

# National Nursing RESEARCH UNIT



Employee engagement and retention  
in the nursing workforce:

A case study of  
an inner-London acute trust

Final Report

March 2008

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**Work undertaken at London School of Hygiene and  
Tropical Medicine, 2004-2007**

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## Acknowledgements

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I would like to thank a number of people who made this study possible. Primarily this includes the research participants who gave their time and insights so generously and honestly- thank you all. Also thanks to the senior staff in the case study trust who were willing to allow me access and who generously supported the work in so many ways.

Other key advisors and supporters included, my post doctoral mentors and colleagues, Professors Anne Marie Rafferty, Nick Black and Julienne Meyer and members of my advisory group. These included Professor James Buchan and Dr Dilys Robinson together with members of the trust Senior Nursing Directorate and Human Resources department. Preserving their anonymity and that of the case study trust prevents me mentioning them by name, but does not diminish my gratitude. I would also like to acknowledge colleagues at the London School of Hygiene and the National Nursing Research Unit, who allowed me time to undertake this work and complete it. In particular, Professor Peter Griffiths, Director of the National Nursing Research Unit, whose generosity allowed me the time to complete this work in a new post.

Finally I would like to thank the Health Foundation, the Consortium for Healthcare Research (based at Queen Mary, London, Hertfordshire University, City University and my own research base for this post doctoral work the London School of Hygiene) and the leadership programme team at the King's Fund, for the financial and research support afforded me by the post doctoral fellowship I was awarded. Thank you.

Notwithstanding my illustrious advisors, the responsibility for the content of this report and any errors contained therein lie entirely with me, and I take full personal responsibility for the content.

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March 2008

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## Executive summary

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This report summarizes findings from a study involving nurses' engagement and retention issues at an inner-city London trust. Using several data-collection methods, the author followed a cohort of nurses and other key staff in the case study trust from 2005-2007 to allow analysis of attitudinal and opinion changes over their time in post.

After discussing employee engagement and other relevant concepts, this report outlines the case study site, the research design, aims and objectives, and the sample, data collection and access issues facing the researcher. Questionnaire findings reveal respondents' demographic and work experience, as well as their reasons for choosing to work for this trust.

Interviews identify intrinsic and extrinsic motivators as personally significant in respondents' decisions about their workplace. Why they chose to become nurses in the first place (meaningful work, opportunities for development) and what continues to motivate them in nursing were among the most detailed and consistent responses. Improving practice, maintaining healthy relationships with managers and the rest of the trust team, feeling valued and the synergy of working for a larger good were all mentioned by interviewees.

The converse of some of these motivators was also cited, in the forms of demotivators, violations of the psychological contract and reasons for leaving. The report's policy recommendations can perhaps more easily target these negative factors than ensure that nurses have positive intangibles like teamwork and camaraderie. Finally, appendices support these findings with the data-collection documents and information about the timing of interviews.

Participants in this study were asked what they felt made a good working environment, and also how to retain nurses in the trust and indeed in the profession. They were also asked to identify what trade-offs they would make and what aspects of their work were important to them in their posts in the trust. Unsurprisingly, many aspects of these three questions showed significant overlap; therefore significant responses to these are presented here. Where aspects were only mentioned in one area or another (i.e. no overlap) this is highlighted. Where issues were mentioned only at interview 1 or 2 is also highlighted, but most were identified consistently at both interviews.

- Good team, good teamwork; staff help each other, are friendly and offer camaraderie
- Good support and feedback
- Adequate staff, with good ratios and safe staffing levels
- Good staff development and education; feeling stretched, learning, being developed
- Good management that is approachable and supportive
- Feeling valued and appreciated
- Ability to give good quality care and to make a difference to patients

- Flexible working (in trade-offs and what retains nurses only)
- Well-equipped unit (in good environment only)
- Good communication (in good environment at Interview 2 only)
- Quality staff (in good environment at Interview 2 only)

Broadly, other significant findings might be summarised as follows:

De-motivating factors for nurses working in the trust differed across the two interviews, with interview 2 issues emerging during discussion of the financial savings the trust was making, and the perceived impact of this on the quality of patient care.

At interview 1, the worst experiences described by interviewees included:

- Lack of support, including unsupportive or untrustworthy colleagues
- Poor skill mix and heavy workload
- Lack of cleanliness or hygiene
- Abusive and aggressive patients
- Feeling useless and not able to fully practice (mainly internationally recruited nurses from India and the Philippines during and just after adaptation)

At interview 2, the worst experiences mentioned were:

- Feeling stressed
- Carrying people, doing other people's work
- Feeling unheard, or feeling as though nurses can't change things in ward or trust; includes changes proposed as a result of need to make financial savings
- Poor leadership or manager
- Poor skill mix, the stress of having to support others
- Lack of professional development
- Feeling more could be done to help patients, dissatisfaction with care given.

Nurses report increasing stress and disillusionment in their second compared to their first interviews. The interview results in particular revealed a workforce whose pride in their professionalism is challenged when they see standards suffer from budgetary pressures, and certainly when they see patients suffer from their speeded-up workdays. Satisfaction from teamwork and from doing a critically important job very well are counterbalanced with frustrations over low pay and deferred development opportunities.

However, good management strategies and a sense of management responsiveness can retain staff – even in cases where nurses announce their intent to leave. In such cases, even conflict or confrontation can be positive, leading to resolution of the immediate issue as well as better cooperation over the long run. Such issues can be quite serious, as in the case of a nurse who demanded action on a trust failure to enforce policies that protect nurses'

physical security; this nurse mentions a colleague whose injuries due to such a security failure kept her from returning to the ward for many months.

These interviews detail how frustrations and failures are or can be balanced by encouragement and professional growth. One focus of frustrations was a hierarchy that was, at times, felt to dismiss the nursing point of view; another focus was intra-organizational competition for resources and control. The dilution of nursing expertise under the official explanation that it is meant to improve patient care incensed some participants. Others mention that the time spent instructing unqualified staff who replaced trained nurses cuts further into patient-nurse interaction time.

Lack of time for patients is a recurring theme, as is a sense of overwork. Being appreciated is important, and nurses in this study report that their work is misunderstood by patients and a public that accepts that nurses should be ever more highly educated, yet remain poorly paid throughout their careers in the profession. Several nurses compare their working conditions to those of their colleagues in other countries, and internationally recruited nurses (IRNs) contribute valuable insights about their expectations and experiences in their work at the trust and elsewhere.

Other interviewees, both nurses and stakeholders, perceive management as devaluing nurses and nursing. Free coffee and tea symbolise the sort of small cost-cutting victory that leads to resentment and, ultimately, defeat in retaining employees. A cup of tea sounds petty until one has worked a 12-hour shift, at which time some employer assistance to see workers safely and comfortably home seems more reasonable as well.

If the trust wants a more satisfied nursing workforce, it can choose to focus on a wide range of interviewees' concerns, indeed ranging from tea to safety. For this reason the policy suggestions are highly tentative and intended to contribute to discussion of nursing retention strategies, and are not meant to represent a hierarchy of interviewees' priorities.

## **Recommendations**

Create a workplace environment that promotes employee engagement by addressing nurses' stated concerns about these issues:

1. **Security and safety** measures protect staff and patients, and the trust can reduce employee stress by:
  - A. Ensuring there are no lapses in security programmes or provision of safety items (safe lighting, door guards, working alarms);
  - B. Ensuring that all employees understand security procedures, such as knowing the security staff's emergency response number and how to safely restrain abusive patients;



- C. Considering demonstrating the trust's concern with safety by offering practical support to reduce risks, such as providing safe transport (taxicabs, escorts to tube stations) at late hours or after unusually long shifts.
2. Creation of and reliance on **feedback mechanisms** can help counter some nurses' (and stakeholders') perception that the nursing staff is not listened to or consulted in policy-making by management. These feedback mechanisms could include:
- A. A process to welcome and implement suggestions from all staff (via newsletter, an interactive web site, a monthly contest, etc);
  - B. Planning for two-way evaluations during staff appraisals, including regularly (and independently) asking workers how satisfied they are in post, and what factors might influence them to leave or stay (this would include management visibly acting on feedback provided in the regular post-appointment questionnaire data);
  - C. Many large organizations empower an ombudsman to try to mediate or resolve conflicts. Some even have one for issues of professional practice disagreements, and one for employee-management issues. Both of these functions could address concerns mentioned in this study, and offer an always-open door and a sense of being heard by management when staff have conflicts with supervisors.
3. Communication tools such as newsletters and interactive web sites can be used also to address concerns about the trust's uneven provision of **learning and development opportunities**. Information about upcoming programmes, educational media about procedures and skills, and other news should be equally available to every employee, and:
- A. Where possible, the trust can negotiate at board level for monies for staff education and training to be ring fenced and not used elsewhere for other activities; and
  - B. The trust can ensure that all staff have appraisals and personal career development plans; streamlining appraisal paperwork is another option to achieve this end.
4. Interviewees' concerns about the **fairness of advancement** through grades and bands can be addressed by ensuring that consistent and clearly stated rules are implemented. Again, a feedback mechanism is needed here for disputed cases or if an arena for appeal is felt to be needed.

5. Because **feeling valued** is a major factor in employees' commitment to a particular workplace, the trust can examine factors that can make management more supportive:
  - A. Increase management support through higher visibility; for example, occasional front-line rotations (spending a shift or a longer period in a busy ward) would address complaints that managers don't know what their nurses are up against.
  - B. Raise the profile of issues such as 'feeling valued' across the trust, so staff and managers are aware of the importance of this concept through, for example, presentation of research findings, training and personal development.
  - C. The loci for feeling valued should be expanded, with employees being encouraged to nominate their peers for regular performance awards, trust media sharing stories of teamwork or other celebrations of outstanding nursing.
  - D. Units or wards that experience unusually high nursing turnover might benefit from special attention to management-employee relations, and from a trust damage-control intervention to stop employees, stressed by the high turnover, from leaving themselves.
6. Interviewees' concerns that there is a non-transparent **performance management culture** need addressing; some staff's poor performance is not perceived to be managed whilst others' excellence is not always recognised or valued. Management of poor performance can be addressed by greater support and training for managers on such difficult human resource issues, and by transparent and fully implemented guidelines. This may require increased human resource support for managers.
7. Trust managers could compare the **psychological contract** that they are perceived to be offering with the more open and stated conditions of work. This perceived but unstated contract attracts new employees, but as interview 2 showed, high hopes for development and that the trust can provide the best conditions for patient care can lead to later disillusionment and untimely departures.
8. Although **pay levels** were mentioned by a small minority of respondents, if the trust is to continue to offer current compensation while increasing the workload and stress of highly trained staff, it may well face competition from other employers in terms of keeping nurses in post. This may be particularly true with the increasing number of foundation trusts in London that can each set local pay.
9. In this light, provision of coffee, tea and other "**comfort benefits**" such as the transportation options mentioned above could outweigh the cost factors involved in replacing and retraining staff frustrated with perceived deterioration in nursing conditions. Other initiatives to

recognise and support nurses, such as subsidised transport for nurses travelling to work on rail and tube, could be explored with the mayor of London's office.

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## **1. Introduction**

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This study was undertaken between 2004 and 2007 as part of a post-doctoral programme of work at the London School of Hygiene and Tropical Medicine, and was supported by the Health Foundation.

### **1. 1. Background: Recruitment and retention challenges in the nursing workforce**

The National Health Service is the largest employer in Europe, employing 142,000 staff in London alone (Department of Health 2000a), yet when this study commenced it was felt that the United Kingdom did not have enough doctors and nurses to meet demand (HM Treasury 2002). There were recruitment and retention challenges across the whole NHS, but these were particularly pronounced in some cities, especially London. The vacancy and turnover rates in London were higher than in other parts of the UK, with a greater reliance on agency and international staff (Buchan et al 2003). For example, vacancy rates in London were reported to be twice as high as the NHS average for some occupations (Buchan et al 2003). The population of the capital is expected to grow by 700,000 by 2016 (Mayor of London 2002), and a well-trained and motivated workforce is essential to meet the health-care needs of the ever-growing city. Among the challenging workforce trends are some specific to London, such as a young, transient and international staff pool (Buchan et al 2003). Other trends are common throughout the NHS, such as the high cost of housing and the effects of an ageing workforce.

The government in responding to this challenge has created a number of policies addressing issues of changing work practices and staff retention and motivation. These are summarised in the NHS Human Resources strategy published in 2002 (Department of Health 2002). Many of these strategies are therefore relatively new or newly implemented, such as Agenda for Change (Department of Health 1999) and Improving Working Lives (Department of Health 2000b). The impact of these policies on staff motivation, recruitment and retention are as yet unknown. Whilst there is some work under way to assess their impact, these evaluations often focus on large staff surveys. Such surveys may not reveal the complexities, fine details or indeed overlapping areas of these policy initiatives, nor how they affect the working lives of staff in an inner London trust. The project proposed here seeks to understand the policies' impacts on the NHS staff they have been designed to assist, by looking at the staff's experiences in depth, both over time and cross-sectionally at various stages of their working lives in the trust.

## **1. 2. Employee engagement**

Employee engagement (EE) is a concept that is gaining considerable popular currency in the business world, where it appears to have an intuitive appeal to senior managers and Human Resources (HR) practitioners. This focus on engagement has been led by consultancies and survey houses rather than researchers, although the academic world is starting to take notice (Robinson et al 2004). Engagement has as its intellectual foundation two well-researched precursors: employee commitment and organisational citizenship behaviour (OCB). The performance benefits resulting from increased employee commitment have been widely demonstrated in the literature. These include increased job satisfaction (Vandenberg and Lance 1992) and increased job performance (Mathieu and Zajac 1990), with decreased employee turnover (Cohen 1991), intention to leave (Balfour and Wechsler 1996), intention to search for alternative employers (Cohen 1993) and absenteeism (Cohen 1993, Barber et al. 1999). A line of research focusing on 'met expectations' suggests that employees will be more committed if there is a good match between what the person is looking for in a job and what the job provides (Dawis 1992). Guest and Conway (2002) have used the concept of the psychological contract to focus on 'met expectations' through analysis of the relationships between obligations and promises between organisations and employees. These authors suggest that increasing pressures of work make it likely that the psychological contract, particularly in the promises and commitments made by employers to employees, would be violated. The CIPD survey of 2002, undertaken in the UK by Guest and Conway (2002), notes that there has been some decline in job satisfaction since 1990 and that this is most notable in the public sector. In the health service in particular, workers were identified as being under stress, with heavy workloads and working hours likely to harm health (Guest and Conway 2002). In summary, commitment is a two-way process which the organisation itself has to initiate. This can be achieved by creating a clear employer brand and group identity so that the right people are recruited. The organisation then needs to ensure that the values of its brand image are delivered by treating employees fairly and maintaining trust. This is often achieved and translated through front-line managers (Purcell 2003). Job satisfaction is an important component of commitment, but should not be perceived as equivalent to it. Commitment has more positive outcomes for the organisation in terms of employee performance. This study has been able to focus more strongly on EE than on organisational citizenship behaviour (OCB).

## **1. 3. The case study site**

The trust selected as a case study for this research is Trust A, an inner-city acute trust, which reflects the diverse population of London and the workforce challenges faced by all trusts across the capital. An initial scoping study revealed that throughout 2004 the vacancy rate in nursing in Trust A averaged 18% and the turnover rate also was 18%: not the highest in London, but also not the lowest and considerably higher than in many cities outside the capital (Office of Manpower Economics 2003). The trust's aim was to have a vacancy

rate of 6% and a turnover of nursing staff close to 13% by March 2006. The scoping study revealed the trust had a well-established recruitment and retention team with a number of key strategies to aid both recruitment and retention under way. In 2004 the trust collected data from its workforce to try to understand trends using a questionnaire. Response rates for exit questionnaires were low at 18% (n=45) and for questionnaires returned by people new in post, 23% (n=221). This potentially gave the trust an unreliable and skewed picture of why people were leaving and of their experiences as new staff. It is anticipated that by offering a face-to-face interview off-site with an independent researcher, uptake may increase and information that would not otherwise be available to managers and employees of the trust may become available. It is also anticipated that following a cohort of new staff from the beginning of their employment over two years will shed much light on issues affecting the quality of nurses' working lives that relates to employee engagement and retention.

During the study period the trust was implementing a number of the government initiatives: Agenda for Change was to have been assimilated in March 2005 and the trust achieved Improving Working Lives (IWL) practice plus the same year. This trust also is implementing a trust-wide leadership programme and a nursing leadership programme devised by the Foundation Board in the USA (Advisory Board Company 2002). These are important contextual factors, and this study aimed to explore the effects of these interventions on the engagement, motivation and retention of trust staff.

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## **2. Research design**

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This study is a qualitative case study (Gomm et al 2000) in the interpretive tradition, seeking to access the experiences and perceptions of nursing staff and their interpretations of the world (Green and Thorogood 2004). Interviews allow for much greater flexibility than questionnaires, allow question order to be varied and provide opportunities for probing and follow-up questions (Robson 2001). The participants are also given more voice, being allowed to guide the interview and share their experiences:

Unlike survey interviews, in which those giving information are relatively passive and are not allowed the opportunity to elaborate, interviewees in qualitative interviews share in the work of the interview, sometimes guiding it in channels of their own choosing. They are treated as partners rather than as objects in the research. (Rubin and Rubin 1995; 10)

Analysis was undertaken utilising aspects of a grounded theory approach (Glaser and Strauss 1967, Strauss 1987) including constant comparative analysis and some initial open coding. Theoretical sampling, in vivo codes, analysis of deviant cases and selective coding were all used in this study. Issues of rigour were addressed throughout the study (Seale 1999).

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### **3. Aims and objectives**

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Aim:

- What keeps nursing staff engaged in an organisation and what influences NHS nursing staff to leave or stay in post?

Objectives:

- What are the trade-offs that staff make in their assessments and decisions to leave or stay?
- When does intention to leave set in?
- What effects do met or unmet expectations (within a psychological contract) about a role or job have on people's intentions to leave or stay?
- What are the effects of trust and government initiatives on employee engagement and intention to leave or stay? (For example, effects of flexible working and of relationship with managers)

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### **4. Sample, access and data collection**

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- Questionnaires were completed by all new nursing 'starters' in the trust over 2 months (n=108). These were administered face-to-face to all new nursing staff at 2 trust induction days in July and August 2005. They were used to gain initial insights and to allow purposive sampling for the in-depth interviews.
- Eighty-four of these who responded to the questionnaire were willing to take part in one-to-one interviews, and from these a sub-sample was determined (n=26 interviews). These staff were interviewed on two occasions by the researcher:
  - During the first few months in post (2-7 months in post)
  - After a period of time in the trust (14-18 months) or before that period if they decide to leave earlier.

These staff were sampled where possible to:

- Reflect staff going to work in high-retention areas (low turnover) and low-retention areas (high turnover)
- Reflect a range of nursing grades
- Reflect a range of speciality areas
- Include internationally qualified nurses – both those directly recruited to the trust (internationally recruited nurses, IRNs) and those who qualified abroad and came to the UK independently.

The potential and actual sample is detailed in Table 1 below.

It was decided through discussion with the advisory group to exclude unqualified staff, as their motivation, engagement and other issues were thought to be different and best kept separate to those of qualified nurses. At the time the study commenced, the old grading of D-G was still in use. The researcher thus used these labels as they were still used by the majority of the participants. In 2005, at the time of initial sampling, the trust was finding it more difficult to retain E grade nurses, and so a greater proportion of E grades were recruited to be interviewed (six out of nine – or 66% of those willing to take part). All G grades willing to take part were interviewed and almost 50% of D grades, plus over 50% of F grades. At the time of data collection a large number of Indian and Filipino nurses were commencing work, having been directly recruited to work in the trust. Five nurses from India were sampled and one from the Philippines. A greater proportion of the sample from the Philippines was initially desired and all nine of those who had said they were willing to take part were contacted, but unfortunately this resulted in only one participant willing to meet the researcher and be interviewed.

**Table 1: Interview potential and actual sample**

<b>Staff grade</b>	<b>Completed questionnaire</b>	<b>Willing to participate</b>	<b>Interviewed</b>
Health care support workers	11	7	0
D grade staff nurses (4 IRN)	27	17	8
E grade staff nurses (Not IRN)	9	9	6
F grade junior ward managers	7	7	4
G grade ward managers	4	2	2
Directly recruited Indian IRNs (D / E grade)	33	33	5
Directly recruited Filipino IRNs (D / E grade)	17	9	1
<b>Total</b>	<b>108</b>	<b>84</b>	<b>26</b>



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## **5. Researcher's access to case study site**

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In general, permission to access the trust as a case study site was granted by the head of nursing and the director of human resources at A Trust. Access to new staff was through the human resources department and attendance at the trust's corporate induction days.

Nursing staff joining the organisation over two calendar months were recruited to the study in person by the researcher, who attended two induction days in July and August 2005. The researcher had a slot of approx. 30 mins on the timetable where the research project was presented verbally and in written form via project information sheets (Appendix 1). All attendees were asked to complete a questionnaire (Appendix 2) giving demographic details, why they had chosen to work at the trust and their willingness to take part further in the research. All questionnaires had unique identifying numbers, and only those who agreed to take part further were required to give any identifying or contact details. Potential interview participants were contacted by telephone, and were given time to consider their further participation in the study and an opportunity to ask questions. When they had verbally agreed to participate, a mutually convenient time for an interview was arranged and participants were asked to sign a consent form (Appendix 3) before the interview began. Appendix 4 details when each participant was interviewed after commencing work in the trust, and Appendix 5 notes the dates of interviews, the order undertaken and number of months between first and second interviews.

Another phase of the research ran simultaneously to give insights into the wider contextual factors within the trust.

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## **6. Organisational response to retaining staff: A case study**

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Aim:

- To determine contextual factors in the trust relating to employee engagement and retention of staff.

Objectives:

- To identify trust policies that may impact upon retention, employee engagement and turnover of nursing staff
- To identify the retention strategy of the trust and any changes in policy during the lifetime of the project
- To identify key issues in relation to context and retention of staff in the trust highlighted by key stakeholders in the trust

### Sample, access and data collection:

- Interviews were undertaken with key stakeholders (e.g. senior nurses, senior managers in human resources (HR), n=9) in the trust to determine the policies and strategies that may impact upon employee engagement, retention and turnover of nursing staff.
- A focus group interview was held on one occasion with matrons in the trust (n=15 participants).
- Documentary analysis:
  - National and Trust strategy documents which set out the policies and strategies that may impact upon retention, employee engagement, and turnover of nursing staff were examined.
  - Secondary analysis and audit of the anonymised exit interview questionnaires and starter questionnaires used by the trust were undertaken during data collection.

### Key stakeholders

- A list of key stakeholders, or people with a professional interest in employee engagement and retention of nursing staff in the trust, was identified by initial contacts in the trust. Names were added through a 'snowballing' strategy of sampling (i.e. commence with one sampling unit, in this case a key stakeholder, and this person identifies other participants of a similar or known type, i.e. others interested in nurse retention in the trust (Mason 1996).
- Stakeholders were invited to take part in a face-to-face interview with an independent researcher at a time and place of mutual convenience.
- The researcher attended the recruitment and retention meetings in the trust in 2005 and through the end of 2006. Phases 1 and 2 were undertaken simultaneously, from June 2005 to October 2007.

### Ethical issues

- Ethical approval for this study was granted by the Local Research Ethics Committee of East London and the City Research Ethics Committee as well as the Ethics Committee of the London School of Hygiene and Tropical Medicine (LSHTM). The researcher negotiated access through the trust's R & D office, and held an honorary contract in the trust for the project's duration.
- The research was undertaken ethically and trust procedures in terms of research governance were followed. Issues of anonymity, confidentiality and informed consent were addressed in the recruitment of participants, the data collection processes and data storage. The principles of beneficence and non-maleficence were adhered to.

## 7. Questionnaire findings

As outlined above, initial questionnaires were administered to new staff at two trust induction days. One hundred and eight nursing staff new to the trust completed questionnaires (100% response rate).

### Questionnaire sample characteristics

- Age range: 20-55, with majority being between 21-35 years of age (see Table 2)
- 89% female (n=96) and 11% male (n=12) (Table 3)
- 78% had not worked in the trust before, 6% had, with 13% having been students in the trust (Table 4)
- 46% (n=50) were directly recruited IRNs (30% Indian, 16% Filipino)
- Of the 50 IRNs, 33 were from India and 17 from the Philippines. Of these, 52% of Indian nurses and 22% of Filipino nurses had previously worked outside their own country.

