing how they're coping and you get a bit of a team spirit so I could ring so and so on Ward 22 and just say "Have you done your bench mark, give us a hand" sort of thing...' F8

However it had become increasingly difficult for Fs to attend the away days because of poor staffing levels on the wards:

> '...I don't think attendance is as good as it used to be, when I first used to go most F grades from the surgical wards used to go, from what I gather I think attendance is pretty down but that's because there's such pressures on everybody at work that covering you to go becomes more increasingly difficult... 'F1

The Fs also felt that the very nature of the away days had changed to concentrate more on Essence of Care issues as opposed to the Fs discussing clinical and operational issues:

> '...but those days now, they used to have set sessions where certain people would come in and talk to you, it seems that it's turned into talking about the Essence of Care, and that seems to be all the F grade away days are channelling into, which seems to be talking about your benchmarking and where you're going next with it...' F1

> 'They've changed drastically whereas before we used to get a lot of information from the general manager, she used to come at the beginning of the day and inform us of what changes were happening within the Trust, that sort of thing, I don't think we get any of that input now, lately it's been more study day type updates and...Essence of Care, is an F grade led thing and that's when they catch up on what's happening within that...' F5

F6 was frustrated by the lack of influence the Fs had as a group to effect change at a senior level, and she felt that the away days should have done more to enable this:

> '...the F grade sessions are a complete waste of time, we talk about the Essence of Care and then we might have a teaching session on something like blood transfusions, but most of us just get, we just get really demoralised...we want to do things on wards and then whoever is running the F grade day will say to us "Well why don't you do this, why haven't you tried that?"

and we're like "We have but we can't change anything" and all we get is frustration back really that we can't, we don't have a huge effect on anything higher up, lower down yeah I think we do great in supporting the staff but then...y'know you see what it's like today, because I've got my own workload of patients, how can I support other people effectively.' F6

- **Confusion over development programmes for E and F grades** - Only 3 (E2, E3, E5) of the 9 E grades were aware that an E grade development programme existed within the Trust but none had attended it. Fs said that there were various study days and courses that they could tap into to develop their knowledge and skills, but these were not part of a formal F grade development programme. Only F1 said she had attended one session on a development programme, but that programme 'fizzled out' shortly afterwards. No-one else mentioned or was aware of such a programme but Fs said it would be useful:

    'I think I did one session and then it seemed to, that programme didn't seem to last very long….' F1

- **Working part time**
  Out of the total 21 E and F grades, 4 E grades and 4 F grades worked on a part time basis. The main reason for working part time was having a young family which took priority over work:

    '...I decided to stay part time because it helped with family life...' F3

    '...because I'd had kids, I obviously had to wait, I didn't want to take on a more senior position…it's only since...I think he was at secondary school that you feel that you can do days, but it's fitting everything in around family…' F11

    'I mean there are more opportunities for me to do things if I wanted to do them…but it's mostly done in your own time and obviously with young kids your time is y'know, it would be hard for me to fit it in but if I was very ambitious and really wanted to go places, I would be able to, the opportunities are there, I could be doing a lot more than I am doing…' E6

  There were implications for working on a part time basis:
    - *Having fewer responsibilities*: Being part time often meant having fewer responsibilities than their full time equivalents/peers. This was mainly because of the hours and shift patterns that part time nurses worked e.g. working 2 days a week, one being a night duty, the other being a weekend shift, or starting a shift later than the rest of the team. This was the case for E8 who had different work times to her colleagues and so was not team leading, although she was capable of doing so:

> '...even though I'm an E grade and I'm quite capable of team leading, I don't tend to because obviously I come in a bit later so that does kind of limit me in some of the management I can do...
> I: How do you feel about that, does it bother you…
> E8: Sometimes and not others, I mean yes it does bother me sometimes because I feel that I'm not using all the skills that I have and I know that I've got good management skills, I'm quite an organised person so, you feel like you're being a bit deskilled but saying that I also like to be able to support everybody else so I'm still using a lot of my experience anyway and as you can see…it's highly skilled nursing for the sick patients that we have, so it keeps me abreast as it were…' E8

In another case, E9 rarely took students because of her working hours:

> 'It's very difficult for me to have students because I only do 2 days a week and they wouldn't get the continuation so much and also I work every other weekend as well and students don't tend to work that many weekends in their allocations...' E9

And it was a novelty for F5 to be in charge of the ward too:

> '...this is a rarity for me today to be honest being in charge of the ward, it's about twice a month I get the opportunity because I'm usually on with one of the other F grades and coming in at lunch time which I normally do because of [childcare], obviously they've done the long day and they've been here since the morning so I just tend to take a bay of patients, which doesn't bother me...but it's quite nice to do what I'm supposed to be doing really...' F5

o **Being involved in the ward**: Working part-time had implications for how involved the nurses felt in the running of the ward. For example, E6 had worked full time before she had her family, and when she came back part time she felt isolated because she was not on the ward so often and so did not feel so aware of what was going on, especially in terms of updates and new practices. But then the priority was her family, so she went along with it:

> 'I came back on, having been full time days as an E grade, and taking charge and being quite involved in running the ward to 2 nights a week, 2 separate nights a week, yeah very isolated, not isolated in staff wise but isolated in the fact that paperwork changes and you're not really aware of it and all these things, when you see a

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> *new wound or something, you've got to fill in this form and that form, I felt very…just not aware of it and even though there's loads of update folders, you don't actually get chance to sit down and read them, so I found that really hard because you didn't really know what was going on, but then on the other hand you're back from having a baby and...it becomes less important I suppose…' E6*

When E6 returned to work after her second child, she decided to change her hours so as to feel more included in the team and the running of the ward:

> *'...that's why after my second child I didn't want to come back on 2 nights, I wanted to get a day shift, so I now do a day shift and a night shift and that's made a big difference…just you know what's going on and you're around and when reps come in with new pumps...you get to see more, there's much more continuity really…' E6*

o **Not being known very well on the ward**: Another issue was that not being on the ward full time, some part timers felt they did not know the doctors teams well enough to have a rapport:

> *'one thing I do find being part-time is that I don't know the teams of doctors and who's working for who well enough so if they're on the ward I can't say "Oh by the way while you're here can I just let you know" they've sort of been and gone and I think "Oh god that was the [name of doctor's] team" so I think when you're here full time you build up more of a rapport because you see them on a daily basis and I don't so...yeah so its because I don't know who I'm talking to really, so I find that a bit hard...' E6*

E9 felt because she had been on the ward for a long time that she did belong to the team and knew the doctors well, but she understood that this was a problem for some part time nurses:

> *'...I know a lot of part time nurses that do feel...well they just come in, do their job and go home really it's just part of making ends meet at the end of the month really and they kind of don't get involved in things as much because they know they're not here...' E9*

o **Come to expect less than full timers in terms of career development:** It seemed that those who worked part time felt it was a matter of course that they would not necessarily be afforded the same developmental opportunities as their full time peers, because their commitment was to

their families and not the ward. For example, both E6 and E9 have been approached by their ward managers and asked to act up, which they found flattering. E9 said she also felt quite lucky to have been given the opportunity:

> '...I was quite shocked because I didn't expect it, I think when you're part time you don't expect as much y'know...I suppose you just think "Oh I'm happy doing my part time work" and that's it really, lucky enough to do that than to actually work to something a bit more...' E9

The time was also right for E9 to start coordinating as her family circumstances had recently changed:

> '...I haven't done it for 5 years but WM2 decided that it's time I got back into it, which it is actually, and the kids are older now, [oldest child] is at school y'know as WM2 sensibly says you need a few years to settle into having a family...' E9

On the whole, the part time nurses felt satisfied with what they had been able to achieve so far in their careers. They felt that there were opportunities available for them to develop if they wanted to:

> '...that's how far I've wanted to go with it I suppose, y'know if I did want to I could have gone to WM2 and said "I want to do this" and she would have said yes or no but I haven't really because I've been quite happy with what I've done...' E9

They also felt that their ward managers had been supportive of them and they were grateful that they had been flexible in terms of working hours and shift times:

> '...I mean they were brilliant, both times when I came back from maternity leave they basically said "You tell us what you want to do and we'll try and accommodate you" so yeah I'm very lucky and I guess that's probably why I've stayed here, because I live down the road and it's convenient and they're very understanding with child care...' E6

> '...WM2's very flexible with a lot of her staff and very family friendly, a lot of staff come back and do nights or weekends and she's happy to accommodate to keep her staff...' E8

E6, E8, E9 and F5 were all keen to start learning more now, to either do more formal training or take on more responsibilities. This seemed to be because of a combination of their children getting older and also their ward managers taking an interest in their development:

> *'At the moment it's alright but I am beginning to feel like my brain needs probably a little bit of stimulating, so I should think that when my youngest is a bit older I probably will get myself onto, I mean there's the HDU course and that sort of thing would be quite useful so…but as it is at the moment I feel quite stable…' E6*

> *'…I am quite keen to do some more E grade study days and up my learning, as I said, initially when I was working, moving on in my carer wasn't imperative, I mean as a single parent…managing my work and home life was enough for me without taking too much studying on academic wise but now that things have settled down a bit I really want to move forward and do some learning, getting back into that, so I've got a couple of courses on this year…' E8*

ACTION POINTS

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

Career Motivation and Intentions

SUMMARY POINTS:

Of the 9 E grades, 4 could see themselves moving into ward-based F grade roles. Three preferred to stay as senior E grades because they wanted to maintain direct patient

contact. One of these had been a G grade previously and had no wish to return to the role. Two E grades had recently been approached by their ward managers and asked to act up as F grades for a period of time, which they were looking forward to. Two felt that moving into a ward-based F role would take them away from direct patient care. They also felt it would be very stressful. They preferred to move laterally into education or practice nursing, so they could maintain a degree of patient contact, keep on using their skills and knowledge and move into F grade positions that they considered were less stressful. Of the 12 F grades, only 2 said that they could see themselves as moving into a ward manager position. It was not a question of capability, as the Fs felt they could do the job, it was more a question of whether they would be happy in a G grade role and whether it was really what they wanted. The Fs felt that as a G grade their clinical input would be limited and the focus on business management was not attractive. They also perceived the role to be isolating, stressful, mentally exhausting, thankless, and 'more hassle than it was worth'. Four were content to stay as F grades for the moment, as 3 of these considered themselves to be relatively junior, and 1 had been a G grade before and did not want to return to the role. Three Fs had experience of acting up into the ward manager's role. Two were glad to return to being F grades but one found it very hard to settle back into the role and relinquish the responsibility. Support from senior management for those who acted up and were then demoted was poor, as was support during the acting up period in general. It was very much left to the individual to find and develop their own support network, as opposed to a structured support network being in place for everyone. Two of the Fs were demotivated and had lost interest in their work. What was the Trust doing to recognise this and encourage senior people with extensive knowledge and experience to stay?

Of senior E grades	Number of Participants (n=9)	*Of F grades*	Number of Participants (n=12)
Previous experience of F or G grade role	2	*Previous experience of G grade role*	1
Has been asked to act up as an F grade	2	*Has been asked to act up as a G grade*	3
Future aspirations		*Future aspirations*	
Stay as senior E	3	Stay as F grade	3
Ward based F grade:	4	Stay as F grade or specialist nurse role	1
Practice nursing	1	Ward manager	1
Education	1	Ward manager or specialist nurse role	1
Midwifery	1	Practice nursing	1
		Specialist role	1
		Mental health nurse	1
		Working abroad	1
		Unsure	2

Of the 9 E grades, E3 had already applied for an F grade position on the ward when she was interviewed, and she had experience of being an F on another ward and also of acting up on her present ward over a 3 month period. As an acting F, E3 did not think her role changed that much, as her ward manager wanted her to maintain clinical standards rather than get involved in the managerial side:

> '...we shared the 6 months, myself and another staff nurse, and our role was mainly to maintain clinical standards basically, clinical excellence is what she wanted, rather than...getting too involved with the other side of things...' E3

Three of the E grades could see themselves moving up into F grade roles on a ward. E6 had been approached by her ward manager to act up for a few weeks so as to cover her annual leave and E6 was looking forward to this. However she did not feel it was the right time for her to move up permanently:

> '...it would be nice to move up but just not yet, it's just not the right time yet…I can't see myself here retiring as an E grade "Oh I've been here 30 years" that's not what I want, it's just that at the moment it's very convenient...' E6

E6 felt that her skills and knowledge in some areas were good enough to enable her to act up, but in other areas they were lacking. She hoped to receive some kind of handover before she took on the role:

> '...basic care and the running of the ward, I do feel that I've been here long enough to carry that on, but there are a lot of things, y'know I only work on a Tuesday and I know there's lots of infusions and other things that go on other days of the week so...I would hope that…I'd be able to work with somebody first before they suddenly let me loose and I'm sure they will, because there's lots of figures, I mean off duty I've never done off duty so I hope they would prepare me…so yeah it would be a bit scary but quite challenging I think to give me a taste of it…' E6

E9 had also been asked by her ward manager to start coordinating the ward. As with E6, she was looking forward to this change in role and could see herself becoming an F on a part time basis in the future:

> 'F grade I'd be quite happy being...especially here because you're not always in charge and coordinating, it's like this afternoon I think there's 2 F grades on and one will team lead a side and look after patients and another one will coordinate so it's nice up here because it's not always that you're in charge...and they're even more trouble shooters with things and you get to do a bit more teaching as well...' E9

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But she did not want to become a ward manager:

> '...I don't want to go any higher than that ever...no because I think you lose patient contact then and that's what I'd really [miss]...I think a lot of people come into nursing for the patient contact and if you haven't got that...you're lost above that really aren't you, I feel sorry for WM2 in a lot of ways because I know that she enjoys the care and it's sad that someone of her experience doesn't get to do more of it...' E9

Five could not see themselves moving into F grade roles. Three of these were happy to stay as senior E grades because they wanted to care for patients first and foremost:

> 'I see myself staying as a senior E grade in the future, from a management point of view I don't want to do a management role…I just want to be on the ward with the patients, I prefer that, from a personal point of view, but that doesn't mean to say that I don't want to learn...' E1

> '...I don't know if it's the enrolled nurse that'll always be in me, which is always the bedside nurse and I think that's just in me, I don't think it'll ever change and that's what I like doing and that's where I want to stay really, I don't want to get too involved with management...' E4

> '...it depends what you came into nursing for, I came into nursing really to nurse people, not to deal with budgets and spreadsheets...' E5

Two could see themselves moving laterally into practice nursing or education:

> '...I've never really felt that an F grade on the ward is something that interests me, I'd rather go into lecturing or something or sort of academic...' E2

E8 felt capable of becoming an F grade but she was not sure it was for her:

> '...I think if I wanted to change my career, rather than move up I think I would move sideways, as I said I'm quite interested in being a practice nurse...' E8

They both felt that becoming an F grade on a ward would take them away from direct patient care:

> ...I enjoy my job as it is, I enjoy the nursing, I sometimes feel as though I can't give the level of nursing care that I would like

to and I think that would probably become even less if I was an F grade...' E2

'I enjoy my teaching I enjoy my patient care, I think that's why I'm not that keen to go too much into management because it takes you away from the patients which is why I'm here really and it's what I enjoy the most although I do enjoy management and I am efficient but I don't want to lose sight of actual patient care...
I: And that would happen as an F do you think?
E8: It tends to happen, I've seen a lot of my colleagues who don't really do as much patient care I think as they would like and they get caught up in politics and money and things like that...' E8

The stress of an F grade role was also a factor for E8, especially as she had child care responsibilities at home:

'...I don't really want to move too far forward and take on responsibilities where I increase the amount of stress in my life...so in a way I'm quite happy to stay where I am and keep the stress levels manageable rather than move forward into a position where maybe I'm taking on a lot more responsibility because when I leave work I've got responsibility at home as well so...' E8

For the F grades, feelings were mixed about moving up to ward manager level. There was only one definite yes, from a junior F grade, but the majority said no (n=8). Of the 5 junior Fs who had been Fs for less than 2 years, 3 said they did not want to be ward managers. Five of the 7 senior F grades said they would not want to be ward managers either. It did not seem to be a question of capability though, as the F grades felt they could actually do the job, it was more a case of whether they would be happy in that role:

'...I'm not saying I wouldn't go for it if it was there, because it would be that bit of progression but are you going to be happier with it?' F2

'...well part of me thinks "Yeah I could do that in a few years" the question is "Do I want to?"...' F10

The Fs felt the role had lost its appeal because now the emphasis was on business management as opposed to clinical management. As such the F grades questioned the appropriateness of the role for a highly skilled and experienced nurse:

'...I must admit I do look at what WM1 has to do and it doesn't a hundred per cent make me feel "Oh I want to do that job" I think it would be nice to be the one in charge, yes, but I do look

> *at some of her work and think "Oh there's even more paperwork than what we're having to do now" and I think that's a shame with that role...and a lot of it, I've heard other ward managers say the same, it's not really that a skilled nurse needs to do some of the work, y'know some of the figures she has to do and feeding bits into the computer...it's not what a G grade has to do...' F2*

F8 felt that it was too much hassle being a ward manager, especially for the amount of hours worked and the huge responsibilities:

> *'...I wouldn't be in a rush to go into WM18's shoes...I think for the meagre pay rise that you'd get for going into WM18's shoes, I wouldn't bother with it...I mean WM18's here day and night, she's here gone 4, 5, 6 every day, and for what, complaints, unfair complaints too, y'know you don't feel like you have a voice sometimes...I don't want to do what WM18 does, I think I'd like to have a life outside...' F8*

For F3 who had been a ward manager before, the role was seen as harder now because of the pressures within the NHS:

> *'...it's too cold, it's not what I came in for...management the way it is now in the NHS is not the way it was in the past, they've got a terrible job to do and I think it's very political at the moment, I mean it always has been but it's very political, and it would be very difficult, you've got to be a very tough person to survive in the management structure today in the NHS and I don't think it's me at all...' F3*

Again, she felt she could do the role, but she knew it would be very difficult:

> *'...I could see myself doing it but the issues that are out there are just, I mean I do [part time] hours I suppose I could do [full time] because my children are teenagers but would I still have the same enthusiasm for my job...I don't think the enthusiasm would be there and you need enthusiasm for it to keep going with other nurses...' F3*

F4 was quite happy to stay as a senior F grade and was not prepared to put her mental well being on the line to become a ward manager:

> *'...from my point of view, looking at the stress that managers are under and they're all the time pushed to achieve more at the end of the day...I don't think I'm prepared to take on the role that I am going to sort of put my mental well being on the line because I'm so stressed out about the job...' F4*

F4 thought it was too far removed from clinical nursing as well:

'...it's just not something that I'd like, I wouldn't want to sit in front of the computer all day...I mean there's accountancy, there's budgeting, y'know its very much a management role and it's managing resources and it's also very much managing people, but the big emphasis at the moment is on managing resources and it's not something that I particularly want to do, I came into nursing to look after patients...I feel I would get de-skilled too quickly...and at the end of day you're as good as your last performance, you're as good as your last job... life's too short...' F4

F5 did want to be a ward manager at one point before the move into business management:

'...years ago I wanted to...but there's just too much involved now being a G grade, budgets and oh the G grades are forever sitting in front of this computer doing so much paperwork and going off to this, that and the other meeting...answering complaints, justifying this, that and the other and oh I can't be doing with it to be honest, I just want to do my job and go home...I mean I know I could do it but I just don't want to anymore...I think their post has completely changed over the last few years...they were more hands on in the ward...I think they get more stress these days because they're forever answering the people above them about why have they done this, why are they overspent this month, "Why have you spent so much on this?" why, why, why, they're always being asked why...' F5

F5 was bored at times with her present job and had been looking to try something different, but at her level she felt that her options were quite limited:

'...unfortunately when you get to this particular position, your options are quite limited because the specialist nurse posts don't come up that often so...' F5

F6's 9 month acting up experience as ward manager made her realise that she did not want to do the job on a permanent basis:

'It was a fantastic experience because it really made me realise that I don't ever want to be a G grade, it's a horrendous job, absolutely horrendous...you're responsible for everything with little back up or support...' F6

F6 enjoyed working for the staff and trying to improve their working lives, but it was hard trying to please staff and managers, when their agendas were so different:

> '...I loved the team side of it, pulling the team together, doing things for the team...for the ward level but not really interested in all the paperwork, policies, all of the budget things and y'know trying to please two completely different minded oppositions, because you're trying to please managers at one point, you're trying to make sure that we're cost effective and not over-spending and then you've got the team that want things and can't understand why we're so overworked and you're stuck right in between with no support because you're the sole person for that job...' F6

F6 went back into an F grade position on the ward and gradually lost her motivation:

> '...it's just a job now, I come in to get my money and go home and the sooner I do that the better...' F6

She was frustrated in her efforts because she felt that patients were not the Trust's priority anymore:

> 'All people are interested in the Trust at the moment are targets, budgets and breaching, that's all they're interested in...they're not interested in the patients, they never ask...' F6

F1 also found her role frustrating when she came back down to an F grade after acting up as a ward manager. Because of this she thought about changing jobs 'every single day':

> '...I feel sometimes so infuriated...I think a lot of my problems are that I've worked in a position higher than I am, I am still finding it very difficult to be in an F grade job...' F1

F9 and F10 were happy to stay as F grades for the foreseeable future. F9 was satisfied with what he had achieved in his career and the level he was at. F10 felt that he was still being challenged in his present role and would like to spend at least 5 yrs as an F before considering what the next step might be:

> '...I think at the minute I've reached a level where I'm still being challenged and I think "Yeah this is still interesting for me" I've still a lot to learn and I'm at that stage where I think "I want to learn a bit more" I can see myself doing other things, I'm not quite at the stage where I'm bored yet but I'm at the stage of yes I can do things better, I am becoming more proficient and that's nice...' F10

F9 did not want a ward manager's post because again of the hassle and the loss of direct patient contact:

> '...I've no intention of going for a G grade because you get far more hassle up there than what I'm getting here and also you do sort of lose contact with the patients as a G grade a bit more, which I'd be reluctant to do...' F9

F10 also felt that being a ward manager would be quite isolating and so was not particularly in favour of becoming one:

> ...but to do WM8's job I don't know, I don't know if I could take the flack from all sides because I think the higher up you get the lonelier it becomes and I think "Well do I want that?" even stepping up to the sister's post became a bit y'know, there's not that many you can talk to around the group if you're deciding who's getting jobs, who needs pulling up...' F10

From the ward manager's point of view, the general feeling was that F grades did not want to be ward managers anymore because of again, the hassle that comes with the role:

> '...F grades have always been very popular because you get paid more, you're in navy blue, but you don't have the overall responsibility, that's always been a very popular role being the F grade but getting past an F grade was always more difficult but I find in this Trust it's not competitive and...people don't aspire to it I don't think because they see the crap that comes with it...who'd want it?' WM14

ACTION POINTS

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

Support for training and development needs

SUMMARY POINTS:

In terms of support for training and development, Es and Fs would like role expectations to be more explicit, from ward level staff up to senior management. They felt that creating more awareness of peoples' roles within the Trust would go some way to building more of a supportive working environment, as would more open and honest communication between ward staff and senior management. Having more time to spend with senior colleagues was considered beneficial, to update, educate and feed back on certain issues, and having appropriate admin support was important in freeing up seniors' time. Seniors would also like more staff and more time to deliver patient care, yet they realised that in the current financial climate, support in this sense would be practically impossible to achieve. Seniors would like more consistency in the Trust's approach to allocating study leave and funding, as it varied so much between wards, and they would also like a structured teaching programme that is ward based. Because of the difficulties in actually attending study days, Es and Fs felt that teaching sessions should be more on an ad hoc basis, so in their workplace, maybe during lunch time or during the handover period. They felt that mandatory study sessions could be amalgamated so as to limit the time that staff spent away from the ward. Es and Fs would like teaching on human resources, such as capability and disciplinary procedures; 'tips of the trade' type sessions on for example, how to write an off duty or coordinate the ward; people management skills, such as conflict resolution; financial planning and budgets; IT knowledge and skills and using them in practice. Seniors would also like a structured induction programme to guide those in role transition, rather than being 'thrown in' and 'left to get on with it', as seemed to have been the case for most. They also thought that a career development programme within the Trust from D grade through to G grade, would be of great benefit, in helping staff prepare for the role ahead.

What support for training and development E and F grades would like

- **For peoples' expectations to be much more explicit and their roles clarified- from HCA through to senior management**. Creating an awareness of exactly what other people do within the organisation, what their responsibilities were and how they fitted in with everybody else's, seniors felt would help make others appreciate one other more:

  > '...when you step from being a staff nurse into becoming an F say, you often used to moan about "Why haven't we got staff, why haven't we got this, why haven't we got that?" and you never used to look beyond that and now you realise y'know how difficult it can be, you're much more aware of budgets, I think all staff, from all the way down to the HCAs should be told about "This is how much we've got in the budget" so if we really don't need that extra A grade at night time, it might come in handy another time....everybody lives in their own little bubble and they just want to get through...' F8

> *'I also think we do a lot of other peoples' jobs now, I think we've taken over a lot of other peoples' roles "If it can't be done ask a nurse to do it" kind of thing...dieticians, the MUST tool, yes it's been given to us because they've only got what 3 dieticians in the Trust, so they just come in to do the TPN and it feels that you're doing all the ground work for them now which we never used to do...I just feel that everything's getting planted on the nurse...they're expecting nurses to know more about what's going on...and like stores are left up to us to make sure we've got them sorted out because they're short staffed...like physios we're taught how to assess chests...and because we can now do that they only take patients under certain criteria and "It isn't that hard, the nurses can do that" y'know things like that keep getting handed back to nurses and then they wonder why we need more staff to accomplish these things...' E9*

- **Improved communication between staff and senior management**, more honesty and openness:

> *'I'm a great believer that people should talk a bit more than they probably do, and I think if people communicate better, your team work on the unit is better because people are more willing to help each other out...' F1*

- More **time to spend with other seniors to discuss ward issues**, update one another and feedback on aspects of their role, such as manpower figures:

> *'...it's just the management, about whole time equivalents, because some people come down and ask me a question and I think [name of job share] and I just look to each other, but [name of full time F grade] and WM10 will know the answer, and that annoys me sometimes, manpower figures and understanding who's doing what and because they interview they know who's coming, who isn't and it does frustrate me...it's more the personnel side of our roles and the management, but I still think they should feedback to us about that...' F3*

- A more **formalised, structured teaching programme that is ward based and multidisciplinary** – so as to create more interest in education and make it more relevant to practice, as opposed to something they have to leave the ward to do.

- **Consistency in the Trust as to study leave allowance and funding**

- **Amalgamating mandatory training sessions** so that maybe 3 can be done on one day, as opposed to separate days. This would limit the number of times staff would have to leave the ward:

'...the ALS I tried to get on for April but that's completely full, which is the second time I've tried to get on it, so I've got a place in June...you understand to a certain degree because if they're full, they're full but y'know it's a shame that there aren't more courses and you feel like you're trying to update yourself all the time, but you don't always get given the opportunity to do so, and it's not through your ward manager...it's just lack of funds sometimes because I know obviously, there's a freeze on the courses until April so you can't do anything there...' E3

- For all wards to have **appropriate administration support**, so as to free up the time of seniors:

  'I think I would prefer it to be that other things support that role, in terms that you do have a proper admin support, that people are dealing with things that don't infringe on the nurses time so that the nurses can concentrate on giving the patient care they want to give, that things don't deviate from that...I think personally we should have more ward clerks here to allow for the turnover and like a normal business has a receptionist, we don't have that on the ward and people therefore feel a bit lost when they stand at the desk...' E5

- Having **more staff and more time** to deliver patient care, and less pressure to move patients through the system (seen as an impossibility):

  'Probably more staff, but that's never going to happen...' F11

  'We need more staff...because more staff would then mean that we wouldn't have to be used as, as in me and [name of other F grade] and WM9, as y'know taking patients all the time, which doesn't allow us to manage, all we're doing is getting through that shift and that's not the same as managing a shift well, we're just struggling through it, it doesn't necessarily have to be an extra person for all 3 of us it just needs to be that y'know once a week we can either get together or each have a day when we can do other things other than just managing a shift...' F6

- Workplace sessions on **human resource issues** covering theoretical and practical aspects, for example, the Trust policies on capability and disciplinary procedures; understanding the policies and how they are applied in a clinical setting, so how to put a member of staff on capability, what evidence is required for it, how is it monitored, reported, who should be involved, resources available to assist, and troubleshooting concrete scenarios so 'what happens if...?'. Also the chance to hear from others with experience of using the policies in practice, so what was their example, what did they do, did it work, if so why and how, if not why and how, what did they learn from it, what could they have done differently, what would they do next time? And following that up with practical support in

practice.