**Table 2: Age of participants**

Willing to participate?	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	No answer	Total
Yes	1	19	27	20	8	4	2	1	2	84 78%
No	0	4	4	8	3	1	1	0	3	24 -22%
<b>Total</b>	<b>1</b>	<b>23</b>	<b>31</b>	<b>28</b>	<b>11</b>	<b>5</b>	<b>3</b>	<b>1</b>	<b>5</b>	<b>108</b> <b>-100%</b>

**Table 3: Gender of participants**

Willing to participate?	Female	Male	Total
Yes	73 (68%)	11 (10%)	84 (78%)
No	23 (21%)	1 (1%)	24 (22%)
<b>Total</b>	<b>96</b> <b>(89%)</b>	<b>12</b> <b>(11%)</b>	<b>108</b> <b>(100%)</b>

**Table 4: Worked in the trust before?**

Willing to participate?	Not worked in trust before	Yes, had worked in trust before	Yes, worked as student	No answer	Total
Yes	22 + 43 =65 (60%)	5 (5%)	10 (10%)	4 (3%)	84 (78%)
No	19 (18%)	1 (1%)	3 (2%)	1 (1%)	24 (22%)
<b>Total</b>	<b>84 (78%)</b>	<b>6 (6%)</b>	<b>13 (12%)</b>	<b>5 (4%)</b>	<b>108 (100%)</b>

Participants represented different specialities in the trust (Table 5).

**Table 5: Clinical area / Directorate**

Willing to participate?	Yes	No	Total
Surgery & anaesthetics	16	7	23 (21%)
Renal and cardiac	19	3	22 (20%)
Women & children	15	3	18 (16%)
Medical & emergency	10	2	12 (11%)
Cancer	6	4	10 (9%)
Theatres	6	3	9 (9%)
ITU	4	1	5 (5%)
Other	6	-	6 (6%)
No answer	3	-	3 (3%)
<b>Total</b>	<b>85</b>	<b>23</b>	<b>108 (100%)</b>

Participants were asked an open question in the questionnaire (Question 8): “What are your reasons for coming to work at this trust? Please give as much explanation as you can.” Responses have been separated into two groups – Table 6 details the responses from UK-trained and other internationally qualified nurses (not those directly recruited from India and the Philippines). Table 7 details the responses for those nurses directly recruited by the trust

from India and the Philippines (IRNs). This distinction was necessary because the data and therefore categories generated were quite different between these two groups.

**Table 6: Reasons for choosing to work in the trust? (Non-IRNs) (n=58)**

<b>Reason given</b>	<b>Number of nurses (not IRNs) and percentage</b>
To gain more experience, knowledge and skills	33 (58%)
Professional and career development	31 (54%)
Good reputation of the trust	20 (31%)
Education and training opportunities	19 (35%)
Enjoyed working here in the past (as student or member of staff)	15 (26%)
Good working relationships; friendly and supportive staff	12 (21%)
Good location / travel distance	9 (16%)
Multicultural trust	8 (14%)
Job security / opportunity	4 (7%)
Opportunity to work with leaders in their field/ highly qualified team	4 (7%)

NB: participants could give more than one response so 5 do not total 100%.

**Table 7: Reasons for choosing to work in the trust? (IRNs) (n=50)**

Reason given	Number of nurses (IRNs) and percentage
Better opportunities / bright future / earn good money	30 (59%)
Learn to use and work with advanced technology	20 (39%)
Experience a new / different culture	10 (20%)
To serve the sick people in the UK / London	6 (12%)
Safe environment at work / good conditions	5 (10%)
To be with my family	5 (10%)
To help my family	5 (10%)
New health care system / international standards	4 (8%)
Trust recommended by friends / family	4 (8%)
Equal opportunity for all	2 (4%)

NB: participants could give more than one response so 5 do not total 100%.

The 'better opportunities' identified in Table 3 included the opportunity to learn and develop professionally. This was a high expectation of internationally recruited nurses and proved to be one of the key areas for discontent identified at interview 2, as detailed below. The following sections of the report reflect interview findings, starting with those dealing with motivation.

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## **8. Intrinsic and other motivators**

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This section of the report concentrates on presenting the main findings from the individual participant interview data. Where relevant, data and key findings from the interviews with stakeholders and from the focus group with matrons are also presented. Because interview data were collected at two points in time (2-7 months and 14-18 months in post), they are presented cross-sectionally from each data set and also longitudinally where issues span both data time points. Also, key issues from interview 1 data are specifically compared with data from interview 2, noting changes and differences between the two.

The data are organised and presented around key issues and themes. One major theme is “Why I nurse: participant’s motivation to commence / remain in nursing”. As part of this, key issues of both intrinsic and extrinsic motivation are explored. Intrinsic motivators include: being able to undertake meaningful work; to progress and see improvements (including personal growth and the ability to improve nursing practice); health relationships (with managers, peers and wider team); and feeling valued. The latter section includes an exploration of the importance of feedback, the importance and outcomes of feeling valued, and more widely, an exploration of whether the nurses feel their contribution within the trust and wider society is valued. Extrinsic motivators are explored before threats to intrinsic motivators are examined. What makes a good working environment is presented, as well as aspects of the psychological contract and perceived breaches thereof. This leads into an exploration of participants’ reasons for leaving or considering leaving the trust. Finally, national and trust policies to support retention are discussed.

## **8. 1. Why I nurse: what is the motivation to commence / remain in nursing?**

The issues presented in this section emerged in the analysis of both sets of data and reflect some of the major themes to emerge from the data. These include issues of meaningful work – for example, how nursing and caring for people at their most vulnerable is rewarding and sustaining, as long as nurses have sufficient resources. Relationships at work were identified as vitally important, and relationships with managers and other nurse colleagues in particular resulted in satisfying and enjoyable places of work for some, and poor and demoralising work environments for others. Nurses in this trust valued the idea of improvement – both personal development and progress, and making changes in the work environment to make it a better place to work and better for patient care. Finally, most participants spoke of their need to feel valued in the work they do – valued by patients, colleagues and indeed the wider community. Also, the role nursing plays in the organisation was particularly highlighted in interview 2, when money-saving initiatives were seen to reflect the lack of value placed on nursing within the trust.

Examining the literature, notions of intrinsic and extrinsic work motivation appeared to fit well with the inductive issues and themes emerging from the data in this study. This section has been organised with these intrinsic and extrinsic motivators in mind. Examples of extrinsic motivators would be rewards, such as salary and promotion; 89% of managers believe that, in general, people work mainly for money, whereas employees suggest their primary motivation is not financial reward (Kaye and Jordan-Evans 2002) and this study’s findings support this latter interpretation. The sociological, psychological and organisational management literature suggests that work is very much intertwined with a person’s social identity (Terkel 1972). Work provides a source of meaning in people’s lives, and people work to contribute to society, to leave a legacy (ibid.).

## 8. 2. Intrinsic motivators

Research on intrinsic motivators suggests that these are related to meaningful work, to the opportunity for work to provide meaning in our lives. Work also provides opportunities to develop competence that leads to a subjective sense of knowing one is good at something. Work helps employees to have and develop choices through autonomy and control in the workplace, and to make progress and see improvements as a result of their efforts. Furthermore, the opportunity to have and develop healthy relationships in the workplace is a motivator. This includes feeling valued for your efforts by others, and in nursing the importance of teamwork and relationships with patients. When asked at interviews 1 and 2 about their 'best experiences' in the trust, all participants referred to aspects of their work that could best be described as intrinsic motivators, with some differences (explored below) between the two sets of interviews. It is important to highlight those aspects described as positive and participant's best experiences, as these give insights into factors that motivate staff. Many are mirrors of the worst or negative issues. Overall, these included:

- Knowing you had given good care
- Developing (long-term) relationships with patients
- Developing expertise and competence
- Learning new things through experience and training
- Making friends
- Working with good colleagues / a good team
- Giving and receiving support
- Helping make changes

Some aspects were consistent across interviews 1 and 2 (see Table 8) . These included:

- Good support
- Gaining through more responsibility
- Good teamwork
- Relationships or contact with patients.

Differences were noted between the responses of participants at interview 1 and those same participants at interview 2. The following were not cited at interview 2:

- Feeling valued
- Good staffing / skill mix
- Good leadership
- Professional development

It was noticeable that these reflect key aspects of dissatisfaction at interview 2, with staff largely not feeling valued, morale being identified as low, employees given less or limited opportunities for professional development and some aspects of teamwork giving cause for concern. The issue of being



treated with respect by the wider team was noted at first interview, particularly by IRNs. This group's members also upon initial exposure to the NHS were struck by the greater autonomy and voice nurses in the UK had.

**Table 8: 'Best' experiences at interviews 1 and 2**

Interview 1	Interview 2
Relationships with patients	Contact with patients
Experiencing good teamwork	Working in a great team
Treated with respect by wider team	
Feeling well supported	Receiving good support and feedback Passing on knowledge and supporting others
Given responsibility, being trusted to do more	Gaining confidence through more responsibility, being stretched and rising to the challenge
Learning and gaining professional development, training and education programmes	Gaining knowledge / experience / learning so much
Good leadership and ward well managed	
Being appreciated by patients / colleagues Feeling valued	
Good staffing / skill mix	
Nurses having more voice and autonomy in UK (IRNs)	
	Ability to give quality care
	Friendly hospital, friendly staff and made some good friends

Examples illustrating these include:

[JM: What would you say your best experiences have been over the past year?]  
Um, I think just having such a really good relationship with the team, because it's a multidisciplinary team and we all – they're all just really good people to work with, and we don't step on each other's toes. (ID088:interview2:p23)

[JM: What's been the best thing about your work over the last year and a bit?]  
Hmmm, I think experience, by probably, err, you've got really supportive staff in the ward (..) [M]y ward is really good, and everyone is really sociable and friendly and supportive, and for new staff this is really important. (ID079:interview2:p21)

I have had really good days. The team, the E grades, there is some fantastic nurses on it, which is great, seeing all the old kids again, you know there was a kid come in the other day for a closure of a colostomy that I was her nurse when she was diagnosed seven years ago (..) So she said it's my anniversary P (nurse's name), and like you know they remember stuff that you don't remember, "you taught me how to swallow tablets" and, you know, stuff like that. [T]hat's what I missed when I was away from ward nursing: I missed that. (ID021:interview1:p10)

The following sections examine the key intrinsic motivators identified in this study.

### 8. 3. Meaningful work

In this study, there was evidence at both interviews that primarily nurses were motivated by doing an important and valuable job, helping people and making a worthwhile contribution to society, and this gave staff job satisfaction:

In my case I have to feel that I am valued, I am doing something that is valued, and something that actually helps other people. (ID080:interview1:p12)

Nursing is a strange job. If you worked in an office, you could feel valued to your co-workers because they told you so. But your job might be, I don't know, filling in forms that [are] for some business somewhere, and in terms of your job you'd never feel valued because you know that you know it doesn't make a difference to other people's lives, whereas I think here you know directly you are influencing other people's lives. (ID084:interview1:p9)

It's more rewarding. Like, someone that's sat on a computer, they're working, I don't know, for some trading company, or banking, um, that sort of thing. I do feel like I'm giving a bit to the community, I guess [laughs]. Like, I mean in that sort of sense, but... (..) you can't go through life just taking and taking, you need to give back somehow. (ID019:interview2:p19).

Nurses also talked of feeling privileged to be involved with people's lives at difficult times:

We had this lovely man, he was so sweet and he'd met the mother of a daughter downstairs who, the daughter had leukaemia and he's the kind of guy who you knew hadn't had the best of luck in life and he'd just fallen in love with this woman, and they'd met like a couple of days at the coffee shop because obviously he was in hospital, and he died, which was a shame. So yes, you do have some sad tales. But yes, in a way that makes it quite special, the job, I think. (ID078:interview1:p7)

On a day-to-day basis, intrinsic motivation was manifested through making a difference to patients' health, and at the more micro level by supporting ill people, making them smile, and helping them to feel more comfortable:

If there is one thing that I really love, [it] is talking to the ones that are ill (..) It means a lot to me, as long as I do it to one person. Even if the person is not my patient, just to make them smile, it means a lot to me, because every day I have to ask myself what have I done, what I have done to help somebody (..) Even that little smile, for me to make a person smile it means a lot to me. (ID090:interview1:p8)

Getting positive feedback from them is what I nurse for really. You know, making someone happy during the day at work, or having someone say, you know, thanks for washing my hair, for example, thanks for giving me a shower, you know. That makes me feel valued (..) If I didn't feel that I was having an effect on my patients in a good way, then I wouldn't be doing nursing. (ID076:interview1:p21)

Giving good-quality care to patients was important to nurses, and affected their motivation and job satisfaction:

I want to give the best level of care and anything less, for me, will not do, you know, and that's what keeps me ticking over, I think. Because I know that I'm there; I'm

motivated; I'm interested and I want to do a good job, and I want what's best for my patients. You know, and I'll give my best on that shift (..) I want to be able to come to work and do my best. And you know, if I got to that stage where I weren't interested, and I were just working for the money, then I'd think, well, why the hell am I in this career when it's not really what I want to do? And I think that that's probably the time that I would hang up my uniform. (ID083:interview2:p25)

We have a patient here that has been admitted here for almost a year. So we have nursed that patient and we can be able to transfer her out of here to a nursing home without any bedsores, she's an MS (multiple sclerosis) patient, so I must, I am very proud of that, and we've got a patient here (..) He's got a decubitus ulcer, before, you can put your hands inside of his buttocks, and now it's closed (..) Basically that reflects the nursing care here.

[JM: And you feel proud to be part of that?]

Yes, I do. (ID030:interview1:p6)

**Gaining feedback and appreciation from patients was evidence of this and made staff feel valued:**

We are very close to the patient and the patient's talking to us, and we are talking to the patient, and when they are satisfied when they go home, you know, it's, err, it's really, um, very good (..) Also, a hundred times they said, "oh, you look after me so much. Oh, thank you." So, you know, it's all appreciation. (ID095:interview2:p24)

When someone says thank you or someone appreciates in a genuine way, you can just tell that this person is appreciating you in a genuine way, especially the elderly, the ones who are not able to do anything. When you give him that good wash, when you sit down with them, just to chat or to feed them, it means a lot to them. Even if you just hold the patient's hand and sit down there for only two minutes, it means a lot to them. (ID090:interview2:p13)

**Others talked of challenging and demanding patients, and how difficult circumstances made it especially important to gain job satisfaction from a sense of making a difference:**

Some of the patients are really grateful, some of them they just treat you as a slave – this is your job (..) Some they just go home and say, "Why am I here?" People just don't care (..) They think that I'm a slave rather than just here to help them (..) You think, why do I want to go to work any more, if it's not just worth it? You think about money, it's not good money (..) So, I think job satisfaction is really important for everyone working in the NHS (..) I think for me, at the moment, it's probably when you see patients come in, they do surgery, and then they [go] home and recover. I think that's the best thing (..) they're getting better and I've done some difference. (ID079:interview2:p35).

**Making a difference was not always therefore evident on a day-to-day basis, and nurses said it was helpful to see patients after discharge to help them and the team appreciate what had been achieved:**

Sometime down the track, maybe it's when the parent brings the child back two months later and you think, oh thank God she's grown, or you know, God she was sick for so long, thank God she got home (..) It (job satisfaction) might not be there on the day that they leave because you are absolutely exhausted, but somewhere down the track it comes back (..) I don't think I'd be there if it didn't. (ID087:interview1:p22)

**Thus nurses in this study highlighted again and again that they were motivated by and received job satisfaction through giving good patient care.**

## **8. 4. Progress / see improvements**

Progressing and seeing improvements has been identified as an intrinsic motivator (Thomas 2000) and the data in this study supports this identification. All study participants were keen to see progress and improvements in two ways; either in their own practice, in terms of developing more experience and expertise, or through progress and improvements more generally in the ward structure or environment in order to facilitate safer and better patient care. Some staff desired both kinds of improvements.

### **8. 4. 1. Personal progress and growth, supported in learning and development**

Nurses identified this as an important aspect of their work and as an important motivator. Being supported in learning and career development was also an aspect of feeling valued (see later section) noted at both interviews:

Most of them will take their time to go through it at some point when they can (..) there's a couple of excellent E grades who are good at taking you and saying, look, we've got IV's, let's go and do them and let's do this (..) so that's good, good learning and good for me. That makes me feel like they're taking on board what I need to be doing for my development. So that's good. (ID 077:interview1)

I think every day we are developing (...) I think I have done, most of the study days are good, in diabetes, in pain, in, um [inaudible]. Yeah, most of the things, yeah. (..) Some people have been very encouraging, yeah. (...) My manager or my sister, my team leader, she was very good. She always encouraged us to go, and on most of the study day I have attended (..) Yeah, but I have done my cannulation course, I have done my IV courses. (ID059:IRN-India:interview 2:p24)

The majority of interviewees at interview 1 were satisfied with their progress and the way their skills were being developed, or were at least willing to have a wait-and-see attitude, feeling it may be too early to judge these aspects of their experience as they had not been in post that long. Some participants, particularly those in specialised areas or with specialist skills (e.g. venepuncture), did not feel they had adequate support either to gain the skills they needed for working in their area or support to utilise the skills they had. For example, two nurses working in a cardio thoracic unit and a cardiac unit felt they did not know enough about the speciality and wanted more educational input and training more quickly. Expectations were high for some nurses, and after three months in post, frustrations were beginning to set in:

When I had my interview, I was told I would have a chance to go on study days and bits and pieces, even the first week when I got there, they say book you on some of the study days and never happened yet. (..) I used to do phlebotomies and cannulations, but I end up have to wait because I don't have a trust certificate. (ID079:interview1:p5)

Many IRNs came to the UK with experience in cannulation and venepuncture and were keen to continue to use these skills as they feared losing them.

Others were concerned that they had insufficient training to care for patients on their ward, e.g. patients with a tracheotomy (095), and would have liked more on-the-job training more quickly.

However, by interview 2 many staff were feeling unhappy at their level of personal development. Budget cuts in 2006 across the NHS meant savings of £4.6 million from the nursing budget in the case study trust. This meant that the budget for education and staff development study days had been reduced, and many were unhappy that they had not been on study days and had no sense of a personal development plan or of skills being developed.

I want to gain the best knowledge that I can so that I can input that to my patients, and for me to understand myself, as well as being able to pass on to other members of staff, you know, that's the way that I see that you should learn for those very reasons.

[JM: And what's the barrier to you doing the courses, would you say?]

Well, there's no money. There's people queuing up to get on courses (...) they're saying – well, staff that's been here, you know, years should go on the courses first, basically. (ID083:interview2:p7)

For this nurse and others, this was de-motivating:

I think that if you are on a ward or in an area where, you know, you want to do more and you want to progress and you're being held back, then I think that that just demotivates people. (ID083:interview 2:p66)

For nurses recruited from India, gaining more experience, training and development was a primary driver. Although they felt they were getting a lot out of the experience, most of the five nurses from India did not feel they were receiving much career development or planning:

No development, yeah. (...) If the people, those who have means and were, like, asking what you have done and what you would like to do, or something like that. And sending those people, those who are interested, to do something, there will be a development. But there is no one is asking. But just going down and doing whatever we have to do in a ward really, and that's it.

[JM: And how does that feel?]

It is too shameful.

[JM: Oh, does it?]

[Laughs]. Yeah, because unless we do something which, err, we can do, then only there will be any improvement, isn't it? (...) Or we will stay where we are. (...) Within this one year, after the PIN (personal identification number given to nurses in the UK as a unique identifier once qualified / accepted onto the Nursing and Midwifery Council register) number, as I told you, I haven't done anything. (ID094:interview2:p24)

When I started, I told you it was all right, you know, like, um, the staff, they were more supportive to us. But, later on, nowadays, I think the, you know, the study days (...) I have passed nearly one and a half years there, and I had completed literally two study days. (...) The support, like updating me and all, is getting a bit slow, low, according to me, you know. And even some other people are saying, like, we are not getting the things to go for study days, and all the things. I think they have to give us more chances in studies like, you know, in venepuncture, all them things. (...) We are not getting anything like that. (ID097:interview2:p2)

This was a common complaint at interview 2, particularly amongst the internationally recruited nurses. Because of the high expectations around being developed in the UK NHS, this can be seen as a psychological contract breach, which is discussed in more detail below.

Thus being supported in and by the trust in their learning and development through staff training and education was important. Other ways in which staff felt they could measure their own personal progress and growth was through being supported with their personal development through personal development plans (PDPs) and the appraisal system.

#### **8. 4. 2. Personal progress and growth: Appraisal / personal development plans**

The trust was committed to ensuring staff had appraisals at least annually and encouraged all staff to have personal development plans (PDPs) in place as part of the AFC package. Indeed, many stakeholders interviewed believed appraisals were very important in terms of retention and development of staff, but required good leadership. A nurse stakeholder at executive level, in response to the question 'What would you see as being good for retention then for staff, good staff?' suggested:

Simple performance appraisal, simple personal development planning, development focused on their career aspirations and what the service needs. It's about, it's like everything, it's comes down to if they are properly led then they will be effective and happy in their job and they'll stay. So it's down to leadership, it's having the right leaders in place. Nothing else is going to do it. (Stakeholder 05:July06:p3).

However, at the time of data collection the realisation of these goals was, in this sample of participants at least, not fully realised. The implementation was very patchy, with some staff receiving regular appraisals and having had PDPs, as well as knowing they were entitled to these, while others were largely unaware, having received neither. Others were aware they should be having them, and had indeed been promised them, but these had not been forthcoming, leaving staff disappointed and feeling no-one was interested in their career plans or development within the trust. The following tables indicate those at interview 2 who had and had not received appraisals and PDPs:

**Table 9: Appraisals and PDPs undertaken by those in post at interview 2 (n=23)**

Undertaken?	Appraisal	(ID nos)	PDP	(ID nos)
Yes	(n=8)	(011); (019); (076); (077); (080); (086); (088); (097)	(n=6)	(019); (030); (079); (080); (083); (097)
No	(n=7)	(007); (059); (078); (083); (084); (090); (094)	(n=11)	(007); (011); (021); (059); (072); (077); (078); (086); (094); (095); (097)
About to have	(n=4)	(030); (072); (079); (095)	(n=2)	(076); (086)
Not asked	(n=4)	(010); (013); (021); (073)	(n=4)	(010); (013); (021); (073)
Total	(n=23)		(n=23)	

Nurse 076, an international nurse from New Zealand, had been in post 16 months and had not received an appraisal or personal development plan; she only got one when it became clear she was thinking of leaving. When I asked her if she felt valued, the story unfolded:

Overall, I think so. Well, like, for example, when I was going to leave and the Matron called me in and said, "What would it take to make me stay?" That made me valued. It was just unfortunate that it didn't happen earlier [laughs]. Yeah, that's one of the reasons that made me stay... (..) He knew I was applying for the job, and he called me in, and he said that he thinks I'd get it and what was going to make me – take me to ... you know, make me stay. (...) But he, um, he was very good in writing out a plan of the options that I could have, you know, dependent on things like funding. But 'cause I felt I was in a point I didn't know what on earth was ahead of me, what I should be doing to get ahead. Um, so he helped me write it out with the various options and things that I could do. (ID 076:interview2:p37)

This intervention by the manager did retain this nurse, as it helped her feel more motivated and valued and set out her options within the trust and for her personal development. As a result, she got onto a six-month course and is now happy to stay in the trust. Others also felt motivated by good appraisals and PDPs that set goals to achieve and also marked their progress in other areas:

You have to actually go through all the paperwork with your mentor and then they're going to approve, "Okay, he's confident to do this; he's confident to do that, or probably he's not confident to do that and he needs improvement(..) If you are not confident and your mentor feels that you need the improvement, then you set up, like, a strategy with your mentor: okay, I need to improve in these areas, and then finally when you are confident enough and your mentor knows about that, then she tick it off (..) The first time it was, like, a couple of things that I needed to improve, and then the second time is dealing with some things I feel pretty comfortable to do, but some things that I need to improve, which means that I talk to her and then, you know, she gives me like planned strategies to ... it is very useful because (..) they highlight the

things that actually are important for you to know, in order to work in [X].  
(ID080:interview2:p5)

Crucially, appraisals gave participants feedback on their performance:

I am getting feedback regularly. I think every three months we are having an interview with the manager, so the last December, December I had the meeting and she told me about all the things, like what is happening (..) She told me of how I am doing my things, teamwork is good, my, I would like to learn more, I am asking all these things, and I have to read more, that is the things she told me: if I want to learn more I have to read more. (ID 097 IRN – India:interview1:p15)

Feedback was identified as an important aspect of feeling valued (see below), so that whilst appraisals weren't the only vehicle for giving feedback, they were an important opportunity to do so formally.

Many, however, were not so lucky and did not receive feedback either formally or informally. Many had not received appraisals and had no idea how they were doing:

I've not had a full appraisal in all the time in how long I've been there. Nearly 15 months and I've not had a proper appraisal. Um, and that's something that they're trying to get on top of now, but it's not come round yet, so – and I've not got a date for one, and some of the other members of staff haven't either.

[JM: And does that bother you?]

Yeah, it does. Yeah, because I think that it's an important factor, you know, you need to know where you're going and what you're doing, and you need some general feedback on things like that. And you need to be able to input as well. So, I feel like that is an important thing, yeah. (ID083:interview2:p20-21).

The lack of appraisal and at times feedback left staff guessing at how they were getting on, and concluding that as no-one had said anything they must be doing OK:

I'm supposed to have an evaluation or whatever after, and I'd have thought after six months would be ideal, and I didn't have anything after six months. And I did kind of mention it and I was given some pieces of paper, something about some K scores, or something, I don't know, which I was expected to fill in, and then bring to my appraisal, which I'm still waiting for. So, it's been, yeah, been over a year now and I haven't had any kind of formal review of how I've been getting on. (..) I mean, you know, I must be getting on all right if no one's had to say, "L, you're doing this wrong" you know, but I don't know if that's right. And it's probably not. (ID084:interview2:p7-8).

In a busy acute service which is stretched, appraisals and PDPs can be a casualty.

I was supposed to actually get a six-month appraisal done; that never got done [laughs], unfortunately. I don't know whether it was just lack of staff, 'cause a lot of people were leaving, everyone was stressed and we'd been busy, I don't know, but I didn't get my six-month appraisal done. My six-month appraisal got done at July, which is almost a year. Um, and I really had to push N to get it done. I kept saying, "When are we doing it? When are we doing it?" and we made about three appointments and they never got done and I said, "Fine". I said "N, I'm coming in on a day off." I said, "We're not going to get it done otherwise."  
(ID086:interview2:p24)



The way the PDPs and appraisals had developed (as part of AFC) was critiqued by some nurses and stakeholders, who suggested the paperwork involved was too complicated and onerous, particularly in a busy acute service:

I think (..) we had to put it in too quickly and people are not trained to use it and the AFC framework's complicated, the assessment process, appraisals, documentations [are] complicated. Who's got time to sit and go through each KSF? I have a real worry about it and if I'm saying that, somebody who believes in, seriously puts two hours into somebody's appraisal and I'm still fazed by it, what are they going to think out there? You know I am a serious believer in performance appraisal but I look at the KSF documentation and I'd rather spend the two hours going through their objectives than talking about, rather than ... it's very difficult, we've got to sort it out. (Stakeholder interview05:July06:p3).

Although some participants were unaware they were due a regular appraisal, others were keen to have theirs and if they had not received one were aware of the omission and wanted one soon, particularly if it were to trigger a move onto the next gateway under AFC, which could mean a pay rise. One participant had created her own development plan for herself without an appraisal:

[JM: I mean, how do you feel about not having an appraisal? Does it feel important to you, not important?]  
Um, it felt important so that I could get my pay rise, but now I've had my increment without the appraisal, I don't really mind, to be honest. Um, in my head I know what I've achieved, and I know what I want to achieve. I've got my plan that I want to happen and I do it in my own way. I don't think sitting down with a matron and just going over the formalities is going to help me in any way. I know how I work; I know what I need to improve on. Um, I did mention it and they're meant to be sorting it out, but that was a few months ago now, so...  
(ID078:interview2:p16)

While ID078 notes she had received an increment in her pay without the appraisal, others did not have the same experience:

I had an appraisal in February, I think it was. And that was quite good, but apparently it wasn't a gateway [laughs].  
[JM: And did you expect it to be?]  
Yeah, well, I thought the first one was supposed to be a gateway. Yeah, but anyway, apparently not. (..) You have two gateways, and supposedly in the first year that you're here, you're supposed to go through the first gateway. So, I've been here over a year and I've had an appraisal and it wasn't a gateway, so it was like, hmmm?  
[JM: And how was that explained to you then?]  
Well, it was just – she said it wasn't a gateway [laughs]. Oh, I'm all confused. And I didn't really – I'm not that fresh up, I'm not the best on Agenda for Change, so I just said, "Okay, so does that mean we're having an appraisal in four months' time?" [laughs].  
[JM: And you haven't?]  
No. (ID088:interview2:p20)

There was much confusion surrounding the gateways and the triggers for going through a gateway at the time of interviews in late 2006. This may now have changed and staff may be more aware of the process required.

This section has examined two different aspects of participants' personal progress and growth in the trust, which is an important intrinsic motivator for nurses. Some staff were supported in their learning and development within the trust and were given time off to study and were supported by staff in learning on the job, whilst others were not. By interview 2, many were feeling that opportunities to go on courses and study days were more limited than when they started, and for many this was disappointing and a potential breach of their psychological contract with the trust. In terms of formal mechanisms for monitoring staff development and giving feedback to staff, again the picture was patchy, with only approximately a third of participants receiving appraisals and/or personal development plans.

Another intrinsic motivator in terms of progress and improvements identified in the study by some participants was the desire and ability to improve practice more generally in the ward structure or environment.

### **8. 4. 3. Improving practice**

Nurses in this study wanted to see improvements in the ward structure or environment to facilitate safer and better patient care. Being new to an area allows people to see practice with fresh eyes and through a new lens. Thus many interviewees had ideas of how they would like to improve the way things were undertaken in the work environment, and of how to improve staff approaches to work and care.

I think it took an outsider, with a fresh pair of eyes to say, "Look at what's going on here." (..) You know, some of them have worked here for ten years... (ID073:interview2:p4)

Some staff identified aspects of the work environment that they liked, such as team nursing (086), 12-hour shifts (086), continuity of care (086), the way the ward is managed (079) and support for staff (076) (079). Other new staff identified issues that they felt needed attention. These areas included:

- Lack of equipment and time wasted by staff looking for and getting equipment (030) (013)
- Paperwork not completed properly – 'slack paperwork' (ID019)
- Lack of cleanliness (072) (076) and poor hygiene practices (083) and infection control / isolation procedures (086) (097)
- Poor privacy for patients and noise at night (086) (090)
- Inadequate staffing to provide good patient care (095)

When asked at interview 1 what they would do differently if the ward sister left or if they were in charge for a while, most came up with ideas and innovations to improve life for staff and patients. These included: reorganising nurses' shifts and doctors' ward rounds to ease bottlenecks in the day; taking on more staff; streamlining to reduce paperwork; changing certain policies (e.g. isolation policy); organising and labelling supplies better and improving cleanliness and tidiness on the ward with a reduction in furniture and bed congestion. More staff-focused ideas included more preceptorship and

support; a culture of more respect between staff; ending staff rotation; (re)introducing opportunities for communication such as ward meetings or social events; and increasing and improving teaching sessions on the ward. Where this last change was possible, it was a motivating force and important to the individual and helped improve the practice environment:

If we have the tracheotomy patient, the staff from this ward should all attend the teaching session of that course; then they can attend the patient when the same thing (...). They should have the teaching session and should know how to do the things and staff should be allocated according to that. Staffing – I'd like to get more staff to give patients good care. Then there may be some changes with the rounds, with the doctors and with the nurses. Here, eight o'clock, if you say it's a terrible time, eight o'clock. Night nurses want to hand over, day nurses want to take handover, doctors want to go for the round and theatre people will be coming at eight o'clock exactly to take the patient down. There is something to be done in that way... (ID095:interview1:p13)

We're starting to have ward meetings again, because which the D grades have their away day and the E grades have their away day and obviously we have management meetings, and I thought they'd slipped away from doing the ward meetings which I think defeats the object, so they've all started up again. And we've started some support groups, which will be better. (ID021:interview1:p6)

Few, however, felt able to undertake these changes or felt that they had sufficient backing and support to try their ideas. Indeed, one participant who left the trust as a result of poor support said not being able to change things was most frustrating:

[JM: And your worst experiences?]

Um, just feeling stressed and as if you can't change things and carrying people, yeah.

[JM: Why did you feel you couldn't change things?]

Um, the senior management.

[JM: Were what?]

Stuck in their ways. Didn't want to change it.

[JM: Right. Did they actively block change, or was it a passive kind of resistance?]

Um, probably more passive than, No, you can't do that, but you just knew. You can't put your finger on it, but you know. Like I know certain things won't change and won't change, and there's just no point. It's... (..) And, like, you would try and change a few things or suggest a few things, but, no, that's the way it's done and that's the way it will be done. (ID010:interview 2:p20).

There was a culture of stagnation in many areas rather than a dynamic of change. One of the G grades in the study felt supported in making changes by her peers but not by her matron:

My peers were, my peer, peers were fantastic. And said, you know, "God, you're so right." "This needs to change." Um, our matron at the time thought we were just – particularly me, was just being obstructive and unhelpful. (..) Um, and just making waves. Well, me and making waves. And God, always complaining about something. Because I was upsetting the status quo (..) Of course, a lot of the staff weren't used to people saying, What are you doing? (ID073:interview 2:p6)

Complacency does set in and people just do let things run as they let them run really. (..) I mean, I have been to her (ward sister) with, with a couple of ideas, you know, that one that I stated and a couple more. I mean one of them she said, oh well you know that was suggested before and we don't think it'll work and blah blah de blah. And I thought, well, I'm trying to sort of improve standard here, which is a little bit

frustrating. (..) I mean I know that money, trust money is an issue; you know that's something that we all have to be aware of. But I don't think that what I was asking for was going to cost the world.

[JM: And what was that example?]

It was, you know, the sharps bins that you have, just little hangers on the wall, just to clip into room or every bay, to save you know, you going out, which you shouldn't do anyway, I mean obviously we are able to take them round on the trolley, but obviously I think it's something that should be in every area, for you to, just for you to be able to dispose of freely. Yes, that was a suggestion I made and nothing's happened (..) I think of just little things, but I think they would make a difference.

(ID083:interview1;p8)

In other areas there was more direct resistance, which was very de-motivating and demoralising for the staff involved. Indeed one nurse left after nine months in post because she felt unsupported and wasn't able to change poor work systems and her manager's attitude:

So... yeah, it's frustrating but I think I've just ... sometimes you've just got to expect that things aren't going to change, and no matter what I do it's not going to change so I've just got to get out and keep my sanity. (ID007:interview2;p5).

At interview 2, participants were asked what they felt the director of nursing needed to know about in the trust, so that perhaps change could be initiated to address these concerns. A number of key issues and areas emerged, which I would argue are all linked to nurses' intrinsic motivation and morale. Some participants felt staff safety was an important issue that needed the attention of the DNS (073); others felt that infection control, hygiene and barrier nursing required attention (073) 9078) (097). Some nurses wanted more support for staff from management and through career development (030) (007) (077) (076) (086) (094) (095).

Nurses have got this culture that they just get on with it, that they just do the job and whatever they say isn't going to make any difference anyway, 'cause although our ward manager co-ordinates us, in the scheme of things they don't actually have a lot of power themselves. So, even if we tell them anything, the likelihood of something coming of it is not going to matter anyway. So, I think mainly a lot of nurses just probably feel that it's not important, like it's not going to work anyway or it's not going to get changed. (ID78:interview2;p24)

It'd be good for them to know about why people are happy in their jobs and why people are unhappy in their jobs. Um, I think the whole thing with changing the, sort of, skill mix is going to make nurses feel less valued, you know. Um, and probably make them feel overworked as well if they're in an environment with lots of healthcare assistants (HCAs) who aren't able to do things like, you know, IVs and so forth. Um [pause] I don't know. It'd be nice if they came and worked on, you know, the ward every so often, you know, just did a little tour of the wards and saw what they're like and saw what conditions are really like for people. (ID084:interview2;p21)

One thing I would have said was cleanliness. Because the hospital, presently, is in a disgusting state [laughs]. And when you see rubber gloves lying on the footpath outside, it's horrible. Um, but, having said that today, I went out near P W and there were no rubbish bins lying around, which is a first, and there was nothing down the hallway and it was actually clean, which I was very surprised about. (..) I think probably being aware of what nurses are worried about at the moment to do with, you know, like with, um, the change in HCAs and registered nurses. Um, burn-out and stress, 'cause it's still a huge thing, especially in nurses. And, this – well, there's funding issues now as well, um, and things like the Renal Course might be a thing of

the past, 'cause they can't get funding. Yeah, and so the nurses are going to leave and go elsewhere. (ID076:interview2:p20)

I think it all depends on how long ago senior managers actually been hands-on in the ward, 'cause it's quite a big difference from even five years or ten years time for patients' care, and the tasks the nurses have to do. I think the director of nursing should just – probably just get her hand or his hand dirty for some time, just to try it, and work with the staff in the ward for some time, so they know the real, on the front line, how do they feel like, rather than just have the office, doing the planning, all the grand plan (..) I think that's the main idea is they have to know what exactly [is] happening (..) I think, err, if they know what's going to happen in the clinical levels, at least they know when they do their planning, run this, sit down at their desk and say, we'll cut down the budget there, to cut down the staff (..) But I think if they really do know what's actually happened in the clinical area, they will change their mind. (ID079:interview2:p30)

I think she needs to be aware on how much of, um, a good job that nurses do and should value that. (..) Um, as regards to, sort of, spending I know that obviously she'll be on a tight budget and is going to be totally aware of, sort of, what's going on and the environment, and everything, and just to keep a, I don't know, a level head, I would say and, um, to be fair. Just to be totally fair and totally honest. (..) And not just nurses, but everybody, um, you know, and to recognise how they're feeling at this time regarding job situations, and money, and spending, and patient care. And to try and, sort of, keep a level of motivation going, and, you know, rapport as well with staff and people that are part of different teams. (ID83:interview2:p8)

#### **8. 4. 4. Conclusions**

Morale was identified as being low at the time of interview 2, October 2006-January 2007 (013) and staff felt that they were not being heard (078) (083). Participants wanted the DNS to be aware of the issues facing staff (019) (021) (076) (084), to involve staff more (078) and keep staff informed and up to date.

Some interviewees also wanted the director of nursing services to increase visibility (073) (084). Others asked for management to communicate more directly with staff (0770 (078), to work 'on the front line' (079) (084), to show more honesty with staff and appreciation of their work, and to value staff more (073) (080) (083) (084).

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## **9. Healthy relationships**

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Good relationships in the workplace are always important, and Thomas (2000) cites healthy relationships as an intrinsic motivator. Robinson and colleagues (2004) suggest that feeling valued, an aspect of and indicator of intrinsic motivation, is linked to positive relationships with immediate managers (this topic is presented in a separate section below). In this study, nurses raised as important issues those relating to management support, transparency, good communication and relationships, both within the wider team and, in particular, in the nursing team.

## 9. 1. Relationships with managers

One of the most consistent findings to emerge is that participants were clear that they wanted strong leadership, to be treated fairly and with respect. Yet equally important, they said, they want to know where they are with their managers, what they should be doing, and to have honest and open communication, a level of transparency and support. Certainly by interview 2 there was evidence that people wanted to be performance-managed. One of the ward sisters (ID 173) in the study felt very strongly about this, and said that many people were allowed not to be accountable for their actions, which allowed poor practice and negative attitudes to work to flourish. She gave an example of confronting a band 6 member of staff who had refused to administer a regime of treatment to a sick patient near the end of shift, and another member of staff who had not adequately documented work, challenging both to consider if they wanted to work on the ward again. However, it appeared that this management style created a culture where staff knew where they stood and what was expected of them that increased their willingness to stay:

You hear people say, "Oh, I want to stay here and I don't want to move." (..) The patients and the staff who go, "Oh, I didn't really want to come, but now I'm here I really don't want to go."

[JM: So, what's your turnover like here?]

I haven't got any. I haven't got anybody who's left. I've got no sickness problems. I've got no capability issues at the moment. I've got, touch wood, no HR problems at all. In comparison to what was there when I first started. (..) And I think it's because if you never are challenged... (..) But I came from an environment where someone would go, "What did you do that for?", "Why are you doing that?" You know, and there's no, "Now, let's have a nice chat about it." It was, "You've done that, don't do it again." (..) I've got all the respect in the world for people who don't learn as fast as other people. But I, you know, I'll only give you that respect if you say, "I don't really know."  
(ID073:interview 2:p71-2)

Another participant was very clear as to what 'made' a good manager, and felt they need to be authoritative, 'know their stuff' and be willing to do anything they asked of staff. This gave them leadership qualities:

Um, so a good working environment, I think it comes down to respect, and respect of your manager, (..) if you've got respect for your manager then you want to do well, everyone wants to do well, and people all seem to work well together, 'cause they're all working towards the same thing (..)

[JM: So what makes a good manager?]

[Laughs]. I think they need to be authoritative; they kind of need to have a certain scare factor, you know, but still be able to identify other people they work with, you know, empathy (..) they have to have knowledge of what they're doing, because I've noticed, um, some managers don't know what they're doing and it's quite embarrassing for them when you ask them a simple question and they can't answer it (..) I think that's probably it. And willing to do the work, you know, they're willing to do anything they ask of the people that work underneath them. (ID076:interview2:p7).

Others felt that for the relationship to work well, staff themselves need to take some responsibility and need to be open and honest with managers, and tell managers what the problem is to their faces rather than complain behind their backs:

I think you've got to come to work with a positive attitude and, um, I think whatever the manager says, if you have a problem with it, then tell them. But if not, then, you know, you've just got to be willing to do what they say, because they're the manager and they co-ordinate and you need to be willing to take orders, I think. Um, and I think, um, I think, yeah, and you need to have the right attitude as well, which is the same sort of thing, isn't it? Um, I think you need to be honest with the manager, which I'm probably not always. Um, I think a lot of nurses complain behind closed doors and don't actually sit down properly with a manager and actually have an adult conversation about what the problems are. Um, I think usually it's just a load of moaning and nothing gets changed, nothing gets, um, developed by just, sort of, having a moan behind closed doors. (ID078:interview2:p24).

These were positive examples of work environments where good relationships with managers could flourish, and where a culture of strong performance management was or could be enjoyed. There were, however, examples of cultures where relationships with managers were not flourishing. In these cases there was a perception of no performance management and perceived unfair practices that were allowed to continue unchecked. Several participants gave examples of staff who were not perceived to be fulfilling their job descriptions, who had verbal warnings yet were not sacked. Interviewees felt these employees would be dealt with differently in the private sector, but instead they were continually accommodated or moved, yet continued to under-perform and retained their salary scale. The only explanation interviewees could provide as a way of understanding this behaviour by managers and the trust was a fear of litigation. The perceived lack of performance management of these staff, however, impacted on those working with them, the participants in this study, and added to their stress and their sense of injustice:

Our senior sisters will come and say, you know, "This person's left and we know that they weren't capable." So they've had to do their notice and they go in on this day, and all of a sudden that person hasn't gone and they're still around. And they, kind of, think, well, if we've put them somewhere where you think you can't see them, then they don't really exist and we don't really have to do anything about it. So, it's been, it's been a really trying year (..) we went to our boss and said, "This is not working. This is what's happening, and we need some help, so this needs to be managed." And it was ignored, and it got to the point where all of us just said, "This is unfixable."(ID073:interview2:p13)

[JM: How do you think that affects people and...?]

Um, I think they get annoyed, 'cause they can see that they're doing someone else's work as well as their own, and carrying them, and this person's getting away with it. And I think it annoys them and frustrates them. And then they don't want to work with that particular person.

(..) But to see them not change and to still being carried, it's just like why, why do they have that kind of culture?

[JM: So, these were some of the stresses?]

Yeah, and then you feel like you're – I felt like I was responsible for everybody, which maybe was part of my wrongdoing, but you kind of are, because everyone will come to you in the role that you've got and put that pressure back on you. But it's when you can see people aren't good enough to do their job and yet you're kind of flagging that to your higher, and then nothing really happens. You think, well, is anything going to happen? So, yeah. I was, err, you know, you can feel yourself getting quite stressed. (ID010:interview2:p7-8)

This was seen as deeply divisive and likely to contribute to poor retention of good staff. Indeed, two participants (ID007 and ID010) left their posts as a

result of perceived unfair practices and poor management. The reasons ID010 gave for leaving were:

- Poor remuneration for the job (was promoted but denied usual increment)
- Stress from 'carrying' staff unable to do their jobs
- Feelings of being unsupported, not valued, not listened to and powerless to effect change

The reasons ID007 gave included:

- Being poorly managed (or not 'managed' at all)
- De-motivating work (failing research study that was discontinued as she left, but not earlier at her request / suggestion)
- Not valued or listened to
- Frustrations of not being able to effect change

Other staff identified different perceived unfair practices that were de-motivating and at times had caused them to consider leaving. These included unjust allocation of resources; for example, working in a speciality that brings in a lot of money for the trust yet not having enough money to buy equipment. Another reason discussed above was the stress from carrying staff who were not able to undertake their jobs. Relating to this, other nurses mentioned persistently uneven workloads between staff and perceived unfairness in the system that provides for staff going on staff development courses:

The same people are getting the sick patients over and over again. Um, and I don't think it's fair. There's a lot of unfair things that are happening. (ID086:interview2:p43)

This section has examined relationships with managers as one aspect of the healthy relationships important to nursing staff in this study. Two interviewees left during the study primarily because of perceived unfair practices condoned or supported by managers and the quality of support they experienced from their line managers. These problems included not feeling valued or listened to and not being able to effect change. Relationships with peers in the nursing team were also considered to be an important motivator and an important aspect of a good working environment.

## **9. 2. Relationships with peers – the nursing team**

What makes a football team play well? I don't know. You can buy the best players in the world, but unless you get them to you know work well together, I think that's quite intangible. (ID084:interview1:p15)

The 'team', specifically the nursing team, was identified consistently by participants in this study as the key to a good working environment or as extremely important:

The work that we are doing is like a chain; it's like everybody here is dependent on each other. So if one part is missing, then the whole wouldn't be done. So, yes, it's very important. (ID080:interview1:p15).



I think it's the people; it's certainly not the money. (ID087:interview1:p3)

I think teamwork's one of the most important things when you're working in a ward environment, because if you feel excluded, then forget it, you might as well move to a different hospital or a different ward. I feel like there is a lot of teamwork on my ward, but I feel that it could be improved upon a little. (ID083:interview2:p11)

Participants identified key aspects of the team and team members required for harmony and to create a good working environment. These included the team creating a sense of belonging and inclusion, and team members being:

- Flexible
- Sensitive to the needs of patients and colleagues
- Willing to share knowledge
- Willing to give constructive criticism, being a good speaker and listener
- Co-operative
- Willing to work together and help each other
- Willing to do a fair share of the work

Being willing to work together and doing a fair share of work were two of the most consistently identified issues, and were identified by all of the nurses recruited from India. Where this was felt to be the case, staff were motivated to work and to come to work:

The team is crucial, yeah. I think you need to create a good team, and you need to be honest, and if you were the senior one, you'd need to be open to change and open to suggestion. (ID010:interview2:p26)

We're helping each other in everything, in doing our nursing independently, in doing our work. If you need a hand they will be, err, it's simultaneous. If you need – you don't need to ask for any – they will be there voluntarily to offer you the help. (ID030:interview2:p15).

Where this was not the case, it made for a very difficult working environment and created a sense of unfairness, or for others, sadness:

Last night I was with a big man, a 39-kilo patient. And he was very restless and, you know, in the morning, it was very difficult to get a person to help me to give him care. And that time I was really sad and, you know, sick also, and now this time, and back pain, and his legs also and he's falling out of the bed, coming out of the bed, to lift him, then, you know. Lots of things to do: at the time it made me feel a bit sad. (ID097:interview2:p30)

Basically a good working environment is people that are willing to help other people. Um, there are certain staff on the unit that are very lazy, um, and I'll say that very – I will say that to anybody on the unit because I think it's true and people know it's true. [JM: Qualified staff?]

Yeah. Yeah, very lazy. They will sit on their bums and just delegate other things to other people, you know, and to us and to help, "Oh, I'm busy", but they're not really, you know what I mean. Um, so people willing to help each other out when they're stressed. People willing to say, "Are you okay? Do you want to talk about it? Do you want to, you know, debrief on what's going on?", um, and people that aren't afraid to ask questions, you know. Some people, I've discovered, you can't approach them. (ID086:interview2:p27)

Going out socially was also important and was seen to provide the opportunity to debrief, unwind and team-build, particularly after a difficult shift:

You can have, I'm sure you can everywhere, have really horrendous shifts and then sort of walk away and sort of forget about it to an extent. And I think it does people good to have the feedback, to be able to say, look, you know we actually pulled it off that day and we were really busy, and sort of "Well done, everybody" sort of thing. (ID077:interview1:p27)

When asked what made their ward or somewhere good to work a good environment to work in, it was the team that was consistently identified:

At the moment we've got, like, a good team of nurses, I feel, and we all get on, and we work well together, and when someone's having – like really rushed down with all their patients, you help each other out. So, I think our whole team morale is good at the moment, like actual – that's what's keeping me here is our team of nurses are good. And we all, um, so that's something that brings me into work, and we get on well, and I mean some of them are my friends, and I see them out of work. Um, so if you've got a good team of nurses, then you're more likely to, I think, look forward to work, and come to work. (ID019:interview2:p23)

For me personally it's probably the team and something challenging. (..) I think when you come to work and you've got the time to support others, but also people are supporting you. (..) Well, just asking, you know, it can be as basic someone saying, "Are you all right?" (ID021:interview2:p21)

Thus the nursing team was seen to be crucial as an intrinsic motivator, important to all participants in this study. Many also identified the importance of the wider multi-professional team.