- Theoretical and practical sessions on aspects of their roles like **writing the off duty** or **coordinating the ward**, so 'tips of the trade' type sessions from experienced nurses:

  > '...running the ward efficiently, knowing what to do in a crisis, which to a certain extent I do know but there are still things that maybe I need to look at, prioritising...' E1

  > 'I know there are lots of study days on certain aspects of the job like for example appraisal training and there's things like the bullying and harassment study day...the extended roles, to learn different skills like cannulating and all that sort of thing...but I don't know if there's anything like formal training to help strengthen the role that you're in...' F1

- Workplace sessions on **people management skills** – dealing with difficult situations and potential conflict, how to avoid and diffuse such situations, learning how others deal with similar situations –again, using **concrete** examples from practice, so sharing experiences and making suggestions as to how to improve practice. Also knowing what resources are available and how they can support staff in practice. Giving staff coping strategies for dealing with difficult situations, so a few ground rules e.g. 'This is how you should try and present yourself; acknowledge the problem and put yourself in the other person's shoes, don't get defensive, try and take a step back, be objective' etc:

  > '...a few study days or courses that would actually be looking at managing a team and looking at attitudes towards leading and certain roles...and different personalities that you have within your group, I think that would have been...very helpful...' F7

F9 said he has had nothing useful in terms of training to develop his people management skills. The nearest thing was a days training on challenging poor practice which he thought was 'awful' because it felt unrelated to practice:

> '...I thought was the most awful training day I've ever been on, it was an in-house one and I thought it was awful because they must have spent loads of money bringing in these actors to give us scenarios, and I felt they weren't real scenarios because these actors were obviously told not to concede an inch, not to concede anything, so it's an unreal situation...and also they gave us only one strategy for dealing with that and that was essentially hit them where it hurts kind of thing, y'know really have a go at them...and I'm sure there must be lots more strategies...' F9

- Workplace sessions on **financial planning and budgets** – so for example, how to read budget statements, what to look for, and what each section means, trouble shooting scenarios:

    '...I just don't have a total understanding of where that money comes from and how much we're allowed and how much we're allowed to spend and what on...' F2

    F8 had been to one session on budgets, which was good, but not enough. She would like more regular sessions because such information needs to be reiterated to understand it fully:

    '...I did initially, it was very good but I could have done with another because it was very much in one ear and out the other, spreadsheets and all that sort of thing...' F8

- **IT training** on the basics of using computer software, from writing reports and updating handover sheets, to using email and spreadsheets, to learning more about the IT tools used in the Trust such as OBSERVE:

    '...there are a lot of things that as nurses you're expected to do but you're not given any training like IT training, I mean I can hardly remember my password name and now they're going to bring in a new computer for x-rays and it gets landed there and we're expected to pick that up and therefore a lot of things we pick up along the way...' F4

- Being able to **implement changes in practice with support from senior management:**

    '...being able to implement some changes and...get them working and just to have a little bit longer to...just reflect and be able to do things as we would want them to be done...in terms of standards...' F9

- **More input from E and F grades into managing their away days**, for example, so setting the agenda and having action plans for dealing with practice issues:

    'I think I'd like to see a less threatening F grade forum...like the F away day, more informal and maybe even more run by ourselves...because I think sharing the experiences, talking experiences through with others, you can actually learn a lot and you can teach others a lot as well...I think we'd like to have a bit more about what is going on in the Trust y'know in terms of the priorities of the Trust, to be able to talk through those a little bit more, and to be able to add a little bit more influence, to have a forum to push things up the line...to be able to have a better understanding of how the hospital's run so you can just

kind of make sense of it and just to be able to influence things...' F9

- **A structured induction programme for those in role transition** – so moving from E to F and F to G. Seniors would like a mentor to guide them through the process and the opportunity to shadow seniors in practice, so as to learn more about the role. They would also like the network of support resources to be more explicit, so being made aware of who is available to help them. For the 3 F grades who had previously acted up as ward managers, they received no formal training to prepare them before they went into these posts or indeed during their time in these posts. They did their learning informally from their seniors, ward manager or other professionals, through trial and error and on an ad hoc basis:

  > *'...I didn't come in as an E grade and then have the induction and everything else, I missed out on all of that so a lot of the things I've picked up along the way, rather than had any formal training...' E8*

  > *'...it was sort of thrown in at the deep end and I mean I'd only been an F grade for 18 months and as an F grade my main responsibility was making sure the off duty was done so then I came into the G grade position acting, and I had to learn everything very, very quickly and it was fine because there were lots of people around who I could ask, like there was WM15 the sister next door, and there's [name of specialist coordinator] who used to be the sister on this ward...she'd come round everyday and she'd make sure I was doing okay and if I had anything to ask I could ask her so...and I was always quite good at phoning people y'know accountants if I didn't understand something I'd phone them, but it did take a lot longer for things to get done because I needed to find out how to do them first...' F6*

- **A career development programme from D grade to G grade**, and beyond; to learn more about the next role up so that staff feel prepared and feel equipped with the appropriate knowledge and skills to apply for promotion:

  > *'...I think at each level it would be good to have a development programme but actually something formal...having something where they go in and they have 2 days in school and then they go back to the ward for 2 or 3 weeks and then they come back in again, I think it's reiterating it really and I think that would be a good way of developing a programme between each stage...you don't tend to forget because you know that you've got to go back in so it's constantly at the back of your mind "Well I need to be doing this and I need to observe that" and then when you go back you share that experience so it's more likely to stay with you...' F7*

ACTION POINTS

- For senior management to make role expectations and responsibilities more explicit, from ward level staff up to senior management
- For improved communication between ward staff and senior management
- The development of an in-house, rolling teaching programme aimed at all ward staff, and devised and constructed by in-house staff. Sessions could operate on a rotational basis so as to reach as many staff as possible. Responsibility for giving teaching sessions could be shared between ward areas so that for example, staff on one ward could teach for a month before passing on responsibility to another ward in the same division
- For Trust policies on study leave allocation and funding to be made explicit to ward staff, so that staff know what they are entitled to. Also for senior management to operate a consistent approach to study leave allocation and funding, so that staff feel they are being treated fairly and have the same opportunities for studying on one ward as they would for example, on another. If this is not possible, then the reasons why it is not possible need to be communicated honestly and openly to ward staff.
- For senior management to be consistent in the study days and courses that it offers staff and think of contingency plans to deliver such training when in times of financial hardship. For example how can they provide training when they are over budget? Also for senior management to be honest and tell staff what is possible to achieve and what is not possible. Maybe asking for help from staff as to what they can do would create a sense of unity in trying to solve the problem.
- For awareness of E and F grade away days to be promoted, especially for E grades as their knowledge of such days was patchy. For Es and Fs to have more of an input into the away day structure and agenda, so as to promote ownership of the days. Fs would like the away days to discuss more day to day clinical issues, as opposed to focussing solely on performance targets, so for example, how they could change and improve practices in their ward area. Fs would also like those who run away days, to follow through issues raised with actions, so that for example, they provide practical support for changing ward practices.
- Senior management need to develop new ways of delivering study sessions so as to limit the time that staff spend away from the ward. For example, ward based, mandatory update sessions during the handover period or amalgamating mandatory training sessions so that 3 updates could be achieved in one day
- For senior management to develop theoretical and practical study sessions on issues relevant to everyday practice such as human resource issues, writing the off duty, coordinating the ward, managing people and conflict, financial planning and budgets, developing IT skills
- Senior management to devise ways to help wards deal with their administrative pressures, so as to free up nurses' time to deliver patient care
- For senior management to help ward managers and their teams to think about how they organise their time and structure their shifts, so they can make changes to improve their working lives. For example, enabling seniors to make time to meet and discuss practice issues together

- For senior management to develop a structured induction programme of support for those in transition, so from E to F (senior band 5 to band 6) and F to G (band 6 to band 7)
- For senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that career progression is less fragmented and seen as more of a natural process.

SECTION IV

WARD MANAGERS

The Managers' Perspective on support and development

Ward managers wanted support and development in a number of areas of their roles. These were clarifying senior managers' expectations of their role, including supervisory status; meeting the various challenges of their role, from managing in the current financial climate, to dealing with Personnel issues; support in managing the effects of change, namely reconfiguration; developing their relationship with senior management; developing themselves and their staff and succession planning.

This section concerns the support and development needs of ward managers (n=11). The majority of ward managers (n=8) had been in nursing for 20+years and the remaining 3 for between 10-15years. Two were junior, having been in a ward manager's role for less than 2 years, and the remaining 9 were senior, having been in a ward manager position for more than 2 years.

Ward managers spoke about a number of issues in relation to support for their professional development; these were:

1. Expectations of their role and supervisory status
2. Challenges of their role
3. Managing the effects of change i.e. reconfiguration
4. Their relationship with senior management
5. Ward manager development
6. Staff development and succession planning

SUMMARY POINTS:

Expectations of role: there was little guidance on how to operate the ward manager role. While this allowed for flexibility in its interpretation, some managers struggled to find a pattern that satisfied them. Reviewing various possibilities and discussing how others were managing would have been helpful. **Challenges**: ward managers were trying to maintain safety standards under pressure of patient numbers and current financial restrictions that constrained staff numbers, making them aware of their limited control as managers in respect of decisions by senior managers. Personnel issues such as staff disputes, bullying and extended sickness were also challenging. **Managing change**: while change could be welcomed, constant changes, often at short notice, with lack of consultation and little support were difficult to manage. Reconfiguration could entail merging new and inexperienced teams and dealing with issues of capability. Being clear and consistent about expectations of staff performance and being robust in maintaining these, were seen as essential to manage the changes. **Relationship with senior management:** ward managers wanted to see more of their senior managers to improve communication and understand each others' point of view. Decisions made by

seniors resulted in actions at ward level which the ward manager was then responsible for but may not have approved. Senior managers who listened were seen as supportive, but ward managers felt there was a lack of positive feedback. There was a perceived blurring of management roles and responsibilities. Ward managers thought they had less authority now but more was expected of them on performance targets. They were saddened by the impersonal relationship with senior managers with the prevalence of communication by email. **Development**: most ward managers started their roles without specific training, relying on informal advice from peers and trial and error. They would have liked help on how to read and understand budgets, personnel issues and monitoring sickness rates. Some had subsequently been to training sessions but not others; they gave their staff priority for course attendance. The RCN course on leadership had enabled some to develop support networks. Staff appraisal was patchy or non-existent. Appraisal was seen as focussed on meeting targets and not personal development. Some found support was there if they asked questions; others felt isolated and out on a limb. The G grade away days could be good for networking but sometimes were seen as overly critical and negative. Administrative help would ease workload. **Staff development and succession planning***: It is difficult to release staff for training because of financial constraints on ward cover. The 3 days annual training allowance appears insufficient and even mandatory training is difficult to fulfil. Records of what training has been undertaken are not routinely kept but at least one ward manager was undertaking this. Training up their F grades for the ward manager role was not generally undertaken and some managers were cited as keeping their role to themselves. Nor were F grades passing on their knowledge to E grades. There was a need to make the ward manager role more attractive to F grades; some clearly did not want it while others found themselves promoted into the role in a haphazard fashion.

1. Expectations of the role and supervisory status

The drive from the Trust for ward managers to work Monday to Friday, 9-5, and be supervisory in their role, was a source of confusion and tension. The majority of ward managers thought it a good idea but for various reasons, had real problems with actualising the role. It seemed that as an initiative, it had started off well but lack of follow through and mixed messages from senior management, meant it had fallen by the wayside:

> '*at the beginning of last year, the Trust had a drive saying that all ward managers **should** consider being supervisory, supernumerary and we all thought "Yeah maybe that's a good idea" but it's already petered out...just because the process wasn't followed through over the year by the management that talked about bringing it in really, and all the meetings that were planned for last year never happened...'* WM7

There was also a lack of understanding as to the nature and purpose of the role and how ward managers were to implement this in practice. As a result, ward managers were left to implement the role as they chose. For example, WM1 had 3 clinical days on the ward and 2 days in the office, whereas WM6 worked 2 clinical days on the ward and 3 in the office. WM1 was reluctant to cut down on her clinical input because she felt that was pivotal to successfully managing and leading her team:

'...I'd like to be able to get more time out on the ward because that's when I find I'm most effective because you can see everything that's going on but I find that…if I don't have the time out on the ward and I spend more time in here [office], I'm missing out on what's going on out there, if I spend too much time out on the ward and not enough time doing the administrative work then I get behind with audits and then...I can't win so I don't think you could spend any less time than I do because you need to know what's going on, because you pick up things, habits, ways and what's going on out there by actually being there, you can't observe it from an office...and I like to be involved in that, the skills of the handover, so that seems to be my best time for any teaching, if there's a question "Oh what was that they said?" "Oh right you don't know about, well let me tell you about X, Y and Z" and we'll discuss things, so it's a good way of teaching as well...' WM1

However WM12 and WM7 were unable to be supervisory because they had small wards, and therefore small establishments:

'…I'm part of the numbers at the moment...I haven't been supernumerary; I haven't been able to be...' WM12

Poor staffing levels and Personnel issues with their F grades also militated against them adopting the role. The majority of ward managers enjoyed being directly involved in patient care, and also felt that this enabled them to lead their team by example:

'I don't ask my staff to do anything that I wouldn't do, I clean the sluice, take patients, I washed a patient the other day and they were so chuffed they said "You're the ward manager and you're giving me a wash"…I get a uniform on and work with my staff, I act as a role model and staff learn from my behaviour and practice...' WM8

Thus some struggled with the concept of their role being supervisory, as they equated this with being stuck in the office all day, which was not appealing to them. Those who had adopted the supervisory role took a while to get used to it. For example, WM13 developed a system of working that suited him, after talking to colleagues who were doing the supervisory role and then trying out different ways of approaching it:

'...there wasn't an awful lot of people who did the supervisory role...I went round and spoke to WM17 next door…and I spoke to WM11 and nobody really had a way of doing it, y'know some people would take a full day management and then other days they'd work on the ward...but I thought that would get a bit confusing, and I thought to myself...people would be wondering "Am I here, aren't I here?" so I was thinking what was I going to do, so that's why I decided in the mornings, do as much as I can on the ward and then in the afternoons, try and do the management, that was just after about a few months of trying various things and seeing what would work best and I think that's what worked best for me really...' WM13

WM13 was pleased with how the supervisory role was working out. He felt it enabled him to do both clinical and managerial work, so he was available for ward rounds and teaching staff in the mornings and then able to do his paperwork, such as the weekly numbers, in the afternoon. WM6 also felt that she maintained her visibility on the ward being supervisory:

> '…you do know what's going on in the ward because although I do 2 clinical shifts, you still need to know what's going on the rest of the week with the patients and so I'm around, sort of observing people and I see myself supporting people and I do challenge and question them about different things as well…I don't like to just sit in the office, I don't see any point in doing that…' WM6

But other ward managers struggled with the role because they had been used to working hands - on clinically. They felt torn because they wanted to be more clinical but realised that the amount of managerial work they had to do prevented them from being so. This made them feel isolated from the team as well:

> 'I just find it more difficult, I'd rather have a smaller ward and be part of a ward team than have a larger ward…I don't know so much about the patients whereas on a smaller ward you know the ins and outs of everybody, from pressure areas to social set up and everything whereas here I find it more of a struggle for me, sort of having to flick through kardexes quickly and trying to pick up on things…' WM9

2. Challenges of their Role
Working under constant pressure: ward managers spoke of the increasing emphasis from senior management on improving bed turnover, and the pressure of trying to admit and discharge patients as quickly as possible:

> 'it's just **always** the pressure, we never have an empty bed, and quite often we've got people sitting in arm chairs waiting for beds…it's just the pressure on discharge planning all the time…' WM9

Maintaining patient safety and standards of care during the current financial crisis: the overwhelming challenge for ward managers was meeting the needs of the service in the current financial climate. The general feeling was that any cut backs to be made by the Trust *'all tumbles down to the ward manager' (WM6).* For example, they explained how difficult it was to provide quality care when their wards were running below establishment and the Trust had banned the use of agency nurses:

> 'I very rarely do go out to agency, but if I needed to go out to agency I'd have a legitimate reason to go out to an agency and I do not need to be **told** by somebody that's never even been **on** the ward whether I can have that agency or not, but I should know how to run my ward and how to run it safely and I said to [the director of nursing] "**I am not** going to put my patients and my staff at risk by running under

what I need..." and some days I do run it under if we're quiet but otherwise I need my full quota, that's my job because as soon as something happens on the ward then it all comes down on me, not them for saying that I couldn't have the agency nurse...' WM8

'...I have made it quite clear that in order for us to be effective and function well, we need a certain level of staff, I've been told that my establishment does need to go up, but currently there is no money to enable that to happen, so they know that I'm under-established...' WM6

Meeting senior managers' expectations: ward managers were frustrated by the expectations placed on them by their senior managers, especially when they felt such expectations were unrealistic:

'...I do get frustrated obviously when the manager expects you to do this, that and the other and you're still trying to work on the ward and cover the shifts and I find that quite frustrating...they expect more and more from you and not just me, I mean the girls out there, but don't improve your working environment, i.e. they don't increase your establishment, you're running on below establishment all the time and you think "Well hang on a minute, come and work on the ward for a shift, just see what it's like and then see how you [would manage], maybe then you can tell us how we can do things"...' WM12

Dealing with decisions that they do not agree with and have no authority to overrule: for example, the ward managers felt they were undermined by senior management when the decision was made to put extra beds on some medical wards, so as to ease congestion in A&E:

*'...A&E and MASU were so busy, they ended up putting an extra bed in the middle of every medical ward...there was one outside my office apparently, opposite the nurse's station, and there was also one in one of my bays...no curtains, no privacy and dignity and that's one of the things with Essence of Care, I mean **completely** out of the window...'* WM6

Ward managers and staff were very angry that senior management had treated them and their patients so disrespectfully and also that their safety had been compromised in such a way:

'...we're putting extra patients into dead space and you've already got a weak skill mix then that increase the risks even further, both for staff and for patients...' WM7

Ward managers also felt frustrated by their lack of control and authority in general within the Trust, especially in relation to budgets and working in a safe environment:

*'...they call us budget holders...I hold it but...I've got a degree of control over it but I actually can't really do what I want with it and y'know now we're in a position where that's even less of an option, so I think that the power, control, authority all the same, is less, definitely less...and you always know that there will be somebody else making a decision that will be the complete opposite to yours...it's limited, very limited, I haven't got the authority to shut beds y'know that could be the classic one and that's the circumstances we're in...and y'know if you haven't got any staff in theory what you should do is close beds, some areas are able to do that, but that wouldn't happen, I haven't got that authority at all, but...**I should have** but I haven't and that's why the role then of the ward manager is undermined or not valued in that sense because you wouldn't make that decision lightly, and you'd explore all the options but at the end of the day if I can't care safely...' WM7*

Dealing with Personnel issues: was mentioned by all ward managers as being an extremely challenging aspect of their role to manage, especially in relation to the diversity of situations that they were dealing with and knowing the correct way to handle them, in line with Trust policies. For example, one ward manager had difficulty monitoring sickness on their ward:

'...I've found that dealing with sickness is an absolute nightmare, I've found it very, very tough to deal with...I don't know if it's because of lack of knowledge of the different processes I can go through to deal with it or whether it's just been the fact that yeah I know they've been sick but maybe I'm just a bit too scared to actually approach the subject so I'm just going to avoid it...but being able to discipline people and take them to one side and say "Look I'm not happy with your performance, I'm not happy with the fact you're taking so many sick days, we need to improve it" and going beyond that point, if it still doesn't improve being able to take it a step further and to do something about it...so that's probably the biggest problem I've had...' WM13

The support they received from Personnel was usually in the form of advice on how to move forward with a difficult situation:

'…there are personnel policies and we have a personnel advisor but that is actually all they do, they will advise, unless you're going through some sort of grievance or capability procedure, or the sickness and absence and you're a bit way down the line, personnel aren't actually involved, you'll have to deal with it...' WM6

Ward managers were frustrated by the length of time it took to deal with certain situations, for example, putting a member of staff through the capability procedure could take months to resolve, which was draining not only for the ward manager but also for the rest of the team. The ward managers gave numerous examples of the difficult

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personnel situations that they faced on a daily basis, which, to illustrate the level of challenge, included such instances as:

- staff getting themselves signed off sick because they did not like the rota of shifts they had been given
- staff being constantly off sick and not telephoning the ward to say they were ill and not coming in to work
- staff making false allegations about ward managers' conduct and behaviour, for example, spreading rumours or making claims of assault
- disciplining staff who were their friends, or who were rude or aggressive to other staff members or patients
- putting staff on the capability procedure if they were under-performing
- dealing with the after-effects of personal staff fall outs on the ward, so for example, when the ward staff take sides and the ward is split, so staff refuse to work with each other and refuse to talk to each other
- dealing with staff who bully other members of staff

Ward managers felt that in order to manage situations such as these, they needed to be robust and self aware themselves:

'...it is all about challenging behaviour, managing outcomes, working towards outcomes, it's about knowing who you are and how you're going to deal with things, you've got to be very self-assured when you're making these sorts of decisions and I think you also have to trust your instincts on things and if you don't then I've found that you pay the consequences for that, if you don't trust your instincts on something it will come back and bite you on the bum...' WM14

3. *Managing the effects of change i.e. reconfiguration*

The majority of ward managers (n=9) had gone through the process of reconfiguration at least once during their time in the role. The type of reconfiguration varied from changing the speciality of the ward, to merging 2 teams of staff with completely different nursing backgrounds, to adapting to a different level of acuity of patients nursed on a ward to actually changing the location of a ward. A number of ward managers had also been asked to 'care take' other wards for a while during a period of change, which they did at the same time as having their own wards to manage. In some cases, the ward managers were asked to move wards at very short notice, for example, asked on the Friday to move the following Monday, which gave them no time to prepare. The ward managers were not adverse to change, in fact some embraced it and thrived on it, but the overall impression was that there had been too much change recently within the organisation:

'I always have my bags packed, ready to go...' WM7

'I just think things should slow down a little bit, everything's change, change, change so they implement things and before it's even implemented they've changed it to something else, it's just all sort of panic you're dealing with...' WM9

Some ward managers felt they had no real input in the decision making processes concerning reconfiguration, that decisions had been made that would affect them and their staff without the appropriate consultation. Some spoke of being 'forcibly moved' to care take other wards. For those going through the process of change, there seemed to be a lack of practical support available:

> '…they came up with wonderful plans, oh we'll have an away day somewhere but nothing ever materialized…' WM9

Ward managers spoke about the difficulties they had in merging teams of nurses from different areas of nursing, for example, staff from elderly care and rehab areas were relocated to acute medical wards who had no experience of nursing highly dependent patients. This meant that ward managers and their teams were 'lumbered' with staff who were clearly struggling or who were obstructive to the changes taking place, who needed a great deal of training to get them up to scratch. This difficult process often resulted in performance and capability issues, which were compounded by staff absence and sickness. Those who had the task of setting up wards from scratch were often not prepared for what they had to deal with either:

> 'I had no staff, I think my establishment to start with was for 25 staff, but the first week the ward technically opened as a medical ward I had 2 full time E grades who'd never been E grades before, I had no F grade and I had 3 D grades, 2 of whom were newly qualified and 2 health care assistants for a 30 bedded ward...that was it and no ward clerk...and that was something else...' WM14

And had little support from senior management in the process:

> '...that was it "You're on your own, off you go"…' WM14

Ward managers said they handled their experiences of reconfiguration by trying to be determined, robust and 'consistent every single time' in their approach, which was hard going. This meant having a clear goal of knowing what they wanted to achieve and translating that goal for staff so that they knew what was expected of them:

> 'that's the one thing I've learned the whole time you have to be clear about what you expect of people and if you're not clear they'll jump all over the place, because they won't know what to do, if you don't tell someone to jump they won't jump at the right spot...' WM14

Even if it meant upsetting some staff, it was important to follow the goal through and deal with the consequences:

> '…I think sometimes you have to just make a change, whether people agree or not, if they don't agree then they will leave, okay, and whereas in the past I would have felt that very personally, I don't feel that personally anymore, y'know if people cannot cope with the way things are, then that's how they choose to show their, that's how they vote isn't it really...I think you just have to dig your heels in sometimes and say "This is what we're doing" and people don't like

that and it's not the best way to do it sometimes but I think you really have to look at what you're trying to achieve...' WM6

Being open and honest and having clear lines of communication with their staff were also crucial to success, as was having a sense of humour and trying to filter that through to staff:

'I try and say have fun with what you're doing, y'know it's a job and it's serious but you've got to have fun so we do try and have a laugh as we go along, it just sort of lightens the load a bit if we can...' WM9

Promoting ownership was also important in enabling staff to feel that they were responsible for their ward:

*'it was getting people to **own** problems, "If you find something and it's not working, that's your responsibility to deal with it" but what they'd do, they'd leave it for someone else, or I'd come in and literally find things piled up on here because "Sister will deal with it" there was no ownership, there was no responsibility for anything, "It's not my job" that kind of attitude and **that** was my **biggest** and still is my biggest enemy on this ward...' WM14*

4. Ward manager's relationship with senior management
The overall impression was that the relationship between ward managers and senior management was poor. Communication was tense and contact limited:

'I think the issues are that there is a great lack of visible management from certain levels in this organisation, you don't see certain people ever, but they are the ones that are making the decisions that you may or may not agree with and if somebody makes that decision about sticking some poor patient in the middle of the ward, where's their accountability, y'know I'm the one who's responsible...' WM7

There seemed little appreciation of each other's roles and a lack of common purpose, with ward managers working for patients and senior managers working to meet targets:

*'I was told by a manager and I was just outraged and I thought "That puts the lid on it really" that "The priorities of this Trust **in this order** are finance, then patient safety" now I'm not here for that reason, I'm not here for finance...and when you hear that sort of thing you think "Why am I bothering?"...' WM8*

Professional leadership for ward managers was also lacking, especially in the sense of motivating and guiding them in their roles. Ward managers recognised that they had to be proactive and use their initiative if they wanted to change and improve their wards:

'...if you want things to progress yeah you do [need to be proactive], if you don't then things won't happen...these days there's no-one sort of with a rod beating you to do things and it's very easy to get lax if you wanted to...' WM1

And senior management only gave feedback if something negative had occurred:

'...in the past I've always felt that you would hear from management if things were bad, but if there was anything positive then you didn't hear anything, which as you know isn't very good for the old soul...' WM1

Modern matrons, care centre managers and general managers were not spoken of as being a source of support in general:

'...I'd say from a level above me I'm not supported, no, and haven't been for some considerable time I'd say, so I can see why if you're not experienced at the role, I can see why people fail, I think certainly in surgery one of the issues is we haven't had a nurse lead for 2 years at the least, maybe a bit longer than that...' WM2

However, if senior managers actively listened to ward manager's concerns and opinions then they were perceived as being supportive:

'I mean M3, I didn't know her that well but she always listened, I think that helped...' WM9

There was confusion among ward managers as to senior management roles, in terms of what they actually did and what they were responsible for:

'...I think it's very confusing, you have site management people, you have matrons and no-one's really clear what each other's doing, what do you go to the site person for, what do you go to the matron for and in it all I don't really have confidence, I mean okay they haven't made things clear as to what their roles are but I haven't got confidence that this structure is going to move nursing forward...' WM2

Some ward managers felt the blurring of boundaries between roles undermined their authority, since they were told they were accountable for their wards, yet their decisions were often overruled by seniors:

'...I think there is blurring between ward manager, matron and care centre manager...I think the more people there are above the ward manager, between the ward manager and say the general manager, the less authority the ward manager has, I mean we're told we are responsible for the ward but we don't actually have that much authority sometimes, I mean we can make decisions about say...we think a patient shouldn't be coming to the ward, site managers can just overrule us...and then you plan your off duty to cover your ward,

if somebody goes off sick elsewhere, and I can understand this, because as a bleep holder in the past I've had to do it myself, you lose somebody, so that the other ward's not completely helpless, and then if something happens on your ward as a result of somebody else being moved, who then becomes responsible...' WM6

The general feeling amongst ward managers was that they have less authority now than they used to but they are expected to achieve more; especially in terms of meeting performance targets. There was also the feeling that senior management were autocratic and did not actively involve ward managers in the decision making process:

'...I think there are certain managers who are very good at communicating and they are very good at getting people to do what they want because what they do is they say "We thought that maybe this is a good idea, what do you think?" and so they try and make you feel included in that decision but at the back of your mind, you're already thinking "Well I've got to go with it anyway because they'll do it no matter what I say"...' WM6

*'...they don't listen so...when you're arguing with someone who is not from [name of speciality], who thinks she knows what's she's talking about and she's telling **you** as a ward manager you don't know what you're talking about and you've got figures sitting there, well what can you do, you can only put your point across and that's it…' WM9*

A few ward managers were hopeful that the current restructuring of senior management would help to forge closer links between them and the ward staff. However the majority of ward managers were cynical that the restructuring would make any difference to the situation, because they had been through this process before and nothing had changed for the better:

'…I can't see it making any difference because the care centre manager is still the same, it's just different people to get used to, I mean M3 the general manager has gone now, but it'll make no difference to the ward in the long run…' WM9

Ward managers felt saddened by the impersonal nature of their relationship with senior management. The increasing emphasis on communication via email was an example of this and as such, often a cause of tension, because of the way in which email could be misconstrued as abrupt and rude:

'I think we all just feel everything comes via email now, the personal touch has completely gone and it all comes via email and y'know you get something through the email saying "Get this done by Tuesday" no "Could you, would you mind, have a go at it" sort of thing "I'll come along and show you what you're supposed to do" it's just "Get it done" and then you get another email if it's a day late telling you off...' WM8

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Ward managers also felt that they would have more respect for senior management if they were more honest and upfront with them about the reasons behind some of their actions:

> '...I think there are frustrations which make me just think "Oh god this is ridiculous, why are you doing this'?" and usually your manager or your nurse above you just says "It's got to be done" but actually what they should say is "Look I know it's a pile of poo but actually I'm doing it because I've been told to do it" you'd have much more respect for people if they just came out and said that, just "We haven't got any choice, this is what's come from Mr Turnaround or Mr so and so, we're not efficient, we need to look at" "Okay fine, let me understand what it is you're trying to get out", rather than make me just go to a meeting every day for the next 2 years...' WM2

5. Ward manager development

The ward managers had no formal preparation when they first went into the G grade role, other than maybe a period of acting up. They also had no mentor or structured induction programme to ease their transition:

> '...I was thrown in here, I was literally asked to do it, was told I would start on 30th March, I saw the Ward Manager that was here before for half an hour and literally she went through the list of staff and that was it really...and I came up to their Team Leader meeting, which was okay and that was it...so I didn't know anything really...I just walked on here and said "Hi" and I just made my own sort of induction and just got on with it...' WM12

They learnt to do the job by trial and error and learning as they went along:

> 'I think a lot of it was trial and error...I mean I got pally with some of the ward managers down at Hospital B and we email each other and if I've got any problems I just emailed down to them and said "How do you do this?" and they used to give me advice...' WM10

> 'when I went to [specialist area] I didn't suddenly have 2 weeks of induction, it was one shift or whatever, she went on maternity leave on the Friday and I started on the Monday, but it was only because I'd picked up bits along the way that it worked out, so I think really if you ask most of the G grades around here, that's how it's been really I think and **still is**, y'know I'm not a business manager **but** I'm now expected to work along those lines...' WM7

Without structured support, it was a steep learning curve:

> '...I got a lot of things wrong, a lot of things wrong and people talk about a learning curve, well I had a vertical ascent...y'know on those fairground rides you sit in they just sort of strap you in and you just

get pulled into the sky, it was a bit like that really for the first year, it was terrifying…' WM14

WM10 became a ward manager during the time of the merger which was difficult because responsibility for a lot of the management tasks previously done by the senior manager were now devolved down to the ward managers:

> '…our manager, she used to do all the management side of things and the ward mangers used to do the general running and obviously she was there to give us help and advice and also she had a secretary who did all like the manpower figures and, there was a **lot** that they took on whereas it was then actually our responsibility…'WM10

There was no formal structure when WM10 first started, no-one to explain how things worked or what was expected, and no mentor to go to for support, which was daunting:

> 'it was just me, that's what I found really difficult…there wasn't anybody, because M3 had gone, we didn't have **anybody**, yes we had M2 and we had M6 but they were based down at Hospital B, they couldn't be here all the time, I mean if you wanted something y'know quite urgent then you had to sort of ring around…' WM10

WM12 would have liked to have had a mentor and an induction period to the role which covered how to do certain aspects of the role on a basic level:

> '…it would be nice to have an induction day where you were given information i.e. like what to do if someone hands in their notice, or what to do if someone wants to change their hours, or who do you contact…things like that…or what do you do if you want to order something, but it's an amount that is higher than you're allowed to authorise and things like that, that you don't know until you're actually sitting here and someone says…and then if M10 isn't around, then you've got no-one to answer that question, if someone just actually said, like the Modern Matron "Let me go through things, everyday, that will happen to give you a bit of [an idea]"…so if someone needs [something] "Oh yeah I remember now, I remember what to do about that" just things like that that you don't know how to do until you're in the post…'WM12

Ward managers seemed to have had a lack of formal training for dealing with the challenges of their role, especially in relation to personnel issues and managing a budget:

> 'one of the things I found the **most** stressful was the budget in fact, as I say I found that **the** most stressful thing and the second most stressful thing I think is dealing with difficult situations, **not** with regard to patients and relatives so much but more with the staff…a lot of time can be spent on dealing with difficult staff…' WM6

It seemed that expectations of what the role involved were not made explicit either and senior management assumed knowledge and capabilities in certain areas without giving the appropriate training:

> 'I think the financial side of things is very difficult...y'know because people said to me "If you can do your finances at home y'know it's just on a larger scale" and I was just thinking "Hmm okay, I don't think it's quite like that"...' WM10

> '...back in the 80s, I used to be aware of budgets but then it was always then managed by a senior manager, that wasn't handed down to ward managers until I suppose the 90s, but then of course there was never any training for it, they just said "Right here's your budget, go away and don't spend it"...' WM7

Going into the role, they also lacked awareness of the importance that senior management attached to certain aspects of the role, such as monitoring sickness for example:

> '...I don't actually think there is any formal training as such; we've had talks from Personnel regarding the sickness policy...but from an actual just approaching the subject and dealing with the subject, I think I came into this job pretty unprepared for that sort of thing...y'know it's something that probably from a more senior management point of view, it's the type of thing that they come down on the ward managers really, really hard on yet when I came into this job nobody actually pre-warned me that this was going to be an issue and nobody says to me "We're going to be watching the sickness on the ward, we're going to be monitoring it"...but no I've never had any formal training on it...' WM13

A few ward managers mentioned attending an in-house course that covered aspects of management, such as budget planning and capability and sickness issues. Some said the G grade away days were also useful for discussing such issues as well, particularly with other ward managers to see how they were managing. A few ward managers had been on the in-house course in the 90s called "Making nursing count" which '*went through the budget in a bit more detail*' and how ward staffing levels were set. However junior ward managers did not know of this course and had little awareness of how to manage a budget when they went into post:

> 'I think with the budget I'm useless...with maths I am totally blind, I cannot cope with figures and numbers and y'know to look at a statement every month, and I still have to think "Oh god what does that mean?" because I just am so useless at reading them, but you can't say that at the budget meeting can you..."I still can't read them because I'm crap" y'know...so I think a good session on the budget really, because I wasn't trained to be an accountant, to run a budget, so I think you're very much thrown in to looking after that without any forethought about "Well let's give them a couple of teaching sessions,

let's give them as many as they want until they're comfortable with what they should be doing or what they should be looking at"...it's just assumed that you should know it because you're now the ward manager...' WM12

Ward managers in general felt that they needed to know more about managing budgets and that this type of information should ideally be imparted to F grades as well:

'...I think really people should do at F grade level, they need to do that before they get to the sister level but at least some training in budget and how to look at the budget lines, or just understanding the layout and certainly an understanding of how establishments are decided on...' WM6

'I get people coming up to me asking me to read their budget statements for them...and it would just take a morning of somebody from finance coming up and maybe a senior manager and getting all the...ward managers together and just going though budget statements and giving you handy hints on that sort of thing...' WM8

One ward manager said that as a group, the ward managers had asked for more budgetary information to be given at G grade away days, such as:

'...a breakdown of everything that's on the budget statement, I mean usually there's 3 columns that I read, what do the other ones mean, how does that influence what I'm doing, what's actually broken down in all the individual bits, so just basic y'know how to read your budget statement...and also the stuff that affects your budgets, so sickness and absence management...so getting that backed up behind it as well...' WM14

The majority had attended some form of management course during their time as ward managers, the LEO course and RCN Leadership Course, being the most frequently cited. The RCN Leadership course was perceived to be '*more grounded'* than LEO and more useful at helping ward managers deal with the challenges of their roles and giving them insight into themselves:

'...in the last year I've done the RCN Leadership course, which is the best course I've ever done, fantastic...I think it helps you to recognise what you're capable of, it helps you to talk to your peers, rather than keeping everything to yourself the whole time, I've built support around me now whereas before I used to rely on friends and friendship, I actually have on my email listings, y'know you have the little files down with personal folders, I actually have a folder in there now with 'Useful people'...and they're like tools in my box if you like...use your network to support you, so now I have support from people that I wouldn't necessarily have a friendship with...' WM14

For senior ward managers it was the first kind of formal management training they received, having until then learnt their jobs 'on the hoof' as it were:

> *'when we did the RCN Leadership course, that was the first formal bit of study, certainly in this organisation that I think generally that had been offered around for ward managers, because you just learnt it on the job, all the stuff that I've ever learnt has just been either through maybe a role model in the past or what I've picked up…' WM7*

The ward managers also had varied abilities when it came to computer and IT skills, which again, the majority had picked up as they had gone along in the job. Senior managers considered IT skills to be essential for a ward manager, yet none mentioned having had formal training:

> *'…I've sort of found with this role that a large part of the work that you do is, you're purely based on using the computer and doing your weekly numbers and putting in bank and agency staff, it's all done on the computers and I think you really do need to…and being able to email appropriately and y'know being able to actually open your emails, use it, insert files, all that sort of stuff, it's stuff that I probably didn't have much experience of prior to doing this job, but I think it's something that I picked up quite well just from people helping on the ward, and saying "Oh well actually if you do this" sort of thing so I picked it up but…as a ward manager you do need to…have pretty good computer skills…' WM13*

In general, ward managers put themselves to the back of the queue when it came to professional development. They saw their staff as being the priority in terms of attending mandatory updates and study days because they were the ones caring for the patients. When ward managers did attend study days, it was often in their own time as it was difficult to get time away from the ward:

> *'…I see them [staff] as the priority, because they're actually giving the care, I want to make sure they're properly trained and skilled to do the care…I mean I still do keep my training going but my needs aren't as urgent as theirs and so I'll take my place in the queue, I will get there but I'll get everything once everybody's trained who's going to be doing the care and I'm trained to do the things that I need to be doing now so…' WM1*

> *'…what I have done has been in my own time and that was one of the reasons for intermitting really because I just can't do it, do that **and** do this without getting some adequate study time…' WM6*

Appraisals for ward managers had been patchy. One care centre manager put this down to the fact that one hospital site lacked a senior nurse for surgery, so ward managers had no-one senior to go to in a professional capacity. Two ward managers said they had had appraisals within the last year or so (WM1 & WM7), whereas others had different

experiences, for example WM2 had not had an appraisal for 5 years which made them feel resentful of senior management:

> '...what I find difficult is when people criticise me when actually they've never assisted me in trying to do anything, all they've given me is stuff to do, that's when I find it difficult...' WM2

And WM8 had never had an appraisal as a ward manager:

> '...I've never had an appraisal so...y'know I could be doing it completely wrong because I've never had an appraisal so…' WM8

WM9 did not think her manager was appropriate to appraise her because she did not know enough about her or how she worked to be able to comment:

> 'I think in all my time as a ward manager I think I've only ever had one appraisal…but then I don't think my manager knows me so I don't see how she could appraise me really…and if she did I think it would be a bit insulting really because she doesn't know what I do and I don't think she's that interested, as long as it doesn't bother her y'know as long as she hasn't got to sort anything out, she's happy it's ticking over…' WM9

Another ward manager felt that senior management were not good at managing performance issues as they arose and dealing with them head on:

> '…I just think going back to the supporting thing, that's where I think we don't do it enough y'know someone said to me the other day in my appraisal "We were worried about you about a month ago" I said "Oh right" and...nobody said anything of course...' WM7

> '...that just annoys me when people are not up front with you and it's almost like they're frightened to approach you and then wait for you to make a mistake and **then** they'll come and say y'know...I'd rather know now than go and make a mistake tomorrow…' WM7

Other ward managers had to be proactive in seeking out an appraisal because there was no senior overseeing their progress as such, which made them feel isolated:

> 'I did get an appraisal a little while ago but that was very much my own self-directed appraisal in the sense that I did an appraisal form and I just went through it with the managers as to how I felt I did...I think in this role...you don't get very much positive feedback, you get quite a lot from a budgeting point of view, if you're spending too much...y'know they'll say "This doesn't look good" you get quite a lot of negative feedback from that point of view but...you don't get an awful lot of feedback really, I think this G grade role can be a little bit isolating at times, it's quite hard to get support and help or advice whenever you want it…' WM13

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A few ward managers felt that senior management had been supportive when they had needed them to be, but they had asked for support, it was not offered:

> 'The support has always been there when I've asked for it, perhaps I could do with more but it's my own fault for not asking for more, I don't think it's any fault of my immediate superiors...' WM1

On the whole though, the ward managers felt unsupported by senior management, especially when dealing with the challenges of their role and during reconfiguration:

> '...I don't think you get a lot of support, no, I think it's a funny job, you're pretty much in limbo really, you're sort of left to do whatever and it's only when you do something wrong that you actually hear about it...' WM13

> '...since we merged with the Trust anyway it all changed and the management changed and everything else, when we'd gone from a situation where we were fully supported by a manager on site, that we could go to with practically anything, to in fact having nothing and I mean I haven't seen my manager for nearly 2 months now...' WM8

They drew their support from their teams and fellow ward managers but felt isolated at times because they were ultimately responsible for the ward:

> '...I think as a ward sister you're very isolated...we're quite a close knit unit...and I suppose the ward sisters are supportive of each other but I think you're very much out on a limb, y'know as an F grade you've got management responsibilities but you've always got someone to pass the buck to, I think as a ward sister the care centre managers are just so out of touch...she's not even had any experience of ward nursing, so she's not exactly the most supportive person to me...' WM9

The majority felt that senior management did not appreciate the work that they did:

> 'even if you manage to run your budget under, you don't get at the end of your budget meeting "Oh well done you're 2 thousand under still for this time of year" you get "Well what else can you do to reduce..." y'know so you never get any praise...' WM8

However some had received positive feedback from seniors:

> '...the budget is always the thing that they comment on and...I've had some good feedback, I have to say that since, I've had some good comments from managers etc and doctors about the ward which has been brilliant and made me feel very good...' WM12

And where feedback was lacking, it was made up for from the positive feedback they received from patients and students:

'...I think simple things like having a lovely card from a patient saying how wonderful their stay was on the ward or a nice letter from a student saying "I really enjoyed my stay on your ward"...little things like that, I think that's the type of feedback you like and that's the type of feedback that really helps...' WM13

Ward managers spoke about developing their own network of support, so a range of individuals whom they could go to if they needed help or guidance. These ranged from modern matrons, to senior ward managers, colleagues and friends. They felt that as a group the ward managers were relatively cohesive and tried to maintain contact with each other as best they could, although this was not easy because of time and work pressures:

'we always pop in and see each other' WM14

'...there's always occasions where you can hand the bleep over...and I have quite a good relationship with WM11 downstairs...and I'll sometimes just pop down...and sometimes she'll maybe just pop in and say "Oh how's things?" y'know and then we'll just have a little chat about what's going on...' WM13

'...if you can't think how to do something then you always know that there's somebody out there that probably does and so you just walk round and find out, so everybody does help everybody else out but...there's no real formal thing, it's just the fact that we've all been here a long time and we know each other so...' WM8

However one ward manager said that she did get feedback from her modern matron and occasionally a senior would come and work in practice with her:

'I think I'm monitored by feedback more than anything; occasionally someone will come and work with me...like from the department of professional practice...but I think more of the vibes are picked up by the modern matron when she actually comes round and sees the ward each day and has a chat that way, she'll sometimes work on the ward as well...' WM1

Those in the medical directorate had recently started to be performance managed during their monthly business meetings, so they were judged on certain performance criteria such as length of patient stay and keeping to budget:

*'...we have a pro-forma now that looks at...how your budget is doing, how many appraisals you've done to date, what your recruitment and retention is like, how many vacancies have you got, what are you doing about it...length of stay is another one they're looking at, they want us to look at the length of stay of patients on **our** ward and what are **we** doing about it...and...there's all this stuff about payment by results in that...'* WM6

This had been met with some scepticism by the ward managers, especially since the focus was on meeting targets and not professional development:

> *'Well I think the way to interpret that is if you don't come up with the goods, then you're out, that's how most of us interpret it...that's how **we** interpret it...' WM6*

Some ward managers found the G grade away days supportive since they were a means of discussing practice issues with colleagues. They were also useful for sharing information and getting ideas on how to handle with situations from other ward managers having similar experiences.