### **9. 3. Relationships with the wider team**

Relationships within the wider inter-professional team were also important for creating a good working environment and making a ward a good place to work, helping retain staff. A friendly team, who worked well together and supported each other with opportunities for socialising together, was identified as significant. One participant highlighted a good experience she had had in New Zealand, with a well-developed multi-professional team that had been created and worked at. She contrasted this with her current experience:

[JM: What would be an ideal working environment for you? What would hold you?]  
I like the idea of a real team working environment (..) and this ward in New Zealand I worked on, everyone worked really well together, including the doctors. Doctors and nurses sat down at lunchtime and morning tea together and just, they had ward outings. Yes, again cleanliness, people helping each other (..)

[JM: And how do you feel about your current team, and teamwork?]

We don't have ward outings and we don't work together. There is some of us that work together and others that don't; they prefer to work by themselves. And there is a lack of respect for staff like our ward clerk; she is there to help and I think she gets kind of dumped on in a sense, given a lot of stuff to do that she shouldn't have to do (..) And also one of the doctors, I get on quite well with the doctors, a lot of them are around my age, maybe a bit older, and we chat about everything, about patients to what we've done on the weekend, and that seems to make it easier, I think for me, later if I've got to ask something of them and [they are] more willing to do it for me.

[JM: Right. So you're building relationships with them. And so, other staff are not doing that?]

No. I get, some people will say oh I don't get on; you know I can't ask this doctor, and that's because they won't do it, or they are rude. I think it cuts both ways. (ID076:interview1:p17)

Another participant highlighted the importance of good relationships in working together for patient care, and felt there was more respect shown to nursing staff by medical staff and others in the multi-professional team than nurses' show to each other:

Your relationship, especially with your medical staff, um, you need a good relationship because if you can't go to your doctors and say, "I'm having problems", and they yell at you and so you don't go back next time, then you're actually going to affect the patient care. (...) Um, but yeah, the way that the medical staff – I've just found the way the medical staff, more so the senior medical staff, um, the consultants and the special registrars (senior doctors), the way they approach the nursing staff if they don't like what they're doing, then they're quite good, um, "No, I don't want to do it this way." We've had the consultants in and they're very good too(..) I think they definitely speak to us with a lot more respect than what the nursing staff do. I just think the nursing staff, within themselves, that's where the problem is. The link between the nursing and medical staff, that's, err, I've never had a problem. (ID 086:interview2:p31)

Knowing other members of the team well helped trust and respect develop, and this was seen to be fostered both in and out of work in Accident & Emergency:

[JM: What is it about working here that makes it a good place to come to work for the day?]

Um, I don't know; it's a good team. Um, not just nurses, but doctors as well, and everybody (...). That's what it is really, it's just a good vibe about it, and everyone works hard and, you know (...) it's friendly (...) – I'm friends with people in work, but then at the same time you see people out of work, which you don't necessarily do in lots of places.

[JM: And is that important?]

Yeah, yeah, I think so. Especially when you work in somewhere like here, where it is flat-out busy and you have to know someone quite well to – well you have to have a good understanding with people (...). Trusting people and know[ing] where you stand with people and know other peoples' limitations and being able to ask for help is also really important here, because there's a lot of things that you are well out of your depth in, and things like that. (ID077:interview2:p17)

Thus teamwork, so vital in good healthcare delivery, was identified as an important motivator for nurses in this study. Teamwork was called an important aspect of making somewhere good to work, and working as a team, not only with other nurses but also with the wider team, was cited as important for a good working environment. The final intrinsic motivator identified in this study also relates to teamwork, because it is the need to feel valued.

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## 10. Feeling valued at work

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“Of course, everyone wants to feel that they are valued” (ID 019).

### 10. 1. Background

Evidence supports the premise that committed employees perform better, and Robinson et al (2004) have suggested that employee engagement is one step up from commitment. It is therefore important to try to understand the drivers of engagement. This NHS research suggests that one of the strongest drivers of engagement is a sense of ‘feeling valued’.

Feeling valued is linked to positive views on many factors, including:

- Access to and support for training, development and career development\*
- Employees relationships and views on their immediate managers\*
- Access to and quality of performance and appraisal\*
- Communication within the organisation\*
- Equal opportunities and fair treatment\*
- Pay and benefits
- Health and safety
- Co-operation
- Family-friendliness
- Job satisfaction\*

(Robinson et al 2004. Factors marked with “\*” emerged more strongly in the interview data across all interviews as important to nurses in this trust.)

Focusing on increasing individuals perceptions of their involvement with and their value to the organisation will increase engagement levels, contributing to increased retention and performance. Increasing the levels at which staff feel valued can be achieved through:

- Managers listening to employees
- Employees having the opportunity to develop their jobs
- Good suggestions being acted upon
- Employees feeling able to voice their opinions
- Senior managers showing employees that they value them
- Employers showing concern about employees’ health and well-being
- Employees being involved in decision-making (IES 2003)

New recruits often arrive with high engagement levels and a sense of optimism, as evidenced in their responses to the open question “What are your reasons for coming to work at this trust? Please give as much explanation as you can” in initial questionnaire:

Reputation of hospital; better funding for courses; opportunities for career advancement; opportunity to be part of a well-respected hospital; better working environment; to find people close to my age to gain friendships and better identify with them; opportunity for job specialisation; to work with patients from a wider culture; to experience London. (ID076; trained New Zealand)

Familiar with trust as trained here; trust has a good reputation in clinical performance and has good links with FE institution to provide training opportunities: (ID079)

Trained university of Brighton (...) was selective in my applications; (Trust A) was among those I applied to because it has a good reputation and I believed I would receive good training, learn new skills and improve career options. (ID084)

Good reputation and teaching institution; I wish to work in such a hospital and gain international standards in nursing; helps to interact with people of different countries and ethnic group which helps develop own outlook; the financial support is also good; personal and professional development. (ID059; trained India)

This trust is top teaching hospital in the UK. I would like to develop my job opportunities and career. (ID 097; trained India)

For continuous professional growth and development; evidence-based clinical practice; a reputable prestigious institution known for developing competent health care professionals here in the UK. (ID030: trained Philippines)

Fantastic opportunity to develop my skills; role uses all my knowledge; opportunity to work with leaders in their field; fantastic reputation of the X team; having met those I will be working with I found them extremely welcoming and supportive; apparent transparency of the trust – forward thinking. (ID088: trained Australia).

Many of these responses demonstrate high levels of engagement with this trust. Such engagement is necessary to imagine oneself working there and to take up post, but the statements are also aspirational, enthusiastic and full of expectation.

Like the psychological contract, engagement can easily be shattered. And in the longer term, initially high engagement levels need to be nurtured and maintained. Robinson et al (2004) suggest, however, that an organisation should attempt to raise engagement levels unless it is prepared to invest sufficient time, effort and money into it. For example, the importance of the line manager's role may suggest the need for considerable investment in management development, or the need to increase training and staff development may require budgetary support.

It is also important to note that not all employees are the same, and one size does not 'fit all'. Some professionals, e.g. doctors, nurses and midwives, may have greater loyalty to their profession and to their patients than to particular organisations. They may care little about the organisation's aims and values, instead preferring to go wherever they feel they can best practice their craft and, in return, receive the appreciation of their peers. (Robinson et al 2004)

When asked whether they felt valued, 19 of 26 recently employed nurses in 2005/6 said they did, although the strength of this appreciation varied.

[JM: Would you say that you feel valued here?]  
I do, because I mean (..) you feel valued by the surgeon that obviously helping them, and then also by the management, I mean you are a valuable resource for them; if they don't have you, who is going to do the work? (..) and so of course I do, yes" (ID 080)

Six participants suggested they were valued by some staff or were unsure:

[JM Would you say you feel valued on the ward?]  
Yes. Yes, I would in one respect, but in another respect I think you're just sometimes treated as a number and I just think, I think that that's just not London, I think that that's everywhere. I mean that was sort of in my last trust as well. And I think that that's something that will always sort of be around as well. Because I think a lot of people do, do feel like that you know, you come and, you know, you do your shift you know, oh so-and-so has phoned in sick, you know what I mean, what are we going to do now? And you know, I think you do feel a bit undervalued in respects like that, yes... Some staff are more appreciative than others, you know. (ID 080).

[JM: And do you think that [valuing of employees] happens here as much as you would like?]  
I think it could be better. (..) Sometimes there are, like, people will come in and be really down on us and will actually run the place down" (ID 092 – IRN- Auz/NZ).

Feeling valued was tied up with being given more responsibility, but also with some higher grading to recognise and reward that:

[JM: Would you say at the moment you feel valued?]  
To a degree. (..) Like, they want me to go on call and they wouldn't want me to go on call if they didn't think I was capable (..) I can see that, but if I don't get an F grade in February, I will feel not valued and I would leave, definitely. (ID010:Interview1:p3)

By interview 2 this had changed. Of the 23 nurses interviewed, just over half (n=13) did feel valued by their nursing colleagues in the team, and eight did not. Seven suggested they were valued by patients, and of these, four nurses suggested they *only* felt valued by patients and not by other colleagues. Seven also specifically said that they did not feel valued by senior managers and/or the trust.

## 10. 2 In practice, what does 'feeling valued' mean?

When asked more specifically about how nurses decided that they felt valued, nurses responded that there were many indicators:

At interview 1, these included knowing you are making a difference to patients (076) and being recognised for your achievements (073). A large part of this was through receiving feedback from colleagues and patients. Other aspects included being supported in one's learning and development, having synergy (feeling a part of a larger purpose) and feeling respected, appreciated and trusted in one's work. Primarily, however, staff suggested that to feel valued they needed to receive regular, constructive and honest feedback.

## 10. 2. 1. Feedback

At interview 1, many nurses cited feedback, saying that knowing you're doing a good job as an important part of feeling valued. (ID007) (ID011) (073) (030) (077) (097)

They're very, very good, you know, saying You're so welcome, and You've done so many good things, and We're really, really pleased you're here. (ID073:interview1)

I think it's just in feedback and knowing that you're doing a good job, and being appreciated for what you do and the contributions that you make to the company. (ID007:interview 1)

Feedback was also important at interview 2, when more interviewees were feeling that they had not had enough feedback. Feedback rarely seemed to be part of regular teamwork, although there were some notable exceptions where staff were thanked and acknowledged for their work. But to be useful, feedback needed to be specific and to contain constructive critique as well as thanks:

I had the sense of feeling that I didn't know how well I was doing or how badly I was doing. I had no idea where I stood, and we went into the teaching room and we sat down and had a long chat, and she goes, "How do you think you're doing?" and I said, "I think I'm coping like crap, to be bluntly honest" and (..) she said to me, "Look, this is what you're doing wrong, but this is what you're doing right." And she, sort of, pointed out a few things. That made a big difference. (ID086:interview 2:p23)

Genuine and specific feedback was also identified as an important aspect of a good working environment in the stakeholder interviews:

Recognition, and then being clear on recognition for what, and genuine recognition, not just the "Oh, well done on that bit of work, on whatever you did yesterday". I think for that recognition or feeling valued to be real it's got to be genuine, and it needs to be on something specific. And I think all too often because you hear quite a lot now you don't get any thank-you's; people are starting to do it more but I don't think it's always that sincere and it might be another motivator for them to say to get you to do another bit of work or at least they can delegate. So yes, that is really important because it's about being valued. (stakeholder09:22.9.06)

If it's ongoing and it's their manager's style to be thinking "I must say thank you, thanks for that, you did well there" with no specifics around it, that can get quite annoying. The first few times you say, "Oh right, great, you said thank you. I fall off my chair, but thank you." But if that's then ongoing and then it gets to the stage where it's like, "Mmmm, what are you thanking me for?" (..) It's about giving good, constructive feedback, isn't it? Be specific, say what effect it's had, how you're going to carry it on, how you're going to change it, what can we do for the next step rather than just..." (stakeholder09:22.9.06)

When staff did receive feedback it appeared to be enormously helpful, as identified by Nurse 086 above, but it was often ad-hoc:

I sat down with V and said that I was enjoying doing it and wanted to stay here and if they had a job, I'd like it. Um, and she said, "Oh, that's, um, sort of, really nice to hear positive feedback and that my nursing was really good and that I knew my stuff", and that was really exciting actually to know that I was doing okay and that she thought I was a good nurse. So, that was really nice, 'cause I don't think anyone has

actually sat me down and said, "You're doing really well." So, I was like, wow, this is new. Um, yeah, that was really nice, but it's just a shame, I suppose, that I had to, sort of, um, that it was me talking to V and that's how I got the feedback, and it wasn't her sitting me down saying, "Look, you're doing really well." (ID 078:interview2:p16).

For others feedback was just absent, which left staff guessing and not feeling valued:

[JM: You hadn't, at that time (interview 1), had much feedback; has that changed?]  
No, I haven't really had any, to be quite honest, no [laughs]. (..) I'm supposed to have an evaluation or whatever after, and I'd have thought after six months would be ideal, and I didn't have anything after six months. (..) So, it's been, yeah, been over a year now and I haven't had any kind of formal review of how I've been getting on. (..) Um, but in one way you could say that's a good thing. I mean, you know, I must be getting on all right if no one's had to say, "L, you're doing this wrong", you know, but I don't know if that's right. And it's probably not." (ID084:interview2:p8)

Some staff felt they got feedback primarily from patients;

The only feedback I feel I get is from parents, and when they say "Oh thank you so much for looking after our child", and you get presents and (..) they thank you afterwards and when they go home, and that's the kind of feedback I get. You don't really get it from your colleagues. (ID019:interview1:p12)

Thus staff were often forced to conclude that they were 'getting on all right' through the absence of being told otherwise (this is discussed in more depth in the next section) when staff equate being trusted to take more seriously ill or heavy patients with being valued. This conclusion may indeed be true, but the extent to which staff were left to speculate suggests insufficient performance management and, crucially, a lack of feedback for many staff.

To be useful, feedback also had to be genuine and sincere, but this was acknowledged as difficult to do:

I think if they've got a problem then, you know, tell me 'cause I'll improve on it. If I know what it is, then I can do something about it. Um, I don't know how many people would actually have the courage to sit someone down and say, "Right, you're doing this wrong, you're doing that wrong." I don't see people doing that. (ID078:interview2:p18)

There was some suggestion that as a qualified nurse one should not need such ego boosting, although it was also noted that without feedback it was hard to appreciate where you were at in your progress, or where you were going:

It's nice when, like, you know, you'd say, you know, nice working with you today or whatever and that's good, but it's not as though they mean it, you know, and I'd say that to people if I mean it, I'd especially say it to students if you know I think they've done well, but I don't know. I think that's the step up from being a student to being nurse, is you're not, you know, you are almost expected not to need that. Kind of, it's like support for your ego almost, isn't it (....) (but) I have felt (..) like kind of "How am I doing?" but then I kind of rationalise it to myself as you're doing all right because nobody has said any different, and you know, or I could just be doing mediocly well and nobody is going to say anything about it. (ID 084:interview1).

One obvious opportunity for feedback was at appraisal. However, by the time we spoke at interview 2 (after at least 12 months), only eight nurses had received an



appraisal, with four about to have one. Nurse 083 had been in post for fifteen months and was frustrated not to have had an appraisal:

That's something that they're trying to get on top on now, but it's not come round yet, so – and I've not got a date for one and some of the other members of staff haven't either (...)

[JM: And does that bother you?]

Yeah, it does. Yeah, because I think that it's an important factor, you know, you need to know where you're going and what you're doing, and you need some general feedback on things like that. And you need to be able to input as well. So, I feel like that that is an important thing, yeah. (ID083:interview2:p21)

## **10. 2. 2. Feeling respected, appreciated and trusted**

Another way staff felt valued was by being treated as equals by practitioners of other disciplines and by nursing colleagues, and sought out for their skill or knowledge:

And multi-disciplinary team-wise, I think this is one of the better hospitals that I've worked in (...) I'm not sure you get multi-disciplinary teams that treat nurses quite on the same equal par as we are regarded here. (ID021:interview1).

Other staff mentioned that feeling respected and appreciated for their contributions was also an important aspect of work:

Yes, that's good when we do a good thing or when we, somebody, does a good thing if you tell them that it was done very good or it was excellent or if it was done in the way which it should be done, then the person who is doing that, that's an encouragement for them. (..) Yes, they tell us when we do something, yeah ... some of them make sure they appreciate us when we do something. (ID 059 IRN:Interview1).

Another thing would be support and appreciation here, you know, if it's really busy for staff of our grades and other grades and, well, and if you go out of your way to do something and you are appreciated, or done something well, to be appreciated for it, which we really are on this ward. (ID 077:interview1).

Manager and the surgeons and my other colleagues, and I think it takes, it takes a while for the juniors to appreciate and respect you, but they eventually get there. You have to be very forthcoming, saying "Do this and do this now" and a lot of them can't see why for a long time, but then they'll kind of get it and then you're OK with them and they're OK with you kind of thing. But it takes a while to get there. (ID 087 IRN Aus:interview1)

Feeling valued meant having your judgement trusted as a professional:

"Physios [physiotherapists], I've always worked with physios. The physios have been great; they tend to come to me and say, "Look, what do you think?", and they don't do that with a lot of the other staff: sometimes they do, sometimes they don't. I think it depends who the other staff are, but they have sort of been quick to get to know me, and one guy, he really values my opinion, and once I said "No, leave him, he doesn't need it" and they go "Oh, okay" (..) So the physio will come and say "Do you think the patient needs us?" and then I'll go "No, I don't think so" and they go "Well I might just do an assessment anyway", but if I say "no, he doesn't need it" then basically they believe me. (IRN 086 Aus:Interview1)

For another IRN, being allocated 'heavy' and 'more difficult' patients meant that she was trusted by her colleagues:

They are giving me more heavy patients, that means they know I am doing good, and to me that's good, and they also give me more difficult patients. Maybe their opinion after they say "You have done all right today and that is good work", even the doctors are saying that, which is nice because the patients like it. Some days it is difficult but some days it is good" (ID 097: IRN – India: Interview 1)

Being trusted by parents was also key, as this paediatric nurse suggested:

I think you just get a feeling (..) you don't bond with every set of parents and they're there for a long time, and after a while they will start to ask you something rather than the next person and they obviously trust what you're saying. (..) You don't very often get a thank-you, but every now and then you know it's a very sincere thank-you and you can't expect parents to walk out every day saying thank you, thank you, thank you and you don't, I don't want that. You know, I don't want to go home thinking seven sets of parents have said thank you. Every now and then you'll get some chocolates or something, and I mean I never expect that, but that's kind of nice. And quite often we'll send the babies home but say come back next week to check the weight or something like that and they might say "Oh, what day are you on, we'll come back then" and then you get the feeling that, you know, they want to come back and show you their baby, rather than the next person. (ID 087 – IRN Aus: Interview 1)

At interview 1 being trusted by others to get on with your job with minimal interference was a way of feeling valued:

I have no frame of reference because I've never worked anywhere else as a nurse, so I can't say, you know, what a good or a bad work environment as a nurse is. I just know I feel comfortable here (..) you know you're doing your job well because nobody is picking you up on it, and they are letting you get on with it and that's, and maybe that's not enough to everybody but to me that's like, that's enough, that's like all you want to do is, you know, get on with your job and go home at the end of the day. And the best placements I had as a student were the ones where I would turn up and I'd be left on my own and I'd be aware that somebody was checking what I was doing but they'd let me get on with it and, yes, that makes you feel valued, because somebody else isn't doing for you. And I suppose that's the same here, nobody else is doing that for you so you know it's valuable, and nobody has a go at you at the end of the day. (ID 084:interview1).

At interview 2, for many a sense of being trusted with more seriously ill patients, being asked to cannulate a patient or being trusted to pass on knowledge were important and made staff feel appreciated and valued:

Even if I'm a junior staff here, they will have that trust in asking questions, err, that they didn't know [answers to], which I know. And, for example, if, err, they don't have the skills to do it and confidence to do it, they will ask for me to do it. That, for me, that means that they've got the trust for me (..) and then they ask me to sometimes to teach them regarding my speciality in C. So I can be able to transfer some knowledge to them, so they could learn as well.

[JM: And how does it make you feel when people say those things to you?]  
Hmmm, I'm happy and I'm amazed as well, and I'm flattered, hmmm. I'm happy because I can be able to share my knowledge to them, you know. (ID030:interview2:p17).

I do feel valued in some ways as well because I am quite a support for my other team members. They often ask me questions on studies or I have to go over and help them take blood and things like that, so they rely on me for the support, but then I don't have anyone to rely on for my support. Not that ... you don't always need a lot of

support, but it's just nice to know that someone's there to help you if you've got a question. So I think I feel valued in that way, that the other team members value me and the work that I do. (ID007:interview2:p12)

Conversely if others did not trust them, it made staff feel very undervalued, destroyed their confidence and caused them to consider leaving:

[I had a] series of incidents, series of people just pushing me out the way and doing things for me, and it's like, they didn't know me very well, they didn't trust me, they didn't trust my judgment. They didn't think I could do the job, and would actually physically push me out the way (..)

[JM: And did you think about leaving then?]

Very much so. Very much so. Um, I think [sighs], um, why didn't I? I was very close to it, actually. I was, [laughs] that's right, I was starting to look into (..) getting my Canadian residence... (ID086:interview 2:p12)

### **10. 3. Feeling valued: Acknowledging positives, learning from negatives**

An interesting aspect of work culture emerged in terms of good work often being known only to the nurse or a few colleagues, whereas a mistake will be known by everyone. This makes something of a blame culture, where only negative aspects of work are highlighted:

Obviously you get, you get this feedback "Okay, you did very well" if you do something good, and yes, obviously I think that it is like, if you do something bad then everybody knows about that, but if you do something good only you and the maybe a couple of other people know about it. (ID 080: Interview 1).

People don't thank people for doing a good job, and I find that just saying, "Oh, you've done a great job with this patient today, thank you very much for your help" -- that makes a big difference in a day. It doesn't matter how shitty your day is, um, as long as somebody smiles at you at the end of the day and says, "You did a great job", or if you did something that made a big difference in the patient or you picked up something early, what is wrong with actually saying, "Good pick up; that was a great job" sort of thing? Just very briefly, and people probably wouldn't even notice if you just said it; you talk, but people don't do that. It's all about negativity, "Oh, you did this wrong; you did that wrong; you did this wrong; you did that wrong." Nobody ever picks up a positive thing (..) it is a very negative thing where they just go out to look for what you've done wrong; nobody looks for what you've done right as well. (ID086:interview2:p8)

When they put in the incident reports they just – it's like they're blaming you. It's not that it's a teaching case, you know, what it's supposed to be like, you get an incident report and you're supposed to learn from your mistakes, and not do it; it's not like that there. It is not like that there at all. It's blank, point the finger and you've done something wrong, you stuffed up. There's no, sort of, let's go back and review, sort of, look back on it and do it that way, and that's the way I prefer to do it. If I've done something wrong I can admit that I've done it wrong, um, and I like to, sort of, go back and, and reflect on what's happened and why I didn't do it, etc, etc. (ID086:interview2:p4)

## 10. 4. The importance of feeling valued

For many, feeling valued was perceived as very important:

[JM: Is it important?]

Yes, very much, very much. It encourages you (..) It encourages to what you are doing, okay, somebody is appreciating my work. No need to, I mean you don't have to give me an award or something, just a few words: that makes the difference. (ID 072 IRN: Interview 1).

[JM: You've talked about feeling valued, is that important for you in the place that you work?]

Yes, definitely. Yes, and I think it comes from people above you, like from the top down, and [from] other health professionals, like different doctors and health advisors, and, you know, we are all working together and treat each other with mutual respect and positive feedback.

[JM: And do you think that happens here as much as you would like?]

I think it could be better. (..) Sometimes there are, like, people will come in and be really down on us and will actually run the place down. (ID 092 – IRN- Auz/NZ: Interview 1).

[JM: And would you say that is important to you, feeling valued?]