> *'...you get a time if you want to say anything...and it's quite good to network with the other G grades because they all have the same problems...' WM12*

However not all ward managers found the away days helpful:

> *'...G grade away days are often occasions where more senior management can get us all into one room and criticise what we're doing...just to inform us that yes we are spending too much money...so it can be just getting us together to let us know where we're going wrong...I'm never completely happy with them because they are quite negative occasions and you don't come away from G grade days ever feeling particularly positive about anything...and I'm quite a positive person but I do find that G grade away days can be quite negative things and they can focus on the bad things that are happening rather than maybe some of the really good things that are happening...' WM13*

And some came away feeling very demotivated:

> *'...I think people just go along and moan and I was just so disappointed with everybody moaning all the time...but it just seems that people at my level just feel so...not good about themselves, not good about their job, not good about the job they're doing and you have to ask yourself "Why is that?" and I've never come away from a meeting feeling so depressed and actually I look at it now and think "Oh blimey I suppose I ought to go to that really" and I look at it and it's not very inspiring y'know...' WM2*

Away days were also used for training purposes, so for example updating the G grades on mentorship issues. However attendance at the more recent away days had been poor which ward managers put down to travelling to the different sites, parking and also pressures on time:

> *'...the problem was we used to go to it and it was always at Hospital B, but we made the effort, we went down there and then not everybody would turn up and it just fizzled out I think, and whenever it was held*

over here nobody would come from Hospital B, no I think only 1 or 2 people at the most...' WM1

The ward managers felt it would be useful to have someone in a mentorship role, to discuss issues with but were unsure as to who would best suit that role:

'...I suppose having somebody who you can go and discuss things with, ask what to do, whatever, I suppose it would be quite handy yeah but it'd be difficult to know who to choose for that sort of thing...' WM13

They felt that modern matrons were not '*the best people to choose really*' because of their workload and relatively new roles.

A couple of the ward managers said they would appreciate some administrative support and saw that this would really make a difference in reducing their workload:

'...I would love some administrative help, that would be the biggest thing because someone to help me with my filing and all these bits of paper and then I'd feel really quite organised...because I know what I want to do and I know what needs doing paperwork wise, and I know what training needs to be done, I know these things, it's just actually physically having enough hours in the day to do it all plus typing things up and y'know it's not really a secretary's job I trained for...' WM1

6. Staff development and succession planning

Ward managers thought that the current financial state of the Trust was having a negative impact on their ability to develop their staff, since it had becoming increasingly difficult to release people to attend study days and courses:

'...at the moment the development side has gone down because of no staff, no agency, the usual...so it's going to be very hard to meet all the relevant needs really because of study leave being st[opped], well...they say that at the moment it's just really the mandatory...and also being short staffed, patient care will suffer, staff morale will go down and sickness will go up and there you go...' WM12

This situation was affecting staff morale too. Ward managers felt staff were '*so busy fire fighting*' that they were overwhelmed managing day by day, and so did not have time to think about their development:

'...that's the first thing that the care centre manager said "You're short staffed so cancel their study days" which I just find unbelievable...because it means I don't order an agency and the overdraft isn't so bad and she looks better [because it looks like the care centre manager is running her wards well i.e. not using agency,

not going over budget, which means she'll get praise from her general manager]...' WM9

Ward managers also thought that the number of study days allocated to staff per year was insufficient, especially in relation to the number of mandatory study days that they were required to attend:

'in theory the Trust sets aside as part of our annual time 3 days a year per member of staff...which is totally unrealistic...the list of mandatory training alone for staff is as long as your arm, the 3 days doesn't cover that...' WM10

'...the girls actually say to me "Well what if I make a mistake now and I haven't had my mandatory, sort of update, is the Trust going to be accountable for my actions?" so...because it's all just money driven at the moment, it's all money...' WM10

Some ward managers also felt that the Trust had only recently started to keep a database of staff development, so attendance on training days, records of appraisals etc, so it had been left to the individual to monitor:

'...we've only just recently in the last few months tried to set up a database, looking at what staff have done in the past, because as an organisation, we've been very bad at recording, and I know individuals should do it but actually as an organisation we've not been very good at recording what people have done, when they've done it, what the follow up and if people go and do clinical skills, y'know if you do your IV meds, if you don't get assessed within 6 months in theory, you've wasted the time, you've got to go back and do it again, so loads of people are doing the study but they're not actually then following up with the skills, but we've not been good at recording it so we're trying to improve on that…' WM7

In terms of succession planning, some ward managers were actively developing their senior staff to take on the role of a G grade, which stemmed from them having had little preparation themselves:

'...as far as actual formal training in the sense of...management skills, as in budgeting, ordering, complaints, dealing with staff issues, various things like that, I don't think...I had an awful lot...before the last G grade left, she ran me through some bits and pieces but that was like just a crash course, like "How do you do this, that needs done" whatever...which is why I think now that...if I'm going away for a week or a few weeks, I'll say to F11 "Well this is what I expect you to do" y'know...like I do 8 to 4 management days, I'll try and give F11 the same if I'm away on holidays too, just to allow her to get as many management skills as possible really, so no, I don't think I was very well prepared for it but I think it was just one of those things really, maybe from my point of view I didn't express enough interest in it

when I was an F grade or [name] who used to be the G grade didn't really think ahead, from the point of view if she left, who would be stepping into her shoes sort of thing, which is what I'm thinking from F11's point of view, if ever I decided to leave, I think F11 would make a wonderful G grade but I would want her to be fully prepared to take on the role...' WM13

However, actively grooming staff for the next grade up did not appear to be a priority within the Trust, which was a concern especially considering the number of Fs whom ward managers deemed unsuitable for G grade posts:

'...they used to use the phrase succession planning but I haven't heard that phrase used for a long time and most of the F grades in medicine have either been acting Fs or junior Fs so it really is...y'know if we all went off sick tomorrow, all the Gs, would all the Fs be able to take over competently and run their units, I'd say here probably not really...' WM7

Some ward managers felt the problem was that some G grades were reluctant to pass on their expert knowledge to their juniors because they felt threatened. This meant that in some areas Fs and Es on the ward were not involved in any management responsibilities, as the ward manager did everything:

'...inone of the Gs had ever had any management responsibility other than clinical when I went there and there were like loads of them, only the one person who was running it didn't let them get involved in any of that so the budget and managing they'd never been involved...' WM7

'...being the F grade, and the Ward Manager at the time, I don't think I knew much about her role because she kept it very much to her chest, that's how she worked...the post as an F grade I don't think was really developed...' WM12

This approach caused problems if the ward manager was away and the F grades were left in an 'acting up' capacity. It seemed that there was almost a 'setting people up to fail' type of ethos in some areas:

'...but her handover, didn't include things like manpower figures, sick returns, we didn't know we had to do that when she went off...because she didn't pass that on so it was a bit like, on reflection I felt she would have been pleased if we'd failed, we weren't expected to do a good job...' F7

Some F grades also admitted to not consciously thinking about succession planning. For example, F6 said that she was not passing her knowledge on to E grades because:

'...it's never crossed my mind to do that, until you've just said it now, I don't know why and also we don't have the time to do that...' F6

The ward managers felt there was a definite need for a development programme for their juniors, and also for themselves:

> 'I think there need to be more development programmes for senior grades because there are a lot of development programmes for Ds and staff nurses and y'know quite a few even for F grades really but there's not so much really for when you get to my level at all....' WM8

However the crux of the problem seems to be that F grades do not want to be ward managers anymore, and ward managers are aware of this, and understand too:

> 'I think if anything the organisation needs to look at developing G grades, ward managers…but there really aren't any F grades around, the F grades are seeing what the G grades do and don't want that job so how do you make that job attractive for them...so you've got to make it attractive for the Gs in order for them to [want it]...' WM7

It also seems that in the past, a lot of senior nurses have drifted into ward manager posts without really thinking whether it was the right choice for them or not, which has led to them struggling with the role. There seems to be a lack of active 'career thinking' within nursing, so some do not think about promotion until it confronts them one day, for some people career progression seems to happen by chance and luck. Such a haphazard approach to career development cannot surely sustain the current workforce:

> 'we all know that there's been Fs put in G posts and they struggle y'know I've experienced that in the past and you don't get the support that you need, my F grade was left last year and it didn't work and that's why I ended up babysitting...they didn't want it in the first place...' WM7

And this was the feeling amongst some F grades too:

> '...there is this thing about there's too many people that have stepped into jobs I don't think they're qualified for, I've seen too many nurses become sisters with very little qualification experience because they just happen to be in the right place at the right time, and maybe they would find it daunting...' F3

> '...I think people tend to get rail roaded, you see the thing is people seem to think that they need to work their way up as quickly as possible and that's not the case, you can stay at the same thing for a long time and...there are certain people who are not cut out for these posts, you can't all actually come in and expect to be the captain of the ship because you need people who are going to row and...there's nothing wrong about wanting to stay at a particular grade and you're happy at that grade…you're actually doing the better job...but I think people have this thing as though "Well I'd better go for it because [I can]"...' F7

ACTION POINTS

- Senior managers' expectations of the ward manager's role need to be clarified and made explicit to ward managers
- The nature and purpose of the supervisory role need to be clarified for ward managers and examples given of how the role works in practice
- Senior management need to decide whether it wants its ward managers to be supervisory or not and stick with that decision, and follow that decision through with evaluations of the role and workshops as to how it can be implemented etc
- For senior management to acknowledge the difficult circumstances that ward managers are working in and actively listen to them
- For senior management to involve ward managers more in the decision making processes that occur – so as to promote ownership
- For senior managers to explain more behind their way of thinking – why did they put extra patients on wards and go above ward managers' heads? What were the consequences of that action? What would have happened if they had not done that? Senior management need to make their 'decision trail' more explicit so that staff understand more, only then can they start to understand the pressures that senior management experience
- There needs to be more practical involvement from HR on difficult to manage situations, more hands on and contingency planning teaching
- For a more practical approach towards teaching i.e. in the workplace to be adopted, so as to limit staff having to leave the ward
- Senior management need to provide more practical support for ward managers and their teams who are going through reconfiguration
- Reconfiguration seems to have been reactive and not proactive for example, in the amount of time given for some ward managers to move wards – why is this and are these processes made plain for those involved in them?
- Senior managers need to be more visible on the wards and talk to the staff as opposed to just the ward manager. They need to work on their image so that staff see them as people and not as 'faceless'
- Senior management need to be available and accessible for senior staff i.e. based on both Trust sites as opposed to one
- Ward managers need to have a yearly appraisal – and senior management need to discuss with the ward managers who the best person is to have the knowledge and credibility to actually perform the appraisal. Who is in the best position to know a ward manager's capabilities?
- Senior management need to show an interest in ward managers' professional and personal development and not appear to concentrate solely on whether or not they are achieving performance targets
- A mentorship scheme should be considered for ward managers so that they have a senior person with whom they can discuss professional and personal developmental issues
- Ward managers need to receive regular, constructive feedback about their capabilities
- Those going into ward manager roles need to have an induction period and structured programme of development and support so as to ease their transition

- For senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that skills and knowledge for the next role are learnt gradually and with structured support
- Senior management need to develop new ways of delivering study sessions so as to limit the time that staff spend off the ward. For example, ward based mandatory update sessions during the handover period, or amalgamating mandatory training sessions so that 3 updates could be achieved in one day
- For senior management to devise contingency plans so that in times of financial crisis, staff development does not become a low priority. Staff need to feel that they are valued in such difficult times, even more so than when things are going well
- Senior management need to devise novel approaches to succession planning so as to encourage staff to move on in their careers and enter into ward management positions
- Career thinking and planning ahead needs to start early on in a nurse's career so as to encourage the gradual learning of skills and knowledge that is required to perform the next role up.

Much of what the ward managers expressed a need for was also reinforced by senior managers as will be discussed in the next section.

The Senior Managers' Perspectives on support and development

SUMMARY POINTS:

Senior managers emphasised the importance of **clarity in expectations** of the ward manager role and that these expectations needed matching to suitable training and development. **Succession planning** was key to preparing staff for their next roles. Four **main areas of training and support** for ward managers were: activity, budgets, workforce/ personnel issues and maintaining quality; understanding roles and systems in the Trust and where to get help, plus IT skills were also important. A **standard training package** was needed for G grades on management/Personnel functions and what was expected of them. More emphasis was needed on practical leadership skills than available in current courses.