Of course it is, yes, of course it is. I mean it's a job and definitely [for] everybody to do their work they have to feel OK. In my case I have to feel that I am valued, I am doing something that is valued, and something that actually helps other people. (ID 080: Interview 1).

This importance also emerged particularly in response to other, often readily and more easily perceived motivators:

If you don't feel valued and supported, then you know, it doesn't really matter how much money you get. So it's not often the money, you know people will say they want more money, but at the end of the day more money isn't going to make you feel valued or supported. (ID007: Interview 1).

And also in response to the demands of the job:

[Feeling valued is] very important, yes. Because if you don't, you don't know if you're banging your head against a brick wall for nothing. (ID 073: Interview 1)

I think it's important in a way because it boosts your morale as well, because we'll be looking forward to it, when you go to work and when no one comes and tells you that, oh well done. Because I remember on one occasion I was given a difficult patient as well, they said we know you've got a very good TLC. (..) Even if they give me very difficult patients (..) at least you can manage them because we know you will give them TLC. So it means a lot, so I'll say OK then (..) I feel appreciated in a way (..) the manager is excellent. I couldn't ask for anyone better. (ID 090 – IRN: Interview 1).

Feeling valued was also tied into job satisfaction and reasons for continuing to do an often stressful job. At interview 1, this was particularly cited in relation to patient feedback:

Yes, I do get a lot of feedback from patients. I think that they are the, getting positive feedback from them is what I nurse for really. You know making someone happy during the day at work, or having someone say, you know, thanks for washing my hair for example, thanks for giving me a shower, you know. That makes me feel

valued. (..) If I didn't feel that I was having an effect on my patients in a good way then I wouldn't be doing nursing. (ID 076: Interview 1)

If you are doing something and if someone tells us "oh it's good then" we'll get that, some feeling like, oh I have done something, isn't it? So then we'll be able to do some more, some more hard work, or if I am happy I'll be able to come tomorrow and work in the same situation. If they are not happy with the work first day or I'll be thinking that, oh how I'll go tomorrow and work there with them, so here it's good. From the patient side, from the staff side, it's good. They are motivating, and they do tell that what to do next and how to do it and something like that. (ID 094 IRN – Indian: Interview 1)

However, patient feedback was less important in terms of retention in this particular trust:

[JM: In terms of retention and deciding to stay in this trust and that ward, is being valued something that's important or not?]

Yes, but more from the nursing staff and other members of the team, not from the patients. When I look at if I want to move from a job it doesn't go back to my interactions with the patients, because anywhere I nurse I would look after my patients and I would hope I'd get the same feedback from my patients wherever I nursed. But [it] is dependent on the teamwork really for me.

[JM: Right. And on balance at the moment is the teamwork and the feedback and the feeling valued enough to keep you?]

It's enough for the moment.

[JM: Right. But if that balance tipped a little bit more you might go?]  
I'd go elsewhere, yes I would. (ID 076: Interview 1)

[JM: Would you say you feel valued here?]

Yes. But I think that's a function of the job rather than... I mean, because nursing is a strange job, if you worked in an office you could feel valued by your co-workers because they told you so. But your job might be, I don't know, filling in forms that [are] for some business somewhere, and in terms of your job you'd never feel valued because you know that you know it doesn't make a difference to other people's lives, whereas I think here you know directly you are influencing other people's lives. Not all of the time but some of it. And so you are always going to feel valued because you know that that's important, so you don't need other people to tell you, oh, you know, "Oh, this is a great job". (ID 084: Interview 1).

This supports the work of Robinson et al (2004), who suggest many healthcare professionals feel more loyalty to their profession than particular employers and will go where they feel best able to practice. If not valued by colleagues, though, nurses may think about leaving:

If I wasn't, and I wonder if I wasn't feeling valued here, probably I would leave.(..) But no, I mean, you know, I don't feel that I'm not valued. I feel that I'm valued. But if I now feel that I'm not valued, then I feel kind of a useless person here, then probably I would think about, you know, changing to something else, and going to some other hospital somewhere, yeah. (ID080:interview 2:p18)

For those who were not feeling so strongly valued there were also some ideas as to how feeling valued could be incorporated more into everyday work and what forms this might take:

I think it'd be nice to thank your staff a bit more for what they've done throughout the shift. Because I think that that's a big factor, you know, to know that, praise your staff for them to know that they've done well, they've done a good job, they've done what they could in whatever situation. I think, you know, to give regular feedback on things

like that, even on to arrange a few more sort of study days and sort of get more information regarding what your staff are really feeling. Because I think that if your staff feel that they are a bit under, undervalued I think that they tend to sort of clam up a bit and, you know, they'll just not speak to whoever is senior about it. So I think you've got to try and build up a better rapport with your staff and get more regular feedback, and listen to them and, you know, hopefully take on board what they say more, to be able to change negatives into positives basically. (ID 080: Interview 1).

## 10. 5. The outcome of feeling valued

What it felt like to be appreciated and valued was also highlighted in nurses' responses:

Feeling very happy (ID 097: IRN: Interview 1)

Nice. It makes you feel like you are, you know, you see yourself as really a staff nurse as well, as part of the team, you are even able to say whatever you think about, you know, your weaknesses or your strengths. It's very nice, I wish everyone could be made to feel that way. (ID 011: Interview 1)

The best thing is that, of course, the co-operation, okay, but now at the end of the day, somebody said "Thank you [P] for being so good", that makes your day. (ID072 IRN: Interview 1)

The impact feeling valued and appreciated had on one's attitude to the job was also mentioned by some participants:

It makes you want to go back. It doesn't make you go home on the train thinking every day "Why the hell do I work there, you know, why do I go from one side of London to the other to go to work, you know?" (ID 087 – IRN Aus: Interview 1).

Being valued was also seen as encouragement and motivating by two nurses. (059) (094)

Yeah, if you do something good, if someone tells that "Oh that's good," you feel like, that means, working more, isn't it? So it's good (..) motivating, yeah. (094 – IRN India: Interview 1)

## 10. 6. Being valued: where and when?

Where and when it happened also varied, with this nurse conceding that she had to ask for feedback from senior colleagues – "I ask for it. It is always wise to ask". Others identified the appraisal as a place for feedback and to be valued, but as noted above, feedback via this route was not forthcoming for all. It was acknowledged that time was a limiting factor for staff valuing each other:

The F grade who does 9 to 5, she's quite good at picking up what you're good at and what you're not so good at (...) Yeah, she can be (supportive) when she has time [laughs]. When she breathes, yeah. (ID 077: Interview 1)

The importance of first impressions and a good induction and welcome was also highlighted as important in making a member of staff feel valued:

I just remember the first time I walked on the unit. Actually, G, who is our modern matron, saw me walk in and she actually came and approached me and she said,

“You must be F”, (...) she just came up to me and put her hand out and shook my hand, welcome, blah, blah, blah, so yes, that was really good actually. (ID 086: Interview 1).

Who nurses felt valued by also varied. The majority felt valued most or all of the time by patients, with other members of the nursing team and wider multi-professional team also identified:

Sometimes patients (...) are basically saying “I am very thankful” for all, all of the things that you have done for them. Your colleagues will appreciate you, it’s very basically, it will be a learning experience as well, I’ve learned new things from them and they’ve learned new things from me as well. (ID030-IRN: Interview 1)

[Colleagues] will, they will appreciate you, like, and they will, they will thank you for the things that you have shared to them or new ideas. (ID030-IRN: Interview 1)

This nurse (ID 030) also felt it was important to have constructive feedback and criticism, as constant positive feedback may cause a nurse to become complacent and result in poor practice:

In general we have a good team, like we have a good pharmacist and the medical team’s good (..) it’s such a small team they know everyone quite well and they’ll ring up and talk to you and ask for your opinion and things like that, so that, yeah, I do [feel valued]. (ID 077: Interview 1)

Staff and colleagues, yes. Patients, yes; relatives, yes. I’m not really sure about the trust, I remember from the induction, you know, “You’re all wonderful and we love to have you all here”, but I haven’t really had much else to do with that. So mine would be more to do with colleagues and patients around the unit. (ID 086 – IRN Aus: Interview 1).

The manager will always say thank you if she thinks you’ve done a good job with something. She doesn’t say it that often, but you know when she says thank you it’s a sincere thank you. You don’t really get, you don’t really get a thank you from your colleagues but I think they know when you’ve had a bad shift, and you know the next shift will come on and you’re trying to finish something and they’ll say “Look, just go, you know I’ll do it, it’s all right, I’ll do it” and I think that’s just an acknowledgement that the place is busy. (ID 087 – IRN Aus: Interview 1)

Another IRN suggested receiving praise or compliments from colleagues was a new, but very welcome, experience of nursing in the UK compared to nursing in her home country:

Managers. Of course, the senior staff (..) but you know normally back home we don’t hear that. (..) I was so delighted when I heard first today that “Thank you P for the help you have done today”. I said, Yes? It’s like, of course, we do get lots of what do you call? compliments from the patients, that’s back home also, it’s used to but among yourself, among your colleagues, that’s the best thing, what I hear from here. Because they are always with you, you know, always with you. (ID 072 IRN: Interview 1).

Others felt appreciated by all / most colleagues including the wider multi-professional team:

[JM: Do you feel you are appreciated by other colleagues and the senior staff?]

Yes.

[JM: Do you feel appreciated by the doctors?]

Yes, I do. Some more than others; I mean, the consultant, I've not spoken to him. But the SHOs (senior house officers) definitely, they are all great, they really appreciate the nurses. (...) And the registrars can be very poor on saying thank you, you know what it's like, they are on to their next job. But yes, not they do appreciate what we do. They appreciate that we get things done on this ward. (ID 077: Interview 1).

So that whole situation was the worst situation we could've been in, but it really worked well. The thing that made the difference, 'cause the consultant came on that morning, knew the patient had died and we'd sent her off to the morgue, um, came in and said, "Thank you guys, I know you've done a really good job overnight, but thank you for doing what I needed to do" sort of thing" (ID086:Interview 2:p32)

Feeling part of the nursing team was important for some and gave a sense of feeling valued, as this IRN recounts:

It's like, you know, they treat you, us, as one of their colleagues and like the staff. It's not like somebody, your slave or maybe somebody, you know, ordering, no (...) It's a team, it's teamwork. If you are located this side and the other side is busy, if your side is quiet and nothing much to do with but these people help the other side. So you just give a hand for something if we need. It's not like, "Oh, it's your patient so you look after them". It's teamwork, it's nice. Nice and good. (ID 095: IRN -India: Interview 1).

Another nurse suggested that she was proud to work in a large teaching hospital and found senior management approachable:

Having the privilege to work in such a large hospital makes you feel valued in general.

(...) We had a team day; we met with the nursing director. She was really nice, she seemed very approachable and she said "If you've got any problems, obviously just come and knock on my door and if I've got five minutes to see you, you know you can come in and we can have a chat", which I think is, is a good thing.

(...) I think that she's happy to listen to [nurses], which is a good thing. Because sometimes, you know, it's so difficult to get someone that's that approachable in sort of that position. (ID 080: Interview 1)

[JM: Would you say you've been valued on the ward?]

By some people. But again, it comes into quite a few of the nurses, I get the sense they feel threatened by me on the ward really. But I haven't really thought about valued. (ID 076: Interview 1)

## 10. 7. Not feeling valued: in what ways and by whom?

Those who did not feel valued suggested they did not feel valued either by specific groups of staff or in specific ways, or both. Senior management, which included both nursing and general managers, were identified as the group people felt least valued by. At interview 1, the view was that some of the perceived 'top-down' measures, such as a smarten-up campaign, were too rigid and staff were not appreciated for their hard work. For example, at interview 1, rule enforcement versus little or no recognition of the sacrifices made by staff was one way of not feeling valued, in examples cited below:

I think possibly some of the senior nurses are a little bit out of touch (...) the senior nurse, she sent round an e-mail to all wards about people having two-hour breaks and sleeping on nights (...) I was doing my five nights at the point, and S the sister showed me this, and said it's all very well but on my first night we did all have a two-hour break, I haven't had a break for the last two nights, because we had loads of



A&E admissions, I haven't written an e-mail to everyone saying I haven't had a break for the last two nights. So what really gives her the right to e-mail round saying that? (...) It's obvious by the way that people don't have breaks when the dependency does go up. (ID021: Interview 1)

Someone came round the other day and said to one of the girls they were wearing the wrong colour hair band. I'm sorry, there are a lot bigger problems in the trust that what colour hair band someone's wearing. We work on a paediatric ward, if you want to wear bright orange socks I don't care as long as they're clean. Where is the problem, we work on a children's ward? (...) People need to look at the bigger picture, because if you start pulling people up over small things like hair bands, people are just going to say, you know, I'm sorry, it was quite a bad day for everybody on the ward and at that point me and one of the girls, and that was like five o'clock, we hadn't had lunch yet and someone comes in and tells you that you're wearing the wrong colour hair band and she was really annoyed, so then that took me off, you know I had to sit her down for fifteen minutes, to say "Look, do we really care what they say, you know, it's not going anywhere you know, calm down", I'm really sorry that happened. (ID021: Interview 1).

At interview 2, changes and policies enacted by managers as a result of budget cuts, together with the director of nursing leaving, gave an opportunity for more reflection on the extent to which staff felt recognised and valued by senior nurses and general managers. The majority said that they did not feel valued, listened to or heard by this group of staff:

I do [feel valued], but not necessarily valued by, or not openly valued, by the management (..)

[JM: if they were valuing you, what would that look like? Is it as little as saying "Well done" and "Thank you", or is it more than that?]

I think for me it's more than that. They would need to, you know, take on board the things that I've said and actually make some positive changes and action things that I've said, like not wanting to take on this new study, or changing, you know, giving someone else my study for six months just to give me a break from it. I think you know, they're all options that I've asked them to do for me (..) but they just didn't take it on board. (ID007:Interview2:p12)

The issues raised by nurses were of management not getting things done for them (073 reported that there were no working alarms, despite serious assault on a nurse); management not being seen to value their work by saying that they wanted to improve patient care through a skill mix review, which was seen by many as a way of cutting trained nurses and not valuing their work; and management not communicating sufficiently with staff about changes, redeployment and ward closures at an already stressful time (077, 078).

[I want] staff to feel safe, um, in every sense of the word. I mean, for example, and I don't know if you're aware, but a couple of nurses on X were attacked (..) and nearly a year and a half later, the nurse still can't return to work because her injuries are so bad. Um, and so, they put pinpoint alarms [like a rape alarm] in here, because the patient is still here, and we get – every patient with violent or aggressive tendencies, um, come here. (..) And a CCTV system. (..) A patient went to attack a nurse with a stick last week, and she pulled her pinpoint alarm and it didn't work. So no security came. So what kind of message is that that we're giving? You know, a week later, despite the fact I've jumped up and down every day to the people who I think might be able to sort it out, it's still not fixed. (ID073:Interview2:p55)

As for feeling appreciated. I would like to have more honesty about what's happening, in terms of recruitment, (..) the 'best value' stuff and the acuity stuff. Because it's insulting your intelligence, isn't it, to say – "Do you know what, if I tell you it's [skill mix

review] going to be better for patient care, I know you're not going to believe me, but I'll pretend that you do." I just find it really dishonest, and I hate that. (ID073:Interview2:p59)

Err, well, again, it's different from the point of view of the, um, the Big Brother watching over us [sigh]. And again, it comes down to personal experience, and this time it just feels like you're, well, you are the money saver, you are the pawn of being moved around. And again, for the new ward that's opening up, the two new wards that will open, (..) there will be staff that are left over and they will have to go somewhere else. (..) I think there's staff members there that will have to be moved up to the other wards as well, because they won't need as much staff (..) It feels (..) like we are being compromised in order to do the money and try and make up some of the money. Like, obviously if we weren't here, then it wouldn't work and the place would fall down around their ears. (ID013:interview2:p27)

People, like, especially on the wards, have not really felt they've been dealt a fair hand, in that there's no communication as to what's going on with ward merges and things like that. And even just things like building work, like a ward was moved upstairs for, like, two weeks and they didn't know it was happening until the day before, and things like that. And that doesn't take too much to tell people, I don't think. Just better communication, I guess, really, between everybody (..) [JM: And how do staff feel about that, and what does it make them feel?] Um, not valued, yeah. Quite, like, insignificant, I guess, really. Not taken into consideration in the grand scheme of things. (ID077:Interview 2:p33-4).

They're thinking about, um, changing all the wards around again, moving staff; um, no one really knows what's happening. Um, and I don't really agree with that. I hate it how they don't have a plan and they think they can just move us around how they please (..) I mean I don't mind coming down here and I don't mind helping out other wards once in a while, but when they sort of have all these plans and don't really communicate them, it makes me feel unsettled, and I don't feel very secure anymore. (ID078:interview2:p3).

The director of nursing was perceived as being remote, and few if any of the cohort I interviewed had met her, some knew her name but were mostly unaware aware that she was leaving and that a new director was starting or in post at interview time.

Even though she is director of nursing and they are in the most of the time, in their office. They should come around; they should talk to the nurse. To be honest, I don't know who was (name). I have heard of her. I have not seen her. I've not seen her. You know, it may be surprising, but they should come around and they should know what is happening around, how are the nurses, are they getting on okay; is there any issues to be sorted out? Just to have a five minutes, ten minutes chat with them. Are they okay? I don't know, but they, is that in their, what you call, um, oh, what do you call that, job description? (ID072:Interview2:p31)

It'd be good for them to know about why people are happy in their jobs and why people are unhappy in their jobs. Um, I think the whole thing with changing the, sort of, skill mix is going to make nurses feel less valued, you know. Um, and probably make them feel overworked as well if they're in an environment with lots of healthcare assistants who aren't able to do things like, you know, IVs and so forth. Um, [pause] I don't know. It'd be nice if they came and worked on, you know, the ward every so often, you know, just did a little tour of the wards and saw what they're like and saw what conditions are really like for people. (ID084:interview2:p21)

I think the director of nursing should just – probably just get her hand or his hand dirty for some time, just to try it, and work with the staff in the ward for some time, so they know the real, on the front line, how do they feel like, rather than just have the office

doing the planning, all the grand plan. (..) I think that's the main idea, is they have to know what's exactly happening. (ID079:Interview2:p30)

The effects of not feeling valued were also clear. Staff felt invisible, that they or their opinions did not matter, and this was identified as de-motivating.

Do I feel valued? Sometimes I don't think they even notice really. I feel that it's more the people who speak a lot, speak very loud (..) are more in the limelight really. You know they hear about those people more than the people who are quiet and get their job done (..) it's my perception, or at least from what I have seen, that if you are not very vocal, then they think, "Oh she's not talking very much about something that she's done or something that has happened, then probably she doesn't know" (..) so in those terms, no, you don't feel valued. (ID009: Interview 1)

This nurse cited one occasion where a senior nurse had told her she had done a good job:

I was very surprised because I wasn't expecting that. It did make me feel good, yes. I prefer to have her say that, you know, "You've done a good job" rather than "You've messed up." But it was quite a shock for her to come out and say something like that when I didn't think anything of it really; so, yes, it did make me feel good. But you don't see that happening very often really. (ID009: Interview 1)

Other staff compared their current job with previous experiences either positively or negatively:

I think so, [I have] had some praise from the rest of the staff. Whether in jest or not but it's all a bit more positive. Because I have found, say when comparing it to other places, that in my last job there was very little feedback from anyone. (ID013: Interview 1)

Clearly, feeling valued is a critical part of nurses' commitment to their current workplace. The trust can explore how to enhance this experience with "comfort benefits" like hot drinks as well as with overt encouragement and praise. Please see policy recommendations section for other ideas of how to make workers feel more valued.

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## **11. Is the nursing contribution valued?**

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Interviews with some stakeholders in the trust suggested that for nurses individually to feel valued, nursing as a profession and its contribution to the work of the trust needed to be valued. Some stakeholder interviewees went further and suggested there was a culture of bullying towards nurses and senior nurses in particular, with heads of nursing perceived as not respected by other senior managers in the trust and nurses' views not taken seriously by non-nurses in the trust. The hierarchy within the trust appeared to marginalize nursing and nurses' views, which meant senior nursing staff were themselves undervalued and some would say bullied, perhaps making staff unable to support junior staff because they were unsupported and did not feel valued. Initially the views of stakeholders are reported; then the views and experiences of individual nurses are presented.

## 11. 1. Nursing valued? Perceptions of stakeholders

I don't think nursing is respected in this organisation at all (..) At a senior level, nursing and its contribution isn't respected. (IDstakeholder06:6.9.06)

There was a sense from a number of stakeholders interviewed that nursing was not valued within the organisation and that there was a culture of the nursing voice being marginalised and not heard:

[Nursing] doesn't have a voice. Sometimes when that voice is trying to be heard it's just blocked. It's a nurse, so why would we listen? I may be being harsh but having sat in meetings and actually observed that sort of behaviour, I'm not being harsh (..) There isn't a value in nursing, there isn't. And that's disappointing (..) Certainly in terms of dissatisfaction of staff [this] has an impact on patient care, no doubt about that. You certainly observe it at a senior level being played out publicly as well (..) Because I'm relatively new to the organisation, you know, less than eighteen months is still quite new, you observe things still as an outsider (..) And it's startling to me, the way parts of it get played out in public (..) I think I wouldn't want to work here as a nurse.

(IDstakeholder06:6.9.06)

The people that actually understand how wards, departments, how things really run or who are often best placed to tell you how things really run are nurses. And they spend the most time with patients, more than any other staff group, and I think they probably understand patients' needs better than other disciplines (..) What I do know is that we appear to have a group of staff that are excluded and that can't be right. But you may go to speak to therapists and they feel equally excluded, and I would expect that, but again what you see played out is this nursing tension. You know: what does nursing know; that's the nurses again; Nurses never do this, they never do that. To be frank, some of it comes from only one or two individuals but that's all it takes, especially if they're very strong. (IDstakeholder:06:6.9.06)

The department of human resources was also seen to be included in those aspects of the organisation that were not valued within the trust:

I think there's lots more to do about that relationship (..) nursing and HR and how they're valued (..) I think organisations vary. I can think of other organisations where it wouldn't be like this, but I can think of ones where it probably would be like this. I think it's possibly fairly amplified here. (IDstakeholder04:19.6.06)

The director of nursing was perceived to have a hard job, and this would be true in many trusts throughout the UK. Good relationships between staff at the executive level were identified as crucial to the effective functioning of the work of the trust, but were identified by some in this institution as not cohesive and damaging to the organisation.

I think that there isn't a cohesiveness at a senior level; that is then cascading down the organisation. I think that power struggle that you can see, and the tensions that exist, are translated down the organisations so where there is conflict at exec[utive] level, in my mind, it should stay at exec level. And what comes out should always be a very united position, and it doesn't get played out like that. So there is a criticism of professions and disciplines to groups of staff (..) which is unhealthy, unhealthy in our organisation. So how one then changes that culture and that value of nursing when it appears to come from the top is not clear to me, how you do that. (IDstakeholder06:6.9.06)

[The nursing director's role is an] ambiguous position with that team. It shouldn't be. It doesn't have to be. If the team had a united view, if they didn't try and undermine each other at every turn, if you could trust going away and spurious decisions not being made in your absence, those types of issues.

[JM: Is it the team undermining each other or is it the team undermining nursing?]

No, it's the team undermining each other as well as nursing. I think there is, if you looked at it, there are competing, I don't know, sometimes I think of it like Ming the Merciless keeping people warring in order to maintain to control, as it were. But I'm not entirely sure. (..) I just think there is a lot of (..) real competition within the group, and not only the nursing, which is a soft target and the biggest workforce, the most visible. It even comes down to little comments. I've heard one executive say "Oh yes, and I notice people 'in uniform' walking past people and not helping". It's a very subtle comment. What does it matter if they're in uniform if they're an employee? But of course it's pointed to nursing. (ID stakeholder07: 22 Sept 2006)

The relationship between general managers and heads of nursing who headed up nursing directorates were identified by a number of stakeholders as problematic. Agenda for Change banding in the trust had ensured that general managers were often banded higher than heads of nursing, and if there was the same banding it was reported to have gone down badly with the general managers concerned:

[In] other organisations, heads of nursing equivalent have been banded in the same bands as general managers. And with no outcry whatsoever. Here there's ... so heads of nursing come out at 8B and 8C and general managers come out as 8C and 8D so some might be in the same bands as heads of nursing, and believe me, they're not best pleased the rumour is, but it's interesting, isn't it? It's about confidence in roles. (IDstakeholder04:19.6.060)

One stakeholder with a clinical background in nursing felt having a clinical background helped general managers in their work:

And I look at some, and I don't want to criticise and, I mean, I know it's not all about clinical backgrounds, and some of the general management people are anxious to show their seniority sometimes (..) My experience is that the people that have done clinical backgrounds do general management on the whole much better. (IDstakeholder04:19.6.06)

Aspects of this apparent power struggle were played out in many guises within the organisation, with heads of nursing apparently coming off worse, their voices marginalised or unheard.

There is also a bit of conflict between heads of nursing and general managers, and some of that's about inclusiveness, you know. Heads of nursing don't go through the Senior Management Group. Senior Management Group is general managers, clinical directors and execs, so they are excluded. (IDstakeholder06:6.9.06)

I sit back from it and you observe that ... nursing management, in my view, is not perceived, it's certainly not perceived on a par with general management structures. There's a clear hierarchy and a clear importance that's put on general management and a much less importance on nursing (..) at all levels within the organisation. Much of it led from the top, and that's not X (the nursing director), obviously. There's a strong general management culture. There's a strong clinical director, as in "doctor" culture, and they're the two people that are inextricably linked. And nursing can play along a bit on the periphery of that, but it isn't seen... I came from an organisation where it was very much seen as the three of you, so the doctor, the nurse and the manager (..) I guess the sense is therefore that nursing isn't valued either as something that contributes to management. (..) I think there's a marginalization (..) of

nursing and I think therefore the real contribution that nurses can make isn't recognised (..) and I just think that the potential that nursing has isn't exploited, frankly. (IDstakeholder06:6.9.06)

I am an impartial observer because I have little axe to grind. I was a nurse and this job isn't now nursing (..) I am a bit more dispassionate perhaps round here but I see the organisational damage that's done. Lack of cohesion at exec level is so damaging to an organisation. So damaging. That's not to suggest that they will agree with each other all of the time, and it would be unhealthy if they did, but to the rest of the organisation there should be a united front. That's not to say people shouldn't challenge, but respectfully and properly (..) Things are said at general managers' meetings. Nursing is criticised in general managers' meeting.

[JM: Criticised for what?]

Put down: "What would they know?" "That's just nursing." "Nursing again." You know, it's just that whole "Here we go again, nurses" and that's played out in front of general managers. Quite deliberately in my view. It's not passive, it's active.

[IDstakeholder06:6.9.06]

Matrons in the focus group also felt that the nursing voice was marginalised and unheard within the organisation:

I personally feel that the nursing voice is getting tinier and tinier and tinier. This is my feeling. People are proud to be nurses and say, "I'm a nurse", [but] you talk to people, "Does your general manager know this?" And this system is de-motivating because what does she know about what I do or he know what I do on the ward? Although it may be a necessary measure, I think it does not help. What's actually the main workforce of the trust? It's nursing. Because, I think, what do we do? We care for patients. So really and truly, the nurses have a really, really high impact and, we think, stand because we have the direct hands-on care with the patient and, I think, does that reflect my feeling? Does that reflect when I go to meetings and I talk to people? No way. It's tiny. I think we're probably on a par with secretaries. (ID matrons focus group:26.9.06)

Many colleagues agreed, though others suggested it was not the same for all directorates.

One example stakeholders cited of heads of nursing being marginalised was as part of a drive to reduce the use of bank and agency staff. The decision was taken that only general managers, and not heads of nursing or ward sisters, could sanction the use and employment of such staff. In the view of one stakeholder, this reflected a lack of confidence in the ability of the nursing profession to work efficiently and within budget, despite the fact that they had already over-performed on the target for reducing the use of bank and agency staff:

If we look at decisions that have been made around financial matters, there's a theme perhaps that you might come across regularly in the trust. (..) Decisions were made before Christmas, for example, that the authorisation of bank and agency staff for nursing and for other professions, but predominantly for nursing, would be escalated to Level 1 budget holders, general managers. And essentially ward sisters couldn't make a decision about staffing, neither could matrons and neither could heads of nursing (..) Clearly that sent a message of lack of confidence and the ability of the nursing profession to work within its budget, to work efficiently (..) And that was against the background of an over-performance on our target for reducing bank and agency [staff]. And I found, well, that simply just articulated that they weren't very confident, not only that, but actually nursing is a soft target when it comes to matters like that. (ID stakeholder07: 22 Sept 2006)

Even when the nursing directorate did well, either others claimed responsibility for the success or there was little acknowledgement of their achievements, as they had only achieved what was expected:

It's about decisions that are made, and whether the contribution of nursing and the argument of nursing is seen to be heard (..) so I think there is something about, well, we present our evidence about the achievements of nursing, and it seems that it's no achievement at all: it's what we expect. (ID stakeholder07: 22 Sept 2006)

For example, in terms of general managers taking over the authorisation of bank and agency staff within the trust, stakeholder 07 went on to suggest that by taking over this function at this time, the general managers were able to claim excellent results, despite this being more reflective of a seasonal variation rather than prudent management. And this further undermined heads of nursing within the trust:

We always have a dramatic drop in the bookings over the holiday period, and of course this was hailed as "Well, look what the general managers can do". And nobody seemed to have a memory that this is seasonal variation that always happens at that time of year and if you look at 2003, 2004, 2005, 2006 you'll see the same pattern. Of course it felt to me, and perhaps I'm being a bit cynical, it felt to me like a well-placed bloodless coup. Of course we're in desperate financial straits but is this the time to be undermining the very people who are responsible for delivering the target? Particularly when they've over-performed and delivered savings at a remarkably low target, and then continued to do so. We've eradicated agency to almost nothing, we've eradicated a lot of the use of temporary staff, we've been set a target of 1.2 million to save this year. We've already saved three times that, and yet I understand the control is being taken away from heads of nursing again this week (...) And this was announced in a very intimidating meeting (..) so most people came away from that feeling that their jobs were at risk if changes didn't happen. It's lack of parity that was the key issue: no other profession was called in, so it's really looking at where do we have most control, and let's squeeze as much as we can out of those people we have most control to offset what we don't seem to be able to manage in other areas. That's my perception. (ID stakeholder07: 22 Sept 2006)

This senior nurse in the organisation felt that the key reason to involve and listen to nurses in terms of whether bank and agency staff were needed to staff the wards effectively at any given time was to benefit from their clinical expertise and judgement:

The key thing for me is about nursing uses professional judgement to review things on a day-to-day basis and make assessment about the nurses you need on a day-to-day basis, and I think that decision should still rest with sisters and matrons, not with general managers and not with the executive. (ID stakeholder07: 22 Sept 2006)

When asked if the executive and general managers were aware of the clinical risks being taken at times through not listening to nurses' judgements regarding staffing, they suggested that general managers also had their own problems within the organisation:

I think general managers are [aware of risks] but they're not always confident to challenge the executives. I think there's a real problem there and (..) there is a culture of aggression that's, it's difficult to say how ... it's bullying, I'd say in that case. Aggressive, competitiveness, undermining critique. (ID stakeholder07: 22 Sept 2006)

This stakeholder suggested it was thus a particularly challenging time for nursing within the trust:

I think the heads of nursing probably have a right to be concerned about their positions because if you look at, you know, how things happen when you're on your way out as it were, do people not involve you in discussions? Do you find your power base being eroded? Do you find the portfolio you have shrinking? All of those things are sort of happening in a very subtle way. So I think they should be concerned, which is why they need to unite and respond very forcefully. I'm sure that's going to be met with a lot of resistance. It'll be a "back in your box, nurses" type, so I think it's a real challenging, testing time for nursing. (ID stakeholder07: 22 Sept 2006)

Reflecting on a big project in the trust, another stakeholder gave an example of nurses being directly excluded from the process:

The project, or the overall programme, it's general manager-led and it's often nurses that are excluded (..) There's a clinical evaluation taking place tonight of the options to de-scope the project (..) and the evaluation panel is only doctors, there's no nurses. Nursing has been excluded because nursing has asked to be part of that and has been told "no". Now, if I was a senior nurse and I'd spent the last four years planning my department (..) to find that six doctors on a Wednesday evening sat around and decided just to completely rearrange my department, I would vote with my feet (..) I think there's a message there (..) that is, "You don't have an opinion, and if you do, well, it's not valued anyway because only doctors can make these types of decisions" (..) but that lack of inclusiveness is damaging. (IDstakeholder06:6.9.06)

The UK government's modernisation agenda has pushed some aspects of performance into sharper focus than others.

I think organisationally it's not unique, but organisationally we focus on activity and finance and that's it, and I think if there is a hierarchy that's where it's at, and then you get sort of the rest of the stuff below, so you get, you know, nursing, HR, branding, marketing, strategies and so forth. And I think to be a truly successful organisation it all needs to be at the same level in the integrated strategy, and we're not there yet. (IDstakeholder03:19.6.06)

Although some stakeholders felt nursing wasn't valued within the organisation, this was seen as a bigger problem in that staff weren't valued:

As an organisation, do I see a very clear message that we value nurses and they have a valuable contribution to make, and as an organisation we see that, you know, we couldn't run without them? Well, I see no evidence of that. I see no evidence of that for any staff group. Of course (..) it's very clear that the organisational message is "of course we can't run without doctors, and the rest of you, quite frankly, you can come and go if you please". Some of things that I've said, of course, are not just about the way nurses are treated. My impression is staff are not valued. (IDstakeholder:06:6.9.06)

[As an organization] it doesn't value staff. It doesn't value staff. To the point where staff are openly criticised. Staff that have left, staff that are still in posts. You could sit with the general managers and my staff will be criticised. Well, yes, some of them are not performing at the standard that I would expect them to perform at, but you know you don't have a public discussion about them. There are ways of dealing with poor performers and there's lots of that. Lots of that. (IDstakeholder:06:6.9.06)

Another stakeholder with responsibility for many staff across the organisation, and not just nurses, suggested that some strategies are unhelpful:



You often hear that there's a bit of a blame culture here (..) The reality is, in my opinion, yes there is. (IDstakeholder:09:22.9.06)

After the recording device was turned off at the end of the interview, another stakeholder suggested:

This is the most bullying culture I have ever encountered! (IDstakeholder:06:6.9.06)

These stakeholders personally had not been bullied, though they said they could have been, but had seen others being bullied. They described this as people being constantly undermined, people talked about negatively or faced with ultimatums ending in a threat to one's job.

Of the nine stakeholders interviewed, four have now left the organisation or have moved to different posts. Of people approached initially to be involved and take part in the stakeholder interviews, a further four had left during the life of the project and were unable to be interviewed. Stakeholder 07 left after we spoke and suggested:

I know what working in an effective team's like, and I don't see that. And also you want to be inspired by the most senior people in the organisation, and I don't necessarily feel that. (ID07:22 Sept 06)

## **11. 2. Nursing valued? Perceptions of nurses in practice**

The value of nursing as such was rarely mentioned at interview 1, but emerged more spontaneously at interview 2 as a result of the policy shifts and new directions encountered within the trust by many staff as a result of the trust needing to save money. The extent to which participants felt that nursing as a profession was valued was asked as a specific question in the second round of interviews. This was interpreted by interviewees as either meaning was it valued within the trust and/or in wider society. It was also interpreted and answered in comparison with or in relation to other things. Primarily respondents said this valuation was in relation to:

- Changes taking place within the trust
- Other professions
- Nurses and nursing in other countries
- How nursing is valued in relation to how it was in the past

Other points of reference in exploring this included: Valued by whom? Patients, doctors, managers, the public? Speakers also mentioned how being valued manifested or was measured and evaluated, e.g. through nurses' salaries, or in terms of altruism and the moral aspects of having a career in a helping profession.

In relation to financial cutbacks and resulting skill mix changes taking place within the trust, this was highlighted by some nurses interviewed as an

example of nursing not being valued, as suggested by participants in the stakeholder interviews above:

[JM: Do you think nursing's valued in this trust?]

No. No.

[JM: Can you say more about that?]

Um, but how, how can it be, when it's okay to have so many senior management managing money? And it's okay to spend the money on them, but it's okay to let nurses go? Because of 'best value'. So, how can it be? (ID073:int2:p34)

This time it just feels like you're, well, you are the money saver, you are the pawn of being moved around. Because they're changing their (..) staffing anyway. They're going to have more band 6s and less band 5s... (..) It feels like it's being compromised, that we are being compromised in order to do the money and try and make up some of the money. Like, obviously if we weren't here, then it wouldn't work and the place would fall down around their ears. (ID013:interview2:p27)

In this aspect, the blame fell on managers who were not valuing nursing or nurses:

Well, they're not – well, I don't think so, because they're not listening to us about what we were saying with the healthcare assistants, so they're not valuing our opinions at all. I kind of, you know, we had a big meeting and I was just shocked at what – they need to come and work on the ground floor for a bit and see what it's like. Because they're just saying, "Oh it will be fine, no problems", and I'm just...

[JM: And they being, who were they?]

It would be our managers. (ID019:interview2:p17)

Nursing was largely seen to be valued for the work that nurses undertake, particularly by the public and patients. On the whole, participants still felt that collectively 'the public' valued nurses, particularly as nurses were seen as the main point of contact and a conduit for patients, through whom patients interact with the system:

I think the public value nurses. (ID019:interview2:p16)

The patients generally don't like doctors. They're very thankful at the end of the experience for, um, having their life saved or whatever by some, you know, physical intervention, surgical intervention, whatever, and they're very, very grateful for that, but generally they don't like the way medicine acts on them (..) and their point of contact with the people who are actually responsible for their wellbeing or life or death is really, really limited. And what they have is nurses; that's their only kind of interaction with the system, and you're like an intermediary, you're not on the side of authority, and you're not on the side of the patients, you're somewhere in between. And I think that's why nurses are valued. I think that's why patients like nurses. Um, 'cause they're quite reliant on them as well, but more just because of what they represent in the whole scheme of things, they're like, you know, you're kind of a medium to get through everything. (ID084:Interview 2:p17)

However, several interviewees felt that the public were largely unaware of all that nurses do as part of their role. A nurse recruited from India with a degree in nursing felt the public exemplified by her friend studying for an MBA had no idea how much studying and theory was involved in nursing work:

I think they are [laughs] saying it's a simple job, isn't it. (..) Yesterday my friend was saying, "Oh, I thought it's me, to study lots of things, but the nurses has to study more than us" (..) and he's saying, "I thought it's me who has to do all the things, but the

nurses have to study.” (..) Yeah, he was surprised like, you know, they all are thinking the nurses don’t have anything to study (..) [it’s a] simple job. (ID097:Interview 2:p49)

I never felt that you got the respect (..) people outside always said, “Oh, that’s such a valuable job; that’s such a good job; I wish I could do such a good job”, so in that sense, yes. But in terms of you always seem to be doing, um, people have their defined jobs and then often I thought nursing would do those jobs that no one else really wanted to pick up. So, that always felt quite strange and not valued. (ID010:interview2:p23)

Thus extended roles, rather than some of the more basic nursing roles, were perceived by one interviewee as valued by patients:

I think so, I think so, especially here where there are a lot more things that you can do. Um, I think if I was to work anywhere else, I’d feel that my skills were quite valued as well, ‘cause being able to cannulate, being able to prescribe certain things, and things like that, then yeah, definitely. (ID077:interview2:p41)

But others felt that nursing was less valued now than previously (this is presented in more detail below) and that patients not only did not know what nurses did, but at times treated nurses with little respect, which was demotivating:

I think the big thing is how do the general public look at nursing. I think something like 10, 20 years ago, nurses are still being respected. And still it’s a profession, but some of the time now you just think that, what I’m doing here, it’s not being valued. They don’t know what I’m doing and they just think that I’m here giving them water. Is that all? (..) I think that is the big challenge, because if you’re feeling that you don’t have job satisfaction and you’re not being valued, you’re not interested in nursing anymore. Why I want to get abused and sit here to be a nurse?” (ID079:Interview2:p39)

Nursing was identified by one participant as a valuable job with a moral and ethical dimension. This dimension was at times hard to own and acknowledge to peers who were primarily extrinsically motivated by financial reward in jobs with little perceived value:

If I tell people I’m a nurse, and lots of my friends work in strange jobs like advertising and, you know, things that to me, and I think to them, don’t have any kind of, there’s no moral aspect to them. If anything, they’re doing bad things to the world and getting paid for it, and if you tell people you’re a nurse, I think they see that as very valuable, but almost in a sense that they’re embarrassed by what they do, almost. I notice that quite a lot and that’s a strange feeling. So, sometimes I lie and say I work in the city (..); it’s an easier life. (ID084:Interview 2:p17)

In terms of other professionals, the work that nurses do was largely perceived as valued, as the unit or ward would not run without nurses.

I think doctors need to value nurses, because without us who would help them do their job? (ID076:Interview2:p39)

Nurses were thus valued by other professionals, perhaps particularly doctors, as key members of the professional team:

I think doctors now are beginning to value nurses, because I think they’re realising they can’t do their job without us (..) especially junior doctors, they really rely on us

when they first come onto the ward. (...) I think the juniors do. I mean the consultants do anyway, because if they want a (patient) to come in, they start being nice. (ID019:interview2:p16)

In relation to other professions, particularly doctors, nursing was largely seen as the poor relation in terms of respect from patients and the public:

I think in general, and if you turn around and say to two people in a room and say you're a doctor or a nurse, so the doctor will always still get the high and mighty, whereas nursing staff are, sort of, it's gone down a level. (ID013:interview2:p27)

I always thought doctors got more respect than a nurse.

[JM: From?]

From the public. From people within the team. But then you kind of – patients are strange. Sometimes you get the ones that are really appreciative and thankful, but probably 90% don't say anything, and 5% complain (...) They always seem to thank the doctor. The doctors are the one they listen to; the doctors are the one with the great power and respect (...) whereas the nurses don't do anything, even though you're the ones that see the changes and report the changes and keep an eye on things. So, no, in that sense I don't. I don't think you are [valued]. (ID010:interview2:p23).

In India, as in many other countries, a career in medicine was perceived as better than a career in nursing:

In India it's better to be a doctor, you know [laughs]. But, um, nowadays, I think more people are going for nursing. But at first only a few people just go for nursing. But because their family, they won't allow them to go for nursing like, you know. But nowadays, the chances are there. (ID097:interview2:p47)

Many of the sample had nursed in countries outside the UK and Europe, and their responses to the question of the extent to which nursing was valued drew on these experiences, offering comparisons with other countries. Thus, for example, nursing in the UK was more valued than nursing in India, where doctors were most valued and nurses less valued and respected than in New Zealand, Sweden and the USA. Indeed, nurses and nursing in these three countries was perceived as being more respected than nursing in the UK. This was particularly true for New Zealand, where a strong union was credited with increasing the respect for nurses' work. Respect in such cases was measured or evaluated in financial terms, so that where nurses were paid more they were seen as being more respected:

In America nurses are paid a small fortune comparative to England. So, I was in America last weekend and, you know, people will say, "What do you do?" and I'd say, "Oh, yeah, I'm a nurse", and they'd be like, "Oh, you should come here, you can earn, you know, hundred grand a year as a [nurse]". I say, "I'm a C nurse", and they'd be, like, "Wow, you know, you can earn even more" and I was thinking, well, it's quite tempting really. (ID084:interview2:p19)

I don't have the feeling that the nursing job is appreciated in, err, in the UK as it was in Sweden, where I come from. (...) Definitely it is more valued in Sweden, and actually, if you – I mean here I speak to people and I tell them that I work as a scrub nurse and they go, "What do you do, what does it mean?" Even the, you know, the general opinion of nursing is, like, very low, but, you know, in Sweden if you tell anybody about the scrub nursing, they say "Oh, that is an important job, and you're doing a very nice job." (...) I don't feel that the nursing job is valued in this country, especially in, and as I said, regarding to the salaries. (ID080:interview2:p25)

Others provided a comparison with how nursing was perceived to be valued historically, and suggested that it was less valued in contemporary society than in the past. This seemed to be in relation to respect (or indeed lack of it) from patients, despite moves towards a more educated nursing workforce:

It was valued, but now – I don't know what to say. Sometimes I feel that there's no more value for nursing. Sometimes nobody recognises your hard work. You know, sometimes certain families, the way they behave. "You are a nurse, you have to do it. It's your job." (..) When you compare nursing [as it] was in those days and now these days, and it's a much worse difference, yeah. It was (..) a noble profession and it was valued, you know, in those days. But now, everybody goes for nursing, everybody does nursing. They say it's as simple as doing a simple job. (ID072:interview2:p34)

I think there has been a big change, obviously, over the years, and it's not seen as, err, sort of, up there anymore [laughs]. You know, it does feel [less prestigious], even though they're trying to make it more professional and change it all to degrees and everything else. (ID013:interview2:p27)

One suggestion was that the responsibility for this regard lay to a great extent with individual nurses and the extent to which they provided a good experience for patients:

But I think that's more determined by the nursing individual. 'Cause if you're not providing that experience for the patient and doing all you can for them while they're here, they're not going to give you, you know, they're not going to think highly of you at all. Because there are days when you hear people moaning and complaining about the nursing staff and everything else, whereas you get other ones who have had good experiences and they're all happy and praise and think you're wonderful. (ID013:interview2:p27)

However, returning to the skill mix changes in the trust and the financial squeeze, many suggested that at times this good regard was not possible. This is because it was not possible for individuals to always provide good quality care and experiences for patients within a system that was not supporting them effectively.

However, returning to the skill mix changes in the trust and the financial squeeze, many suggested that at times a positive patient experience was not always possible. This is because it was often difficult for individuals to provide good quality care and experiences for patients within a system that was not supporting them effectively.

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## **12. Extrinsic motivators**

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The nurses in this study suggested that the salary and perks of the job were not their prime motivators. In fact, most suggested these would not be enough to bring them into the profession. Once in the profession, a few suggested pay was not the most important issue for them:

I'm happy just to get paid once a month, to be honest [laughs]. Oh, it's all good. I've never really – I don't really look into pay. As long as I get paid, I'm happy. (ID086:interview2:p46)

Another interviewee suggested she would like more money when asked about the worst aspects of her work, but also suggested it was not really that important as long as she could pay her bills:

I don't really have that many negative things. ... More money [laughs].

[JM: How important is that?]

More money for Christmas presents. Um, not really, not very important. (..) As long as I can pay my rent, I don't really mind [laughs].

[JM: Right, right. And you can?]

Yeah.

[JM: Even though you're living in London?]

Yeah. Just about. (ID077:interview2:p31)

However, some nurses, as they got older and wanted to buy property, became aware of what their peers and friends in other jobs, notably the private sector, were earning or receiving in fringe benefits. When this happened, the lack of extrinsic motivation in nursing became more apparent:

People carry on about money, but I'm not sure it's all to do with money, because when you choose to go into nursing you're aware that nurses don't get paid that much because everyone's aware [of] that. You know nursing isn't the best place to go into if you want to earn millions. But what then I think happens when you've been in the job a few years, maybe your realisation of what everyone around is earning, it becomes more apparent I think, and then (..) When you join nursing, I went in at seventeen and a half, so you've got really no idea, you're aware that nurses don't earn as much as everyone else but you really haven't got a pay structure in your mind, well I didn't (..) so it's not this big thing, but only when you, yes I think then when you look at when you graduate, at what teachers are earning and policemen are earning, and that you're having to do longer hours and you know and things like that. (ID021:interview1:p13)

I'm just renting still. But, you know, when you're like getting to that age and you think, oh, I would like to live somewhere and buy a place somewhere, but – and I probably would have if I wasn't – I was on something a bit – a bit more money maybe I would have been – maybe two years ago I would have got something. But at the moment I'm just – you just feel like you're a little bit behind [laughs]. All of your friends have got cars, this, that and the other and there's that. But that's all materialistic things, so you don't... (ID019:interview2:p19)

I kind of think of, like, my mates that work for computer companies (..) or sales reps who get a car, and if they work from home they get a laptop, and they get healthcare and get gym membership, and those are really good perks. (ID010:interview1:p13)

At least two participants travelled over 50 miles by train daily to work, an added extra expense that cost about £3,500 per year. Schemes that supported reduced-cost travel (e.g. nurse's railcard like armed forces railcard) or free travel on the tube as afforded police officers were highlighted as potential perks for nurses that should be explored nationally.

Internationally recruited nurses who had travelled to the UK from India and the Philippines were surprised at the high living costs in London. Yet most were still able to save, and felt that they were happy with their remuneration in the UK even though it was less in terms of what it could buy for them than they had anticipated. Some (but certainly not all) were sending remittances home

either to support elderly parents or siblings' studies, but London living was expensive:

[JM: You said salary is important. How do you feel the salary is here?]