Senior managers (n=10) thought that ward managers needed support and development in the following areas:

- **Role expectations:** Senior managers felt that there needed to be **more clarity in terms of what was expected of the ward manager role** and that such expectations needed matching to the appropriate training and development:

  '…the ward manager role has changed over the years, from probably the senior sister role that they took on, especially for people who have been in post for a number of years, and I don't

actually think the Trust...has actually given enough support in that role in changing, in developing the ward managers...it's all very well saying "Here's a budget" but you've got to be able to understand budget statements, it's all very well saying "Okay we run our homes" but we don't know they're efficient at running their home, but also to understand a complex budget statement and what it means...they didn't put **enough** *education in about those things, they always seem to do it the wrong way round, they get people doing these things and then about 2 years later they put in the education...' M9*

Senior managers mentioned a wide range of expectations from being a clinical expert, to acting as a role model for staff, to providing a high and consistent standard of care for patients to the best of their ability, to acting in accordance with Trust policy and following the procedures in place, to being an excellent communicator at all levels, to being a good leader and motivator of staff, to dealing with Personnel issues and managing their budget, to being politically aware. In general senior managers expected ward managers to manage their wards competently and professionally in accordance with 4 key areas:

'...that they...completely manage their ward areas within the 4 areas of finance, quality, activity and manpower...' SM3

Some senior managers felt that the lack of clarity around role expectations was because ward manager job descriptions had lacked focus:

'...are we really clear in our job descriptions about what we think that role is, what do we expect that role to be, what do **we** *want from it...are we really clear about what we want and what we expect and what we want to develop if those skills aren't already there, and should we be surprised when we ask these things of our ward managers and they look at you as if you've grown an extra head and say "Well no-one's ever gone through that with me and I don't know anything about that and I don't want to know anything about that"...because what is a ward manager y'know, apart from being your figurehead and your role model and your lead, everyone does it slightly differently which is why I think it's* **incredibly** *important to have a* **really** *accurate description that really reflects the role and the function...I think that's a criticism of the Trust in that maybe some of our job descriptions have lacked flair and initiative and that we've lacked really pushing the other half of the job...which asks for those management functions, hence our expectations of what we want from that role, if they're not articulated or they're not tested, then you can't just expect people to do them...' M1*

Senior managers were aware of the difficult job that ward managers had and seemed to understand that the expectations placed on them were unrealistic and as such largely unachievable:

'...I think the ward manager's role is probably one of the hardest nursing roles, I think there is so much expected of you from everyone...and they are such an important person because the standard of care on that ward is probably directly attributable to the manager and how they behave...' M8

Some were also aware that the culture within the Trust had not been supportive for ward managers:

'...the difficulty I think we have at [name of Trust] is because the culture hasn't been supportive...it has been very much financially driven and targets and that quality element, or that personal support element hasn't necessarily been available...we're not great at communicating below care centre manager level, currently the care centre managers line manage the ward sisters, that will change in our new Divisional structure where all the matrons will manage them and they haven't been very good at communicating that...' M7

- **Succession planning** was considered pivotal in order to prepare staff for their next roles, e.g. training and developing F grades to take on G grade roles.

'...I believe that good succession planning is very, very important, that people are prepared for that role, because it is a very, very difficult role and it's a very important one...and I think the relationship between the F grade and G grade is very important and is quite pivotal in someone developing from an F grade into a G grade and some G grades rely on their F grades and will share responsibilities, which is good, and others don't and I don't think that is good for the F grade really because they need to be exposed to the opportunities to develop and prove that they have the abilities to go up, some F grades of course don't, they're quite happy to stay as F grades but again that's quite an important role for the rest of the team...' M2

However senior managers were aware that development programmes needed to be put in place for succession planning to take more of a priority within the Trust

- **The 4 Key Areas of Training and Development:**
  Senior managers thought that there were 4 main areas where ward managers needed training and support. These related to their overall expectations of the ward manager's role:

  1. *Activity* – e.g. length of stay, getting patients discharged before 11am;
  2. *Finance* – e.g. understanding and keeping to a budget:

'...you actually need to go through these things on a fairly regular basis, I think when you start taking over your budget, it's not only the education that you need to start with, but you

need the support from the accountants and the other people like that as well...' M9

3. **Workforce** – e.g. recruiting, monitoring sick leave, appraisals, off duty, dealing with conflict and challenging people's behaviour:

…very few training courses actually give you practical examples about how to do it, I'm thinking of a recent HR course that I attended as an observer, was excellent in saying "This is how you manage challenging behaviour, this is what you do when you experience difficulty with staff" yet we don't always tell them how to write an off duty rota, we expect them to do that and I think they're the skills that you need in a ward sister...' M7

'…the important things are how do they relate to their staff, what evidence is there to show that they have good, constructive relationships with their staff, from ward clerks and HCAs up to their senior staff...how do they deal with the really tricky things, like the person who does persistently go off sick, the person that's got the bad attitude, who won't hear any criticism of what they do, how do they deal with those really difficult things and they are things that I think really prove...how skilled they are at what they do...' M4

4. **Quality** – e.g. infection rates, complaints, plaudits, clinical incidents.

Senior managers were aware of the challenges that ward managers faced, which, seemed to be a culmination of the 4 key areas of activity, finance, workforce and quality, for example:

> *'…it's those daily [issues], we haven't got enough nurses, we haven't got enough beds, we are restricted financially, the never-ending paperwork trail that they have to deal with as well as still being on top of issues clinically...'M5*
>
> *'…there is **constantly** somebody knocking on the front door for a bed, there's no end to the number of admissions coming through and no sooner are people even **reasonably** well, that we're trying to find somewhere to move them on for rehabilitation or home care...the minute they are reasonably well, they're off, and I think that puts a **huge** amount of pressure on the nursing teams in keeping up with that...and all the while trying to retain staff, and making sure staff get their mandatory training and keeping up with all the things that are happening in the Trust as well...' M3*
>
> *'…it's recruitment, it's individual staff problems, it's constantly overspending and knowing that at month one, you're going to get a budget report that says that you're overspent and the ward managers know they're going to find it nearly impossible*

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to claw that back through the year…it's like being constantly in debt, it's like constantly having a credit card with thousands of pounds on it and you just can't see any way through it…' M4

'...it's when the complaints come through...the wards are incredibly busy because of the pressure of these targets and documentation, to try and get everything that's happened this shift written down, as well as physically deliver the care as well I think is a real challenge and is actually a problem, and they often haven't got time for the basic stuff like fluid charts, how many times has a complaint come through that says "My mother wasn't fed" or didn't have a drink or, and you just can't find that piece of documentation or the fluid chart that tells you if she's had regular, you know surely that the team have popped by and were giving her drinks or whatever, but it just isn't documented and that is very, very hard for them, just to try and keep up with the pressures on the ward...' M3

Senior managers also felt that training and development in these keys areas should ideally start at E grade (senior band 5) level and develop gradually as a continuum of learning:

'...training and development is vital and I think it's at F grade level that you need to have the deeper detail on those 4 corners…although I think some of that should start being embedded at E grade level as well but then there's different levels aren't there and strands but I think E grades should be introduced to some of those...' M2

Despite all 4 aspects being pivotal to the ward manager's role, senior managers had mixed views as to the importance of some, for example financial training and budgetary awareness. Some senior managers felt that financial issues were not taken as seriously by ward managers as they ought to be, whereas others felt that managing a budget was 'no big deal':

'...I wouldn't be too worried about that because a budget, it's like if you've got a bank account, then you can balance a budget...again they're not massive budgets and it would be about setting them up with a proper learning package about meeting on a monthly basis to look at your bank statements or your budget statements, whatever it was, and going through each line until they've really got a grasp of how that works and why that doesn't…no, I think it's important, don't get me wrong, but it's not an essential because it's something you can teach really easily…' M1

'...I mean if [name of ward manager] was a business with a turnover of a million pounds and she was overspent by £200,000 at the end of the year, she'd be declared

bankrupt…and she'd have to lay off all her staff and close down and she'd be out of a job and she wouldn't be able to own another business for however long…we need to think of it in those terms because that's the reality of it and I sometimes think that Ward Managers don't grasp that…' M4

This mismatch in expectations between senior managers has implications for the message that ward managers receive about their budgets.

Other areas of training included:

Understanding the roles of others within the Trust
Understanding more about how the Trust works, systems in place etc
Knowing who to go to for help and how to contact them
IT Skills e.g. how to email, how to use Word/Excel, OBSERVE, Oasis:

- **A standard training package** was needed for ward managers on things such as management/Personnel functions and what was expected of them:

    '…I think as a manager there should be a standard training package for things like budget, performance management and managing sickness and monitoring absence, all the things that if you like have got a management/personnel function that we just dump on your desk and expect you to get on with, or we just say "Read a policy" well reading a policy is not always the way to do it, sometimes you actually need to sit in a group of 2 or 3 of you and read the policy and then maybe draw on personal experiences and say "Oh yeah I've done this with this" and talk it through and make it real, which I think is much more useful and sometimes you need to facilitate that and sometimes y'know nurses at that senior level should be able to facilitate that for themselves, so I think there should be a formal if you like, management pathway designed to address those, if you like, the Trust objectives and performance issues that we will be expecting them to manage on…" M1

Some felt that developmental programmes should be available for all grades or bands of staff, so right through from D to G grade, so as to promote awareness of Personnel issues for example, earlier on in a nurse's career:

    '…I think yes they definitely need to have those, as I say, those 4 corners, there should be programmes developed or days within each of those development programmes for each of those, as I say at different levels, and some will be starting off just an awareness and some will actually be about "Well how do you develop that skill and ability?"…' M2

- **Leadership skills** – e.g. the RCN Leadership Course and the LEO programme were popular. However, there were mixed views as to their value. For example:

'…most people that I know who've done [the LEO course], have gained a lot out of it and that is discernible in the way that they function…' M10

'LEO I've done and yes it was quite beneficial, RCN Leadership Programme I haven't ever done...but I've only known one person that went on it and her practice didn't change and I would have expected her practice to change…' M9

Other senior managers felt that the courses were not practical enough to enable ward managers to change their practice:

'…things like the RCN Leadership Programme and LEO are very good at getting staff to step back and look at exactly what's going on, but I then think we need a programme to say "This is how you do this" I think too often we shy away from telling staff "This is how we do it", we give them the skills, allegedly, to do it but what they often want are practical examples, "How do I manage my day, what do I do when I come in at 9 o'clock?" if you haven't that role modelling opportunity, i.e. if you've been a band 6 nurse and you've had a very good role model then that's excellent but I'm not naïve enough to think that all of our band 6 nurses have been appropriately role modelled, and therefore you can't then say "I want to follow this management style, I want to follow that management style" and our courses don't really fill the gap...' M7

Support for Ward Managers to aid learning

SUMMARY POINTS:

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

- **A mentor** who would focus on the ward manager's own development was seen as valuable by senior managers:

    *'...actual mentorship which perhaps is not so much about the role, but more about **them** and their personal development, so yes we know that they need financial training to manage the budgets and all the rest of it, but how are they achieving that, and about their succession planning, are they shadowing the*

care centre manager from time to time if they want to advance their career in that direction, or are they heading off at the clinical nurse specialist, and I can probably be quite confident in saying that very, very few of them are...sitting with mentors and talking these things through...' M3

- **Time to discuss their career and personal development.** Senior managers felt that ward managers gave priority to developing their staff as opposed to developing themselves.

- **Regular appraisals:** Senior managers were aware that appraisals for ward managers had been neglected:

  '...I think appraisal is actually being paid very much lip-service to ...with it not happening, or else it's a task that has to be done each year, that we have to go through, without regular reviews of it...' M9

And they understood the need for appraisals to be consistent and fair:

  '...if you want to be really clear with someone then you have to have a sit down appraisal, you have to meet regularly, you have to get progress reports, you have to understand where that areas is and what it's succeeding in and what it's not and you can only do that by investing the time with the individual, you can't just give them a list once a year and expect them to come up with the goods, I don't even think quarterly is enough, it needs to be on a regular basis that you review performance and progress and actually find out what's working for them...' M1

- **Developing standards to assess ward managers' capabilities**:

  '...we don't actually have an assessment criteria for our G grades, to say "This is the standard that we require [of] you"...' M7"

  '…I think we should be using competencies...books...to be able to progress so that you should have much more gradual progression rather than this suddenly one day I'm a staff nurse, the next day I'm a sister...' M9

- **Shadowing** a senior colleague to get a different perspective on management issues.

- **Regular contact with their senior managers:**

  '...I think it's important for them to regularly see their line manager and have a conversation about how things are going...' M2

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- **Facilitated clinical supervision** with peers:

  > '...supervision/peer circles where people can come and talk and share experiences and...that has to be facilitated for me, around what's going on in the jobs, how they're developing...just pulling people out for an hour or two once a month, once every six weeks, that's far more useful professionally than anything else the Trust could put on...and it's something we don't do very well...' M1

- **360 degree evaluation is one way of** 'knowing how other people perceive you'.

- **Having protected time for development**:

  > '...we seem to have a rather ad hoc approach to our most valued members, but we could be more structured in that...pulling the ward sisters out and actually going through again practical examples "Well this is how you manage that" asking them to bring difficulties to training so we can actually use that training time to help you, saying "This is what we require of you, what help do you need?" so rather than saying "This is what you've got to do, go away and do it" it's actually giving them time to do it...that's what I'd like to see...' M7

Conclusion

To reiterate, much of what the ward managers expressed a need for in terms of support for learning and development, was also reinforced by senior managers. Both ward managers and senior managers emphasised the need for clarity in expectations of the ward manager role and for such expectations to be matched to suitable training and development. They also held similar perceptions of the training and support required in relation to the 4 key areas of activity, finance, workforce and quality, with the emphasis being on *practical* training and support in these areas. Senior managers and ward managers also concurred that more support was required in terms of understanding the support networks in place for ward managers to access and also the need for teaching and updating IT skills. Succession planning was seen as key to preparing staff for their next roles, yet there seemed to be no line of communication between senior managers and ward managers that was addressing this issue. Thus there seemed to be a lack of leadership to push this forward in the Trust. Senior managers' proposed that a mentor, regular appraisals and time to discuss career development would all assist ward managers' learning and development, which ward managers agreed with. Ward managers felt the need for more positive and constructive feedback as well and for those going into ward manager roles, to have a structured and supported period of induction so as to ease their transition. There was also agreement between both groups of managers that a career development programme from D grade (band 5) to G grade

(band 7) was needed, to enable the skills and knowledge for the next role to be learnt gradually and with structured support.