It's good in a way because that's why we travelled all this way to come here, but it's expensive also (..) We are able to get a very good salary, payment-wise it's very good, but when compared to the expenses that's also so high. So far so good, no problem (..) I am getting more than when I worked back home, but thing is, I was staying in my house, I was just travelling around 10 minutes or 5 minutes, I take food from my house, I can come home whenever I need, so that was the work which I done back home, (so) no expenses at all. (ID059:interview1:p10)

Nurses from New Zealand and Australia suggested that nurses in the UK were not financially well rewarded compared to nurses at home. In New Zealand, nurses had just received a 30% pay rise. Nurses in Australasia were felt to be more prepared to strike and to be demanding in terms of pay and working conditions than nurses in the UK:

They need to get angry, for goodness sake, and make things better for themselves. (..) I think that's what everybody wants, they don't want to be rich, they just want a nice quality of life (..) You've qualified and you're looking after people's lives, and they then wonder why documentaries get made about disgruntled patients (..) And if you're not remunerating you don't attract the right people to the course in the first place, and you don't retain them on the course because they see how bad the conditions are and they know they are not going to get remunerated at the end, so why would you waste another two years? (ID088:interview1:p21).

One nurse felt that the responsibility for people's lives that nurses have meant this should be reflected more adequately in nurses' salaries, but concluded that paying more money to nurses would not necessarily ensure quality:

I don't know with money. I think because it's a very responsible job. (..) It's a very high-pressured job and a very stressful job and it's people's lives. I mean, some of my best mates work in computers and I kind of look at what they do and the bonuses that they get and I think, well, what do you actually do? You set up a system that's financial, that makes the bank millions of money, so you're going to get money because you're making money, but if, you know, somebody dies at the end of the day, what really happens? Or you save someone's life, so you get reward for that, and you shouldn't put money on people's lives, but sometimes you think the responsibility that you have and you do have and you make one mistake, do you... (..) Do you get paid for that? No, you don't, so I think money is a huge, is a huge thing and it always has been, and I think it always will be. But that's not going to necessarily going to bring you quality. (ID010:interview2:p16)

As outlined above, some nurses felt financial rewards signified an increased respect towards nurses and nursing, as in the USA for example, where nurses were more likely to receive more remuneration. Thus some participants were clearly willing to discuss the thorny issue of nurses' salaries and highlight issues and areas where some disparity with others was felt. However, most suggested that salary alone was not the prime motivator for them. Like anyone, they wanted to be able to afford a good standard of living for themselves and their families and to be fairly remunerated. But as many said, "You don't come into nursing for the money"; other motivations brought them into the profession. I would argue it was these aspects, therefore, that were going to retain them or create disillusionment:

Some of the patients are really grateful, some of them they just treat you as a slave, they just keep – this is your job. (..) So, I think it's the perception of patients make a big difference for how nurses feel about they're valued or not (..)

[JM: And does that get to you if every...?]

It does sometimes, you think, why do I want to go to work any more, if it's not just worth it? You think about money, it's not a good money, you think about working in the NHS. So, I think job satisfaction is really important for everyone working in the NHS, I'd say.

[JM: And how do you get job satisfaction then? Where does that come from?]

I think for me, at the moment, it's probably when you see patients come in, they do surgery, and then they [go] home and recover. I think that's the best thing to do. (ID079:interview2:p37)

These intrinsic motivators have been highlighted above and include: meaningful work; seeing progress and improvements in their work; having healthy relationships and feeling valued for the work that they do. The reduced emphasis on extrinsic motivation, I would argue, made these intrinsic motivators take on more importance. Thus any aspects of the work environment that threatened these are a threat to retaining nurses in the particular workplace and perhaps even the profession. The following section examines these perceived threats in more detail.

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### **13. Perceived threats to motivators (good patient care)**

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The intrinsic motivators already identified in this report are meaningful work, progress and seeing improvements, healthy relationships and feeling valued. The perceived threats to progress and see improvements; healthy relationships and feeling valued have already been identified in the respective sections above. This section now examines the perceived threats to meaningful work – i.e. the threats to good patient care as perceived by nurses.

As detailed above, one of the key motivators was meaningful work. In nursing this effectively meant the ability to provide good patient care. The perceived threats to quality patient care were identified at both interviews but were much more prevalent and were a source of greater disquiet at interview 2. The changes required by the trust to respond to the need to make financial savings (skill mix and staffing changes) were particularly singled out as potential or real threats to the quality of patient care. Other issues, such as the cleanliness of the environment, perceived lack of accountability, poor teamwork, poor supplies and the intensification of nursing work, were all also identified as having an impact on the quality of care received by patients.

At interview 1 some interviewees compared the quality of patient care in the trust with past experiences in other trusts or countries. Those who did this tended to compare their new experiences negatively. An IRN from India explained:

Because, to be honest, as a student, from study or something what I had in my mind of the idea of British nursing was excellent. I'm telling you from my heart, (..) it was superior in my mind, I thought they must be doing an excellent job. When I came and



I saw, I was totally shaken. I said no, this is not supposed to be like this way. I felt we are much better back home (..) It's been taught for us when you nurse a patient and you take care of that patient, you should enter into the skin of the patient, and then only we learn what is nursing, what is caring. That's what we are being taught but (..) what I expected back home from here and what it is, is entirely different (..) It's really depressing, you know, that the standard is going down. It's totally going down. (ID072:interview1:p3)

Another nurse who had come from a different trust in England:

I found it very, very difficult initially because I don't think the standards of care are anywhere near as good. (ID073:interview 1:p1)

A nurse worried that her own standards might slip as a result of the poor-quality care she was seeing, and noted patients' concerns too:

I don't want my practice just to slip backwards and learn bad habits, and go, you know, change jobs or go somewhere else later and get pulled up for it... [JM: But generally you have a concern about nursing care standards?] Yes, nursing care ... and patients say about it as well (..) like they find certain staff difficult to talk to. They've noticed the way the nurses practice, their cleanliness, and their abilities to do things. There is a fear amongst a lot of patients about MRSA, and so they are watching them. And I've had quite a lot of patients say to me, you know, the nurse cleaned that bed over there and she didn't wipe round certain areas, or she used the same cloth for the entire thing, the bed and the chair. (ID076:interview 1:p14)

Lack of cleanliness and its impact on patient care was noted by many, particularly those recruited internationally and born outside the UK:

There's no cleanliness if you look around in the ward (..) You put the stuff down, you pick it up. I mean, you can see it going on in the wards, and throw rubbish around and only the domestic has to clean it. Why? (..) You take care of the patient, you look the patient's comfortable, at the same time you look you're neat as well. How clean it is, how tidy it is, how the patients are, how the beds look, I mean, they should be clean and tidy. I don't know, (..) maybe it's lots of work and maybe the manpower is less. (ID072:interview1:p4)

Some others did, however, compare their new place of work favourably in terms of quality of patient care:

You just feel that things are done well here. I mean, for all its faults, I think there is a really strong sense of doing things to a, like, maximise what the patient gets out of it; you know, making sure that they are safe. And I like that, I think that's not something you get everywhere. Sometimes people are looking for their easiest way out and I haven't seen that from anybody here and I think that's, for newly qualified I think that's really good, because that's going to stick with me, you know. (ID084:interview 1:p16)

Few staff at interview 1 cited insufficient staff and a heavy workload impacting on patient care, although two IRNs from India were exceptions. These nurses felt the number of staff available resulted in a poor level of care for patients and also resulted in staff sickness, which created a vicious circle:

It's quite heavy; like, if you say the staffing is very poor (..) we won't be able to attend to patients who are all confused, two patients; we're stuck inside there, no-one can go out with anybody, and maybe complaints will come from the theatre because they are

delayed (..) in my opinion like, staffing is very poor (..) so people are getting sick, they'll be no-one there. If you see the duty rota, every day there will be somebody sick. This is because of overload (..) from my opinion there should be more staff to give quality of nursing to the patient (..) you won't be getting any time to talk to the patient and there won't be enough communication with the patient. There is I don't think a good enough quality of nursing care given to the patient (..) because of staffing. (ID095:interview1:p2)

I really feel the workload is high and the manpower is less (..) than home. During the day it's fine; especially at night, at night it's really hectic. So that's the thing which I noticed. (ID072:int1:p11)

By interview 2 many more interviewees cited staffing issues having an impact on patient care. These issues included frozen posts, planned skill mix changes (which at the time of interview had already been implemented in some areas), reduced bank and cable staff and an increased workload for nurses. Less than a quarter of interviewees were unconcerned by these changes or did not mention them as a dominant feature of their second interviews. This minority either worked in areas unaffected by cuts and changes to staffing, where a heavy qualified nursing presence was deemed essential (e.g. cardiac catheter labs or A & E), or felt that with adequate training nursing assistants could contribute well to the ward team and may be a source of recruitment for nurse training (083, 090,097). However, the majority of interviewees at second interview were very concerned about levels and quality of nurse staffing and its effects on patient care. Nurse 021 was unconvinced that the changes would not affect patient care:

We have to save 26 million in the next two years. And the way that (X directorate) are doing it is to (..) reduce the amount of trained nurses (...) This whole statement that the quality of care won't be affected, I'm not quite sure how we can say that the quality [of] care isn't going to be affected, um, when we're actually taking a nurse away. Um, if you were adding a nursing assistant to the team, rather than taking a trained nurse away, then yeah, you possibly would [improve care], um, and I'm not, yeah, I'm not convinced that that's going to happen. (ID021: interview2:p3)

Another interviewee went further:

And the acuity scores, "We just want to make sure we've got the right nurse/patient ratio". Well, of course we know what it's all about, we're not stupid. (..) I definitely can't cope with unqualified. I can't even cope with newly qualified because they are really sick patients at times. (..) I would rather the management team were just a little bit honest. "Well, look, this is how much money we've got and we've got to save this" (...) [Instead] you hear, "But we think it will be better patient care. We think it'll improve the service." (..) I mean, who do they think they're speaking to? How stupid do you think we can be, you know? (..) "We think it will improve the standard. We think it will improve things", like complaints, etc. I was thinking, you are clearly mad, all of you (..)

[JM: And do you think they believe what they're saying?]

Of course they don't. How could you? You'd need to be stupid, and I don't believe for one minute, that, um, certain people are stupid. Not for a minute. (..) But wouldn't you have more faith in somebody who was just a bit more honest with you? Because it just feels insulting. (ID073:interview 2:p20-21)

Reducing the number of qualified staff and increasing the number of unqualified staff was felt by the majority to threaten the quality of patient care and patient safety:

I think it's – at the end of the day it's patient safety, 'cause some of the time you just don't have time to look at the patients. But I think on a few occasions we've got one really sick patient, but you've got nine patients by yourself, you end up dealing with one really sick patient, and all the eight patients have nothing done all day, that's the problem (...) (and) yeah, not good quality, you just don't have the time to deal with all the patients. You end up – don't have time to talk to your patient, and you just go over to do your task. It's more task-orientated, rather than just look at the whole patients. So, you just go in, I do my dressing, it's done, it's done. (...) Have to run across and do something else. (ID079:interview 2:p8)

I'm in charge quite a bit, and I just think, because they're taking a nurse away we can't leave them to do PCA obs, or things that you could do, a nurse. So I think some jobs are getting more task-orientated, so I will be more – doing all the IV antibiotics, and all the drugs, and they'll be doing all the obs, and things like that (...) I just think – I think something is – I think it's going to be quite unsafe, but [laughs]...” (ID019:interview2:p2-3).

For some the changes had already been implemented, with the resulting impacts on care that many feared. When asked to describe their worst experiences, they suggest that these are the tasks left undone:

I think the skills mix ... the changes, yeah. (...) That does have quite an impact. I just don't have – I feel, like, that I don't have time for my patients. (...) We used to talk about, ask them about different things, how they feel. Probably sometimes just don't have the time to do it, you don't have time to sit down, talk to them. (...) Or sometimes it's like, you're just like so busy, there's – don't, really important, they ask you, they just think that, hmmm, he's too busy. (ID079:interview2:p26)

If you usually, you look after six patients and sometimes we may get ten or 12 (...) So, we will not have enough time to give the proper care of, to talk with the patient or really – well, to understand the problems, we just go and give medications, and we just go and give the care and that's it (...) and that's not good at all (...) We need to understand what the problems they have, and we need to find out what exactly the problem is, but as a nurse I didn't get time to do all these things. (ID059:interview2:p8)

Nurses felt the key difference between their knowledge and training and that of a healthcare assistant was that they knew why they were undertaking certain tasks, which enabled greater awareness and interrogation of their observations and data, and ultimately better patient care:

You know exactly what you're doing, rather than just know the skills, know the technical skills, or just, like, think about doing ECGs. Lots of people can do ECG, a healthcare assistant can do ECGs. But if you have done the course, you know what are you doing and what are you looking for (...) you can train a healthcare assistant to do lots of things, but they just don't know, what's that for? I think that's the difference for qualified staff and unqualified staff. (...) Yes, just put it on there, there, there and there, that's the ECGs, just put the stickers on there. But if you don't know why... (ID079:interview2:p50).

There was a sense of powerlessness voiced by many of those interviewed about the perception that, as suggested above, their seniors were not being honest with them. There was a lot of effort by senior managers to disentangle the skill-mix changes from the need to save money throughout the trust. This was not believed by staff on the ground, who linked the need to save money with the changes:

So now I've been on the ward for a year, as you just said. Um, obviously with the way things are going now with the whole, well, the whole NHS and every trust, it's all a bit – trying to save money where they can possibly. So in the next couple of months there's going to be a new change to our ward anyway, 'cause they're not recruiting anymore, and they're taking a nurse away from each shift. And we're having nurse care assistants, um, instead. So that's going to be new to us. (ID019:interview2:p2)

Regarding the idea that the new changes would improve patient care, staff noted not only the detrimental impact they felt the changes would have or were directly having on patient care, but also indirect influences from such changes. These indirect influences were identified by staff as the added pressure on trained staff to be doing more of the technical tasks, such as medication and skilled procedures, for more patients, thus increasing their workload and productivity, but also through having to supervise, monitor and train the new nursing assistants:

The people those who are coming newly to their new situations, for them it's not their fault, I would say. (..) So we have to tell them each and everything what we have to do. At the same time, we have to do our own work as well. (ID094:interview2:p13)

Many anticipated increased rates of stress and illness in the nursing workforce as a result:

I think it's going to be more stressful. (ID019:interview2:p2)

That really caused mental stress to every one of us (...) – yeah, from the lower level to the manager, managerial level (...) in our ward actually, they reduced 12 beds. They cut 12 beds and they reduced 12 staff from the ward. (..) Yeah, so, well, we were asked to, um, give our choice to go [to] some other wards, and many of us were moved from a ward. No, I was not moved because I was pregnant, but that really affected me. I think that was the reason for my increase in blood pressure. (...) I was stressed. Yeah, I think that also have affected my blood pressure stuff, so in the hospital they were asking "Anything which worried you?" or something like that. I think it's worried me so much. (ID059:interview2:p5)

Some suggested that the real costs of the changes were hidden through staff working harder and coping:

There's the aspect of it being a vocation, rather than a job as such, you know. It's like, um, rather than not doing the things that you don't have time to do, thereby leaving a picture that reflects the fact that you're, you know, you don't have time to do it, is cramming it in and doing it all so that the picture's actually a bit skewed. You're working really, really hard and making it look like you're managing, when actually you're not, you're, you know, if you took your breaks and, you know, worked at the correct kind of pace without rushing, you'd not do all these things, and you'd be able to see that. (ID084:interview2:p24)

But many noted the changes' effects on nursing workforce morale, and said that physically nurses could only be pushed and push themselves so far before there were consequences for their health:

I think a lot of nurses probably lose their focus and lose their faith. I mean, you're on an elastic band: how far can you stretch before it twangs? (ID083:interview2:p71)

The following nurse's comment reflects the mood of many interviewees at the time:

I think the wards are really struggling with it, especially because, um, a lot of them are like quite young, 17-year-old girls sort of thing, who just can't cope with a 12-hour shift, let alone having to – everything else that comes along with it really. I think they are really struggling (..) – as it stands at the minute, 'cause they've only been there a couple of months they have to second-check everything, so there's nothing that they can actually do, really other than, I suppose – I don't know, no, nothing really. They can't do obs without being re-checked, and things like that (..) I don't how useful they'll be really in the long-term. And especially because, as it stands, normally there were four staff nurses on a shift, now there are three and an untrained. So you're short, and they can't do IVs and meds and things like that anyway, so...

[JM: So, what's the word on the wards then?]

Not good [laughs]. Not a good word really. I think everyone's just finding it really hard; the morale is really low. (ID077:interview2:p9)

Thus morale was largely fine at interview 1, with staff full of hope and expectation. By interview 2, for many the situation had changed. Clearly this was not helped by the overall national climate and media reporting regarding the financial crisis in the NHS. Whilst the trust has done well to avoid redundancies, this was not mentioned by interviewees, rather they were very concerned at the perceived job instability, the need to save money within the trust and staffing changes that were affecting morale, which was described in many settings as 'low'.

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## 14. De-motivators in nursing

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The nurses in this study were not specifically asked if they were de-motivated or what de-motivated them. Rather, the issues presented in this section emerged from analysis of the whole data set. Results were found primarily from questions such as “What have been your worst experiences?” (as opposed to best experiences, presented above) and from a category developed through the analysis detailing negative experiences and any reported frustrations. Finally, at interview 2 the issues that emerged during discussion of the financial savings the trust was making, and the perceived impact of this on the quality of patient care, also presented aspects of a de-motivating environment and de-motivators in nursing.

At interview 1, the worst experiences described by interviewees included:

- Lack of support, including unsupportive or untrustworthy colleagues
- Poor skill mix and heavy workload
- Lack of cleanliness or hygiene
- Abusive and aggressive patients
- Feeling useless and not able to fully practice (mainly IRNs during and just after adaptation)

At interview 2, the worst experiences mentioned were:

- Feeling stressed
- Carrying people, doing other people’s work
- Feeling unheard, or feeling as though nurses can’t change things in ward or trust; includes changes proposed as a result of need to make financial savings
- Poor leadership or manager
- Poor skill mix, the stress of having to support others
- Lack of professional development
- Feeling more could be done to help patients, dissatisfaction with care given

Many of these have been highlighted in the preceding sections, but the data illustrating participants’ perceived ‘worst experiences’ illuminate these issues more clearly:

[JM: And thinking about the worst experiences then, what would they have been? What’s been most difficult?]

Um, it’s hard to – or should I say, it’s a bitter pill to swallow sometimes when you know somebody’s not doing their job as good as what they should be, do you know what I mean? And you have to put yourself in that position that they’re not the same person as you and that is hard sometimes, um, you know, and you think “I would have done this differently, or I would have done that differently”. (ID083; interview2: p43)

A nurse who had already been on another ward detailed the effects of poor leadership and management:

X (manager) on Y ward, who I just have very little respect for, and just get the feeling that there's no point asking her something, 'cause she doesn't always know the answer and better to ask someone else, which is sad.

[JM: And so what effect does that have on the team, do you think?]

Um, my observations are, people don't root together, they – when she's on the ward she seems to be that she does purely things like the ward rounds, doctors' rounds, but the problem is, she still doesn't know the patients, um, and there's no communication between the staff and between her.

And, at times it's a horrible place to work, absolutely horrible. I mean I've seen people go off the ward crying, you know, things are just happening that shouldn't be happening on there. It's dangerous.

...What sort of things though?

One nurse said, "Oh, her breathing's not very good." So she went up to this patient and put the oxygen saturation on. She goes, "Oxygen saturation 70%; don't you think you should put her oxygen on?" And, um, the other nurse goes, "I'm busy; I should be having my lunch." You know, that shouldn't happen. In the first place she shouldn't even be able to say that in the first place.

And I don't think that's purely from her own, you know, her own doing. If someone had given them leadership and saying, you know, "You need to have your lunch breaks here and here where necessary, um, but, provided that the place is safe before you leave." (ID076: interview2: p9).

A nurse described the impact of the skill mix changes as their worst experience, even though they had only been in place for 4 weeks at the time of interview:

[JM: What you would say have been the worst experience?]

I think the skills mix ... the changes, yeah. That does have quite an impact. I just don't have – I feel, like, that I don't have time for my patients. We used to talk about – ask them about different things, how they feel. [Now] probably sometimes just don't have the time to do it, you don't have time to sit down, talk to them. Or sometimes it's like, you're just like so busy, there's – don't, really important, they ask you, they just think that, hmmm, he's too busy. So, I'm not for them. (..) That's what I feel for the last, about four weeks. It's not a long time to do the skills mix, but I can see quite a big impact. (ID079: interview2:p26).

The worst aspect of work for another nurse was a lack of support:

The most disappointing thing that I've found over the last year is just, um, basically the lack of support that I thought I was getting, which didn't happen. Um, whether or not it's anybody's particular fault it doesn't matter, the fact is that I haven't felt like – I haven't felt completely welcomed, um, as a general. I mean some people have kept me more welcome than others, but just not feeling very, very welcome on occasions and felt like I'm just there to make up numbers and I don't like that. So that's probably been the most disappointing. (ID086: interview2:p40)

Details of the worst experiences and aspects highlighted at interview that were de-motivating have been given to further support and highlight factors influencing staff motivation and retention. Participants were also directly asked to detail and describe good working environments.

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## 15. What makes a good working environment?

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Participants in this study were asked what they felt made a good working environment, and also how to retain nurses in the trust and indeed in the profession. They were also asked to identify what trade-offs they would make and what aspects of their work were important to them in their posts in the trust. Unsurprisingly, many aspects of these three questions showed significant overlap; therefore significant responses to these are presented here. Where aspects were only mentioned in one area or another (i.e. no overlap) this is highlighted. Where issues were mentioned only at interview 1 or 2 is also highlighted, but most were identified consistently at both interviews.

- Good team, good teamwork; staff help each other, are friendly and offer camaraderie
- Good support and feedback
- Adequate staff, with good ratios and safe staffing levels
- Good staff development and education; feeling stretched, learning, being developed
- Good management that is approachable and supportive
- Feeling valued and appreciated
- Ability to give good quality care and to make a difference to patients
- Flexible working (in trade-offs and what retains nurses only)
- Well-equipped unit (in good environment only)
- Good communication (in good environment at Interview 2 only)
- Quality staff (in good environment at Interview 2 only)

The majority of these fit into the intrinsic motivators already highlighted in this study, giving further credence to this analytic framework of meaningful work, progress and seeing improvements, healthy relationships and feeling valued. Another approach towards understanding the motivations of staff from the human resources management literature is the psychological contract, which is now addressed.

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## 16. Psychological contract

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The psychological contract focuses on the implicit or unwritten aspects of the employment relationship. This is rarely included in formal employment contracts, yet because it considers what employees really expect from their work, it is one way to examine what happens to workers' motivation and behaviour when this implicit contract or 'deal' with their employer is enhanced or broken. (Conway and Briner 2005).

In this study I asked interviewees to tell me what they expected from their employer and what their employer could expect from them.



## 16. 1. Staff expectations of employer

Many of the expectations staff had of what their employer should provide reflect issues already highlighted that intrinsically motivate staff. These included:

- Good leadership and management
- To be supported in their work
- To have their concerns listened to and acted upon
- To be developed and facilitated to keep skills up to date
- To be treated fairly
- To have access to sufficient good quality equipment
- To have access to enough good quality staff with a good skill mix to enable provision of quality care to patients.

[JM: What else do you expect from your employer?]

Um, hmmm, I think the things I've been saying before, you know, being able to do training, career and progress. 'Cause it's important to me, it's not important to everyone, but, um. And if I've got problems at work, then I expect someone to listen to me and help me overcome them, um, whether it's personal or professional. Yeah, err, a happy workplace, if it's possible [laughs]; not always possible.

[JM: What makes a happy workplace, would you say?]

Satisfied staff, good management and respect.

[JM: And how do you get satisfied staff?]