ACTION POINTS

- A dialogue needs to be established between senior managers and ward managers in order to discuss issues fundamental to their roles and practice. It seems that senior managers are aware of the problems that ward managers face but this is not communicated to ward managers, as they are under the impression that senior managers are 'out of touch'
- There needs to be discussion amongst senior managers as to their expectations of the ward manager's role, which then need to be filtered through to and made explicit for ward managers
- A mentorship scheme should be considered for ward managers so that they have a senior person with whom they can discuss professional and personal developmental issues
- Ward managers need to have a yearly appraisal – and senior management need to discuss with the ward managers who the best person is to have the knowledge and credibility to actually perform the appraisal. Who is in the best position to know a ward manager's capabilities?
- Ward managers need to receive regular, constructive feedback about their capabilities
- Ward managers need to have facilitated clinical supervision sessions with their peers
- Those going into ward manager roles need to have an induction period and structured programme of development and support so as to ease their transition
- Current ward managers need a structured development programme that focuses training on the 4 key areas of activity, finance, workforce and quality
- Senior management to implement a career development programme from D grade (band 5) to G grade (band 7), so that skills and knowledge for the next role are learnt gradually and with structured support
- Senior management need to start a dialogue and take a lead in devising novel approaches to succession planning so as to encourage staff to move on in their careers and enter into ward management positions
- Career thinking and planning ahead needs to start early on in a nurse's career so as to encourage the gradual learning of skills and knowledge that is required to perform the next role up
- Ward managers need to be given protected time for their own development, thus sending a message that they are valued by their managers and their contribution to the Trust acknowledged.

SECTION V

CONCLUSION

There are a number of issues that senior management within the Trust need to consider in relation to nurse support and development. These are:
1. Development within a role
2. Succession planning
3. Lack of feedback or support from seniors for senior grades
4. Clinical expertise, leadership skills and management skills

1. Development within a role

Developing within a role is more than simply working towards gaining promotion. The majority of senior nurses in this study, wanted to broaden their depth of knowledge and skills within their current role, as opposed to developing themselves for promotion per se. The question for senior management within the Trust therefore is how they can as an organisation, facilitate the development of experienced nurses who want to stay at their present level, regardless of their seniority? How can they help their staff develop their skills and knowledge within their present role so as to feel satisfied and rewarded with their position and status?

It seems that some senior Fs felt 'stuck' in their present roles, that the only avenues open to them were to become ward managers or move into specialist roles. Feeling 'stuck' led to a degree of disengagement from their work which was often compounded by a change in their level of responsibility or a more general lack of responsibility in their duties. This presents another challenge for senior management in trying to facilitate senior Fs growth so that they maintain interest and motivation at their present level. This needs to be tackled in parallel with facilitating the development of seniors who do want to progress to the next level i.e. those who want to become ward managers.

One of the major problems is that staff do not want senior roles anymore, because the expectations of what is achievable are higher. Stress levels increase dramatically for higher grades and therefore some staff no longer want the jobs because they are perceived to be more hassle than they are worth, for the pay offered. From the data, one way to make ward manager roles more attractive in order to recruit and retain staff is to offer more support, especially, but not only, at the start of the promotion.

Development is not perceived to be a priority within the Trust but is rather experienced as haphazard and ad hoc. There is also no slack in the system to allow for development. Staff do not have the time, sufficient establishment of staff, or the energy to concentrate on development; the emphasis is more towards managing the challenges of the moment. The current freeze on training courses reinforces the message that their development is not a priority. There are problems in accessing mandatory training and this therefore raises the question of where responsibility lies if a nurse makes an error and they have not been on the appropriate training course.

2. Succession Planning

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

There is an associated lack of career thinking, of not having career trajectories in place for staff. In most cases, staff are not being actively groomed to take on the role and responsibilities of the next grade/band up. This seems to be because seniors are not consciously passing on their knowledge and skills to juniors; what does occur appears to happen by chance, almost by osmosis, since they do not have the time or energy to do it properly. However in some ward areas, seniors were perceived to be consciously keeping their knowledge to themselves in what was attributed to be an attempt to maintain their authority and power. The lack of access to certain information made staff feel there were blanks in their knowledge. This affected their understanding of what was going on in the organisation and how things worked. For example, F2 did not understand the ward budget and how to access that. This also affected their vision of how their role fitted in with the overall ethos of the Trust.

The lack of knowledge and preparation for senior grades has meant that too many people have been promoted when they were not ready and some of them have failed as a consequence. Staff have gone into senior roles without actually thinking about whether it is really what they want to do, with its being more of a case of 'I can so I will' as opposed to thinking long term. Promotion is unplanned and about being in the right place at the right time. Again this is associated with a lack of career thinking in nursing in general. Career progression is not a seamless process, it is jumpy and fragmented.

3. Feedback and support in higher grade roles

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

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

Support should be a cascade effect in that the G supports the Fs, the Fs support the Es etc., and senior management within the Trust should facilitate this. However the pressures of work have contributed to a reduction in people's ability to contribute to their collective responsibility. This is almost a form of protection against the stress: 'do not

accept too much responsibility because you've already got more than you can handle' or 'it's nothing to do with me' ethos. How can stress be best managed within the Trust? There is sometimes a cultural resistance in nursing to acknowledging stress formally where nurses feel they must show that they are coping. There is a need to promote self awareness and teach practical ways to handle stress as well as addressing some of the factors that are causing it. For example, staff felt that more and franker communication with senior managers would help them to understand more clearly why certain decisions were being made. This may seem counter intuitive to some senior managers given the amount that those on the wards are already having to deal with and the difficulty of some decisions having to be made. Other contributors to reducing stress, such as recreational facilities and space for staff to relax might be one way of showing staff that they are valued.

4. Clinical expertise, leadership skills and management skills

It is assumed that a good nurse who is capable clinically will be a good leader and manager too. Yet there is a difference between leadership skills and management skills. Clinical expertise, leadership skills and management skills do not necessarily develop at the same rates either as has been shown in the learning trajectories developed by the original LiNEA Project.

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

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

'...I think we all want to be part of a successful organisation and a lot of us are just not confident that y'know it is a successful organisation at the moment, but we don't know why...' F9

Conclusion

The findings of the research have provided evidence to confirm the view of the LiNEA Steering Group that there is a need to consider staff development for nurses as a more continuous and supported process. Since the inception of the research, competition for stretched resources has increased even further in NHS Trusts, with a serious impact on available posts, particularly for recently qualified nurses. In these circumstances, it is more than ever vital to develop the skills of staff rapidly and effectively and to retain them in the Service. The data from this project have shown what staff themselves, from newly qualified to senior managers, see from their experience would make the difference to their development. The career planning and support in order to move to the next stages of learning and progression to management roles have been found to be non-existent at worst and haphazard and fragmented in many cases. This is of concern at all levels: to nurses who need to be more proactive in thinking ahead about what they want to do and in finding out what opportunities there are; to their managers in making sure staff have equal access to development opportunities and have involved their team in learning with succession planning in mind; and to senior managers, who were aware of many of the difficulties and development needs faced by staff, although this did not necessarily communicate itself to those staff.

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

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

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APPENDIX 1

Observational Vignette 1: E4 mentoring a student in practice

E4 is working on a late shift with a third year student. After handover E4 and the student go round their patients in bay 5 and introduce themselves.

1425: At patient 5.6 they introduce themselves and E4 says to the patient 'I'll just see what's going on here...there's a lot of beeping going on' an IV pump is alarming. E4 says to the student 'We need to put an IVI up so we'll check the drug chart'. They go to the treatment room.

1430: The student asks E4 if she can go through what to do for checking the fluid correctly. They both look at the prescription on the drug chart and E4 goes through the procedure 'Okay date, normal saline, clear isn't it, nothing in it, doctor's signature, volume' E4 explains that the patient is on a specific regime for fluid management. 'They're on 50% fluid replacement so we replace his fluid output based on his urine output, so he's on hourly urines, so every hour we replace the fluid...but they don't want us to do that anymore as he's had a huge output...about 500ml, so they want 8 hourly bags and no replacement at the moment...so we'll set the IV pump to go over 8 hours, at 125mls an hour'. E4 runs through the calculation with the student and explains how she came to that figure. Then they go through the IV bag and check that. E4 says 'I need to check this with another trained nurse' so she takes the IV bag and the drug chart to the desk, checks the prescription with a colleague and then all 3 go the patient's bed. E4 and her colleague check the patient's name band, hospital number and date of birth. E4 says 'He was on replacement but that's stopped now'

1435: E4 connects the new IV bag to the giving set and then sets up the IVI pump. The student watches E4 as she does this. E4 enters the volume of fluid to deliver and presses the start button. She checks the rate. 'Can you hear it working?' The student says 'Yes' E4 goes through the patient's fluid chart with the student 'It's a bit confused because we're not doing replacement anymore, but it's still an 8 hour bag so we'll check our hourly urines still...we'll leave it until 3 o'clock and then on the hour we'll check up with everything' E4 tells the patient they'll check with them again at 3.

1445: E4 and the student go to the treatment room to prepare an enema for patient 5.2. They go through how to give the enema, the student reads the instructions on the box. E4 advises the student on what to prepare, so a commode, gloves, KY jelly, inco pads. They take the commode into the bay and leave it by the patient's bed as they are sleeping.

1455: Patient 5.4 comes back from theatre. E4 and the student go to the desk and take handover from the theatre nurse. They both write on their

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handover sheets as the nurse hands over. Then they look through the patient's operation notes and E4 deciphers the writing for the student. E4 says to the student 'Okay we'll split the jobs, if you do patient 5.4's obs I'll do the 3 o'clock urine' 'Okay' E4 goes to settle in patient 5.4 first. She checks their catheter bag, oxygen level and their respiration rate. She hands an oxygen mask to the student who attaches it to the tubing. E4 says to her 'Did you understand what she [the theatre nurse] said?' The student says 'Kind of'. E4 says 'They're [the doctors] expecting a lot of blood because he bled a lot in theatre...so it's [the catheter] on traction all the time, they want 500ml in the bag all the time, which is why it's on traction' They take a look at the catheter bag. E4 says 'It's really clear so we can slow it down a bit...it always flows very fast in theatre...I'll bring some extra jugs because the bag is very full' The student asks how much irrigation the patient will need. E4 explains 'They usually go through a bottle an hour initially but then we tail it off as the urine clears' The student asks how she knows when to tail it off. E4 says 'It's really left to your own judgement, so for example if it [urine] was quite clotty and there was lots of blood then you'd increase the flow...it's something you develop with experience really' E4 goes to fetch some jugs. She comes back and empties the catheter bag until it reads 500ml. She says to the student 'Can I get you to write on the fluid chart...so that's 900 emptied there' The student writes on the chart. She then takes the jugs to the sluice.

1505: E4 measures the urine at patient 5.6 and records it on the fluid chart. She says to the student 'That's good I know where I am with it now' The student asks about the enema. E4 says 'We'll leave the enema for now, our priorities are the post-op patient and getting patient 5.6's catheter fluid balance back on track'.

APPENDIX 2

Observational Vignette 2: F10 dealing with a difficult discharge

Field note: F10 is in charge of an early shift and currently dealing with discharging a patient. The patient's GP is refusing to accept them back into the community because they have been prescribed a 3 month course of subcutaneous Tensaparin.

0955: F10 goes through the patient board with the site coordinator and tells them that the GP is refusing to accept the patient. The site coordinator says 'Rubbish' and offers to phone the GP. F10 says 'The GP says it's a waste of his resources, but the district nurses are happy to go in' F10 and the site coordinator discuss the patient's treatment. The site coordinator asks 'Why are they on Tensaparin I wonder...how long are they on it for do you know?' F10 says '3 months' 'That's unusual, why are they not on warfarin?' F10 is not sure 'I haven't checked the patient's notes' The site coordinator looks through the medical notes trolley 'What team are they [the patient] under?' F10 tells them. The coordinator skims the notes and reads 'Not for warfarin in view of past medical history' They look through the notes together. The site manager then rings the GP and is put on hold. They say to F10 'Could we send the patient somewhere else?' F10 waits by the notes trolley whilst the site coordinator talks on the phone. A team of 3 doctors arrive at the desk and update F10 on the patients they have just seen on their ward round. F10 writes the updates down on their handover sheet.

1005: The site coordinator hands over what the GP has said to F10 'He doesn't understand why the patient is not on warfarin...we need to check with pharmacy when the Tensaparin needs to be given, whether it's 3 or 4 hourly...we need someone senior from the team to explain why the patient needs Tensaparin...why can't they get the nurses to give Tensaparin?' F10 says 'Because the patient is in a residential home' F10 says they'll phone one of the doctors and tell him to ring the GP. F10 and the site coordinator go back to the patient board and go through the rest of the patients and their discharge status.

1030: The ward clerk answers the phone 'Can I stop you there, our charge nurse is dealing with it' the ward clerk calls for F10 and says it's the patient's nursing home on the phone 'They say they can't have her back' F10 takes the call. F10 listens and then explains what the current situation is as they understand it. The staff from the nursing home seem to be confused. F10 says 'The district nurses are happy but the GP isn't, I'm waiting for the Reg to talk to the GP about it...but the GP has accepted the patient as long as they get an explanation about the Tensaparin'. F10 is very polite 'Can I get back to you, it's very good of you to ring and I'll let you know when it's cleared up' F10 writes down the nursing home's phone number. 'Ill get back

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to you as soon as possible' F10 ends the call and phones switchboard 'Have you got Dr [name] Reg's number please?' F10 bleeps the doctor.

1040: The Reg rings back and F10 explains the situation 'This patient has 3 months of Tensaparin written up as a TTO, the GP has kicked up a stink, apparently the district nurses are now refusing to go in...the GP has phoned the nursing home and refused to take her...he won't use his resources i.e. the district nurses' The Reg is unaware that the patient has been written up for 3 months of Tensaparin and says he'll get back to F10. F10 says to me 'But the GP hasn't phoned me to tell me' F10 rings the site coordinator and updates them on what is happening.

1115: The Reg is now at the desk on the phone. F10 signals to him. The Reg tells F10 he is on the phone about the 'Tensaparin patient'. F10 hands over to his deputy nurse on the shift. The Reg ends his call and they discuss the patient. F10 gives the Reg the GP's phone number and the Reg tries to call him. F10 can't understand what the problem is 'It's a simple sub-cut injection'

1120: The Reg finishes the call. F10 comes back to the desk and asks what the story is with the Tensaparin. The Reg says 'The GP said they were thinking of not taking her back anyway' F10 says 'Aah...the nursing home said the only reason they wouldn't take her was because of the Tensaparin' The Reg tries to ring the nursing home but they're constantly engaged. F10 says 'How do you want to play it?' The Reg says 'I'll get back to you, I'll keep trying' F10 tells me that this patient is an EMI patient which means that they are Elderly and Mentally Infirm. F10 thinks that the nursing home now want her to be reviewed to see if it's appropriate for her to return to the nursing home or whether she needs to be relocated because of her present needs.

1240: F10 takes a phone call from the site coordinator and updates them on the patient with the Tensaparin problem. F10 updates says that the nursing home was thinking of not taking her back anyway because she is an EMI patient. F10 says 'Basically they're [the patient] for a review tomorrow'. So the patient stays for now, and F10 can do no more today.