I don't know, probably from – for me it would be, well, I'd just see it about having my, um, being able to voice my problems. Have them listened to, um. Getting help on the ward from more senior staff, having the senior staff there in the first place to get help from. Um, and just feeling that the day-to-day running, err, of the ward or unit, is going smoothly and, at the end of the day, I've achieved what I wanted to achieve. (ID076:interview2:p27)

I just basically expect, err, how can I say it? Err, I expect that I get given options of developing a path for, err, better improving myself sort of thing. Um, I expect that, some ways – not just one way of doing it, but, you know, having options of how I want to develop basically in my own profession, um, and the support for staff to do that. And, you know, people sort of say, "Ooh, look, you should be doing it this way", just the support and the advice on which way to go. Does that make sense? (ID086:p38)

Issues mentioned in this section that were not mentioned in any other areas of the interview included:

- To be paid
- To have uniform laundering and changing facilities
- To provide a safe workplace with security
- To provide a clean workplace

For my staff to feel safe, um, in every sense of the word. I mean, for example, and I don't know if you're aware, but a couple of nurses on A were attacked, and one of them had her arm broken in half by a patient. The patient is still being treated here, and nearly a year and a half later the nurse still can't return to work because her injuries are so bad. Um, and so, they put alarms in here (..) and what happened, a patient went to attack one of my nurses with a stick last week, and she pulled the alarm and it didn't work. So no security came. So what kind of message is that that we're giving? (ID073:interview2:p56)

Um, a safe workplace, I guess. Being able to have, especially around here, have security around, and things like that, so you know people are around if something happens. Um, a clean workplace, so we have domestics on hand, and things like that, (..) To be paid! [laughs] (ID077:interview2:p38)

## 16. 2. Psychological contract breaches

Unsurprisingly, violations of the psychological contract identified in this study correspond to nurses' expectations not being met around key aspects of a good work environment and around other aspects identified as crucial to retaining nurses that were highlighted in the section above. These included adequate staff:

Also just, well, I suppose basic – do you have the staff around you as well to work with, as there are times when you come on and there's only you, and maybe a cable nurse, or you with one other staff member. (ID013:interview2:p20)

Another nurse discussed what she considered adequate and inadequate support, contrasting the two wards or units she had worked on in the trust:

I've been quite surprised about how well I've been, like, sort of, not just, sort of, taken into the routine really here, as opposed to being on the ward. I think it's 'cause there's quite a lot more managers down here, maybe, or I don't know, or it's a better manager, or support, or whatever, but upstairs you're very much left to fend for yourself and not treated particularly well, um, on the wards, I mean.

[JM: In what way? Give me an example of what you mean by that?]

In that you don't, in that you don't know what you're doing from one day to the next. You don't know, you're like – you're not taught, nothing's explained to you, nothing's consulted to you, like you don't know where you're going on rotation, and you don't know how many people are going to be on the shift the next day. Um, just trying to book nurses for cable shifts and bank shifts, you can't do and there's no one around to help you do that, and no one around to do it for you, whereas down here if you need a shift covered, then you just get in contact with someone and they cover it; do you know what I mean? It's very much – you're much more looked after down here than I have been anywhere else. Um, which I'm pleased about here, but also, quite disappointed about being upstairs, like, and not having any support. (..) And when I talk to people who I still know on the wards, I can't believe that it carries on, do you know what I mean? (ID077:interview2:p23)

Many came into the trust expecting staff development opportunities, as the trust had a good reputation for this. For some, this was key to attracting and recruiting them. At interview 2 some therefore identified the lack of training and staff development as problematic, with access perceived to have been curtailed by the trust's financial difficulties:

I want to gain the best knowledge that I can so that I can input that to my patients, and for me to understand myself, as well as being able to pass on to other members of staff, you know, that's the way that I see that you should learn for them very reasons.

[JM: And what's the barrier to you doing courses, would you say?]

Well, there's no money. There's people queuing up to get on courses. (ID083Interview2:p7)

This nurse went onto say that the lack of development opportunities demotivates staff:

I think that if you are on a ward or in an area where, you know, you want to do more and you want to progress and you're being held back, then I think that that just demotivates people, and they're going to feel like they're not getting the best out their working environment. (ID083:interview2:p62)

Others had not been facilitated or supported by their managers to access staff development opportunities:

I've done, like, in-trust things, but I haven't done any courses or things like that.

[JM: Right. And how did that feel?]

Well, I was a bit annoyed about that [laughs] 'cause they do say that when you start, you should be doing lots of things and, um, just because, I think, mainly because there was lack of support and direction on B, I didn't end up applying for things and didn't know about things. Um, and then once I got upstairs to A R, the sister was like, "What do you want to do, and you need to do this [to do it]", so that's why I've managed to get on the course for January. (ID077: interview2: p14)

Apparently small aspects and details of the work environment can create good will and employee engagement; or, conversely these can destroy it. Several interviewees at the time of second interview raised the issue of provision of tea and coffee on the wards, highlighting an email received suggesting staff were no longer entitled to free tea and coffee:

[JM: I wondered if you could just talk me through some of the things you think, start wherever you like, what you expect from them?]

I expect tea and coffee [laughs]. Lately there's been – I haven't received an email, but I've heard some people have, about provision of tea, coffee and hot water and that nurses are not entitled to it, and they must bring their own tea and coffee and use the microwave to nuke their hot water. And I think it's disgusting [laughs], basically.

[JM: Tell me why?]

Because I think we're entitled to basic things like tea, coffee and water (..) – I just expect it really. I think it's cheap and I think it's a way of easily keeping your staff satisfied". (ID076:interview 2:p26)

Those who left the trust signalled that there were psychological contract breaches around those aspects previously identified as part of a good working environment:

I think just the frustrations of the lack of support, yeah, and just the complacency within the NHS. I think the management, you know everyone talks about the complacency and you just learn to ... sometimes you just adapt and you become complacent as well, but yeah, I think that's just really frustrating, just trying to get things done and they take forever and nobody really has responsibility for their own job, they always brush it off to somebody else, and I get frustrated when you're trying to change things and improve things, yeah. (ID007:interview2:p7-8)

Asked if she would have liked an exit interview, she suggested there would be little point in having one with her current manager:

I don't have a lot of faith in, probably, in the exit interview idea because I don't always know that things would be actioned if you made suggestions, I don't think they'd be actioned in our department anyway because you're leaving, so what does it matter what you thought. But then, you know, I know that the NHS is trying to keep hold of their staff and find out why they are leaving, so perhaps an interview with HR would have been good. I don't think it would have been any use having an exit interview with B because he's very negative and domineering. (..) He doesn't really support you at all so, you know, I don't think that there would be ... I don't think he's interested in

taking on any changes or developing the team so I don't think that would achieve much at all. (ID007:interview2:p9)

Another interviewee left the trust after 14 months, as he did not feel the trust treated him fairly. One aspect of this was not receiving adequate recompense for his skills and feeling undervalued. He was promoted to a band 6 post but the date for his increment was changed. It was suggested by Agenda for Change personnel that the trust could easily obtain another band 6 nurse:

One thing that really annoyed me: um, my increment date would've been the July, but I took a promotion in the March. So, there was an increase in pay from the band 5 to band 6 and, err, I think you go up a point as you go across. But they then decided that my increment date would then be March. So for the coming July there wouldn't be the, um, financial reward for being in the trust for one year, which I thought was pretty rude. Um, I think the department tried but were having a headstrong battle with HR and Agenda for Change, who didn't want to have anything to do with it. And basically suggested that I could, um, resign and they would get somebody else from outside the trust that would then be paid a lower band 6 than I was being paid, so they weren't bothered at all. Like, seriously, were, didn't – that's it. HR could see my point of view, but they were stuck, and it was purely Agenda for Change. They made that decision and they made the suggestion. And it was advised that I took the role for my, um, professional development.

[JM: Right, rather than financial reward?]

Yeah. Oh, no, no, it's possible in nursing it's not all about finance, but you get to an age where I think you do want some kind of financial reward and achievements for what you're doing and I didn't feel I was getting that so, that was, I think, probably one of the largest discrepancies, um...

[JM: So, how did that make you feel when they said that?]

Um, really pissed off. Very undervalued and just not worth what you're doing. It's like, they know they can get someone cheaper and that's all they're bothered about, and possibly not quality. (ID010:interview2: p3)

Other factors in his decision to leave included feeling stressed because of 'carrying' staff who were not performing their duties, and because lack of staff to support him and the rest of the team:

I had felt quite stressed in the role that I was doing; not overly, but having had resigned felt a huge weight of relief. So you can kind of see what was happening, and also seeing older nurses around me that looked stressed and I still see them as being quite stressed, but I kind of figured I didn't want that.

[JM: And apart from the things you've already talked about, what are those stresses, what were those stresses?]

I think support, in terms of not having enough staff of the same banding, of the same quality to support you. Um, there should have been, and they said three of me, but there was one to support the senior sister. (ID010:interview2: p5)

Other staff were close to leaving, and sometimes there was a 'final straw' which may have been the result of a series of breaches of the psychological contract. Some of these breaches were shocking to the interviewees, likely because they would have taken the presence of, for example, support from other colleagues for granted. One participant described a difficult incident with a violent patient where other colleagues did not provide support or physical help, and which in turn almost made her decide to leave. Intervention by a manager she felt listened to her prevented her departure:

Before Christmas I would have been saying that I was leaving (..) because I went through a process and I was totally fed up and (..) I had a rough week, one of the

patients, that same patient, lack of nursing support, having to yell at nurses to get me a security officer. Given they were just standing there watching me. You know, I had to yell out the number to them because they didn't even know the number to dial. And I was adamant I got someone then and there. You know the doctor getting frustrated as well. (...) Because they were literally sitting at the desk and I was in front of them having to half-restrain the patient, we're not meant to restrain them in the first place, and saying Get me security now; and then only one security turns up. (...) (I was) totally frustrated and the whole week had just been a series of nursing staff not helping me (...) totally unsupported. Spoke with the matron, and it was a bit hard to just put it down, [that] it was a horrible week. I had students as well and they were deeply dismayed with what was going on.

[JM: And how did you resolve that?]

I bought it up with matron, who held a meeting, held a meeting the next day and addressed the issue straight away. I know who I can count on for support now. (...) I think that week I vented a lot of frustrations at the matron. And that one event had kind of been the last straw, and having a breakdown on the ward basically and seeing the matron and saying everything I had to say when I was at my last point. It helped me feel like I was listened to. (ID076:interview1:p30)

### 16. 3. Employer expectations of staff

What staff felt their employer could expect of them included that they would:

- Provide the best-quality and safest care I can give
- Do my job well and work within my limitations
- Turn up on time
- Work well as a team
- Support others, including junior staff
- Have a professional attitude, adhere to a code of conduct or present themselves well
- Have a positive attitude, enthusiasm for my work
- Follow trust policies

I suppose they expect from me that I turn up for work; err, that I'm, sort of, more-or-less on time and reasonably smart and, um, err, actually, that doesn't seem to be something they care particularly about, the smartness or anything like that. I think they're just happy that their employees turn up. Um, and that I do my job; as you know, I'm sort of specified to do it, because with nursing you're left on your own a lot, you know, you're just kind of doing your job and you're not, sort of, reporting to somebody the whole time, and you're just kind of getting on with it. Um, so just that I'm aware of how to do my job properly, I think that's the main thing. (ID 084:interview2:p28)

Some interviewees highlighted that at times it was difficult to fulfil all of these expectations:

[JM: What do you think the employer would expect of you? What do you need to give the employer or do?]

Um, err, the best quality of care that we can give, you know, and just try and keep that care up to date and everything else, and not to go off sick [laughs]. (...) Which, I must admit, is difficult on times like this 'cause, as I say, with lower morale you just don't want to go to work if you're not happy there. Um, and if the – I think if you're motivated better, well, to put across to people that's trying to give, um, patients and their parents and so on a good experience when they come to hospital, and that is also sometimes hard to do, and working together as a team puts that across. But,

um, obviously, not all the team members do that at times... [laughs] (ID 013:interview2:p38)

Careful analysis of the interviews also revealed that other staff not fulfilling aspects of the psychological (or indeed work) contract contributed to staff generally feeling their expectations of the work environment were unfulfilled. This created an indirect psychological contract breach and at times facilitated feelings of unfairness. These included either staff being late, not pulling their weight, not supporting other staff and staff not being up to date and/or adequately trained. Many of these have been highlighted above, but are worthy of note here because of their relationship to the psychological contract, demonstrating that it is not enough for employers to meet the needs and expectations of staff. They also must ensure good management practices are in place, including staff performance management to ensure a culture of fairness and an environment where all staff are supported by other team members to perform their work effectively. This may be particularly relevant to nursing and other healthcare professions, where reliance on other team members to perform well is paramount.

I think coming from a private sector where you're responsible, if you're not performing in your role then you'd be out the door. But I think in the NHS you can just coast along quite nicely for quite a long time, and I think there's a lot of people that do that in the NHS.

[JM: Right, and that's people in your department?]

That's definitely people in my department, [laughs] yeah, which is frustrating and I think then that breeds complacency. Because you see that and think, well, why should I work really hard or stay late or do all this extra work because they're not? But I have a different mindset from that, so I think to stay that would just get on my nerves as well and just wear me down. (ID007:interview2 (exit interview):p8).

I feel like, um, I'm having to carry some of the staff nurses more, in regards, you know, silly fundamental things that, you know, you should be able to identify straightaway, and they're not. So, you're having to, sort of, take over, you know, and some of the situations regarding, sort of, patient care, which people should know better about, it's just not clicking and I just feel like I'm frustrated. (ID083:interview2:p2)

Witnessing poor performance going unchecked and not being dealt with by managers can breach the psychological contract, resulting in withdrawal from engagement with the organisation and its aims. This results in an attitude of 'why should I work really hard?' or 'why do I bother?':

So, yeah, it's just frustrating on so many levels, and there are days when you think, why do I bother? (ID073:interview 2:p20-21)

In more extreme circumstances this can be instrumental in a decision to leave. Nurse 007 left the trust, nurse 073 had seriously considered it and nurse 083 wanted to move wards but to stay in the trust. As detailed above, nurse 010 left after 14 months.

There were many contributing factors in his decision, including not feeling valued or supported. One aspect of this was 'carrying' staff who were perceived by nurse 010 as not being up to working in a theatre environment:

And also, [laughs] sometimes the quality, and it sounds quite rude, but the quality of junior staff that they brought in I didn't think were appropriate (..) in terms of their experience. And I know that they know that they weren't good enough, and despite me saying they weren't good enough or safe enough, they still didn't really listen (..)

[JM: What would your solution to that be?]

Um, sack them [laughs]. (..) Get somebody that was – wanted to do the job and was good enough to do the job, but you can't sack people in the NHS.

[JM: Can't you?]

Well, no, you can't. Well, you can eventually, after probably three verbal, three written and extended warnings, but, um, there was also another member in the department who, um, was continually late by not five, ten minutes, but by half an hour, one hour, um, which would – I don't want to say mess up, but if you're trying to run a X you need somebody scrubbed, someone to run. If you haven't got one of those, nothing happens, delays the list, um, and patient safety more than anything. Err, would be continually sick, or it was felt that, and it's difficult to pinpoint someone's attitude, but their attitude towards staff and patients was not what you would expect in simple terms. And, um, I know in industry or elsewhere there would've been a written warning, a verbal warning and [someone would be] fired. Whereas we had to bend over backwards to come up with a programme to accommodate her lateness and her sickness and to be very, um, open and forthcoming and write a programme and monitor things, whereas really I felt that the whole unit then started to carry her. So instead of having that number, you've lost one and you carry on. And they're still here and – but maybe that's a bit harsh to sack, but I know if someone's not doing their job properly in an office then they go, because they lose money. But I don't know what it takes [at the trust]... (ID010:interview2:p6)

Teamwork clearly cannot flourish where there is no incentive for performance or disincentive for non-performance by team members. Recognition mechanisms and effective consequences for bad work, i.e. dismissal, can help overworked nurses to maintain patient care quality instead of forcing them to compensate for ineffective performance by others.

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## **17. Reasons for considering leaving at interview 2**

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Of the original 26 interviewees, 15 staff stayed in the same posts during the study. Four had left the trust by interview 2 (after 6-14 months), and two more were planning to leave the trust, with another wanting to leave. Three participants had moved to a new ward or unit within the trust and another was looking to do so. Table 10 below details these movements.

**Table 10: Participant movements during lifetime of project**

ID number	Staying in same post	Wants to move	Moved / moving within trust	Leaving trust	Left trust
007					♦
009	Δ				
010					♦
011			♦		
013	♦				
019	♦				
021	♦				
030	♦				
059	♦				
072	♦				
073	♦				
076	♦				
077			♦		
078				♦	
079			♦		
080	♦				
083		♦ (stay trust)			
084		♦ (leave trust)			
086	♦				
087					Δ
088				♦	
090	♦				
092					Δ
094	♦				
095	♦				
097	♦				

Key:

Δ Not interviewed at interview 2

♦ Interviewed twice

Some staff were happy to be staying, considering their ward or unit an “excellent place to work” (ID080:interview2:p9) with excellent support and great staff with a sense of camaraderie (ID030; 077) and also said they had developed confidence and skills there (ID072). Others felt there were opportunities to be had by staying, such as access to education (013; 019; 090) and personal development (095). Still others were staying in the same ward or unit but had considered leaving, although had not got as far as saying they wanted to leave. Reasons for having considered leaving included feeling burnt-out through stress and lack of support (ID073) (021), and feeling unsupported or unrespected by other staff (ID011). This section analyses the participants’ reasons for considering leaving or deciding to leave or move



within the trust. Overall these consisted of the following key reasons, some the opposites of factors highlighted above as making a good working environment or as issues important to retaining staff:

- Unfair practices
- Stress (perceived to result from poor skill mix, poor staffing levels and poor support)
- Not being listened to
- Working with poor quality staff
- Unsafe care
- Job not as expected
- Wanting to get a different experience
- Heavy workload and inability to provide good quality and safe care for patients

Some of those keen to move wards or units were also keen to stay in the trust. Most liked the trust and felt there were good opportunities for them:

I'm still enjoying my job, without a doubt, but I have decided that I'm not going to stay on the ward where I am. I feel, like, err, I need to progress more, and there's not that much of an option to progress further, if you like, on that ward. (..) Um, so, although I'm going to stay in the trust, I'm not going to stay on that ward, I don't think. (ID083:interview2:p1)

There was also the recognition by some that in a difficult labour market, where over the time of the research project it had become an employers' market rather than an employees' market, there may have been better opportunities within the trust than available for nurses moving elsewhere.

Some staff detailed times when they had been particularly unhappy and had seriously considered leaving, but when an intervention by an astute manager had retained them and helped them enjoy their work again. Nurse 086 had very nearly left the trust but had sat down with her manager and had an appraisal and received good feedback, and with fellow E grade staff had created a support network for the four of them which was helping:

We're getting together and talking about it and debriefing, sort of, basically about it and sort of supporting each other, and I think that is the one thing that's the main very thing; we've got that support network and that has made an amazing difference, absolutely amazing difference. But before that, if that hadn't have happened, I wouldn't be here now. I would've been ringing you and saying, "I'm leaving" [laughs], but, um, yeah, that's the one main difference. The support network and that big, um, err, thing with X, with the appraisal. (ID086: interview 2: p25)

Four interviewees were pregnant at second interview. Three were planning to continue to work in the trust after the birth of their babies and one was leaving to get work nearer to where she lived.

During the first set of interviews many staff detailed reasons why they had left their previous posts before coming to the trust. These reasons (push factors)

also give insights into factors that affect nurses' intentions to leave and therefore influence turnover. These included:

- Poor leadership / management
- Lack of feedback / not feeling valued
- Lack of professional development
- Location issues (couldn't be near family / too much travelling etc.)
- Lack of support

Those factors 'pulling' staff to work at the particular case study trust included:

- Reputation for training / educational opportunities
- More challenging patients / nursing
- Opportunity to be promoted
- Reputation for good patient care
- Speciality / patient type
- Location, reduced travelling
- Availability of hospital accommodation

Other factors that attracted staff to the trust included:

- Ease of application (on-line processes)
- Good website
- Response to application was better than other trusts – quicker, more passionate recruiters at recruitment fairs.

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## **18. Summary: Towards policies to support retention**

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Policies to support recruitment and retention in staff were examined in this study but did not appear to have a large effect. Participants were not always specifically aware of policies such as Improving Working Lives, and although many nursing staff supported flexible working and were indeed benefiting from such policies, others felt they were not at a time in their lives to need them.

Some stakeholders felt flexible working was important, and others that Agenda for Change may eventually deliver a career structure for nurses that enables experienced staff to remain in patient care delivery. For the nurses in the study, the Agenda for Change picture was more mixed, with some staff feeling let down by the process and having grievances with their grading.

Broadly, the findings can be summarised as follows: Nurses report increasing stress and disillusionment in their second compared to their first interviews. The interview results in particular revealed a workforce whose pride in their professionalism suffers when they see standards suffer from budgetary pressures, and certainly when they see patients suffer from their speeded-up workdays. Satisfaction from teamwork and from doing a critically important job

very well must balance with frustrations over low pay and deferred development opportunities.

Interviewees focus on positive factors far more than the negatives, however. Good management strategies and a sense of management responsiveness can retain staff – even in cases where nurses announce their intent to leave, as one nurse recounts in detail the happy ending of a horrible day on the ward. In such cases, even conflict or confrontation can be positive, leading to resolution of the immediate issue as well as better cooperation over the long run. Such issues can be quite serious, as in the case of a nurse who demanded action on a trust failure to enforce policies that protect nurses' physical security; this nurse mentions a colleague whose injuries due to such a security failure kept her from returning to the ward for many months.

These interviews detail how frustrations and failures are or can be balanced by encouragement and professional growth. One focus of frustrations was a hierarchy that was felt to at times dismiss the nursing point of view; another focus was intra-organizational competition for resources and control. The dilution of nursing expertise under the official explanation that it is meant to improve patient care incensed some participants. Others mention that the time spent instructing unqualified staff who replaced trained nurses cuts further into patient-nurse interaction time.

Lack of time for patients is a recurring theme, as is a sense of overwork. Being appreciated is important, and nurses in this study report that their work is misunderstood by patients and a public that accepts that nurses should be ever more highly educated, yet remain poorly paid throughout their careers in the profession. Several nurses compare their working conditions to those of their colleagues in other countries, and internationally recruited nurses (IRNs) contribute valuable insights about their expectations and experiences in their work at the trust and elsewhere.

Other interviewees, both nurses and stakeholders, perceive management as devaluing nurses and nursing. Free coffee and tea symbolise the sort of small cost-cutting victory that leads to resentment and, ultimately, defeat in retaining employees. A cup of tea sounds petty until one has worked a 12-hour shift, at which time some transportation assistance to see workers safely and comfortably home seems another reasonable proposal.

If the trust wants a more stable and satisfied nursing workforce, it can choose to focus on a wide range of interviewees' concerns, indeed ranging from tea to safety, to patient care, skill mix and resources. For this reason the policy suggestions are highly tentative and intended to contribute to discussion of nursing retention strategies, and are not meant to represent a hierarchy of interviewees' priorities.

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## 19. Recommendations

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Create a workplace environment that promotes employee engagement by addressing nurses' stated concerns about these issues:

1. **Security and safety** measures protect staff and patients, and the trust can reduce employee stress by:
  - A. Ensuring there are no lapses in security programmes or provision of safety items (safe lighting, door guards, working alarms);
  - B. Ensuring that all employees understand security procedures, such as knowing the security staff's emergency response number and how to safely restrain abusive patients;
  - C. Considering demonstrating the trust's concern with safety by offering practical support to reduce risks, such as providing safe transport (taxicabs, escorts to tube stations) at late hours or after unusually long shifts.
  
2. Creation of and reliance on **feedback mechanisms** can help counter some nurses' (and stakeholders') perception that the nursing staff is not listened to or consulted in policy-making by management. These feedback mechanisms could include:
  - A. A process to welcome and implement suggestions from all staff (via newsletter, an interactive web site, a monthly contest, etc);
  - B. Planning for two-way evaluations during staff appraisals, including regularly (and independently) asking workers how satisfied they are in post, and what factors might influence them to leave or stay (this would include management visibly acting on feedback provided in the regular post-appointment questionnaire data);
  - C. Many large organizations empower an ombudsman to try to mediate or resolve conflicts. Some even have one for issues of professional practice disagreements, and one for employee-management issues. Both of these functions could address concerns mentioned in this study, and offer an always-open door and a sense of being heard by management when staff have conflicts with supervisors.

3. Communication tools such as newsletters and interactive web sites can be used also to address concerns about the trust's uneven provision of **learning and development opportunities**. Information about upcoming programmes, educational media about procedures and skills, and other news should be equally available to every employee, and:
  - A. Where possible, the trust can negotiate at board level for monies for staff education and training to be ring fenced and not used elsewhere for other activities; and
  - B. The trust can ensure that all staff have appraisals and personal career development plans; streamlining appraisal paperwork is another option to achieve this end.
4. Interviewees' concerns about the **fairness of advancement** through grades and bands can be addressed by ensuring that consistent and clearly stated rules are implemented. Again, a feedback mechanism is needed here for disputed cases or if an arena for appeal is felt to be needed.
5. Because **feeling valued** is a major factor in employees' commitment to a particular workplace, the trust can examine factors that can make management more supportive:
  - A. Increase management support through higher visibility; for example, occasional front-line rotations (spending a shift or a longer period in a busy ward) would address complaints that managers don't know what their nurses are up against.
  - B. Raise the profile of issues such as 'feeling valued' across the trust, so staff and managers are aware of the importance of this concept through, for example, presentation of research findings, training and personal development.
  - C. The loci for feeling valued should be expanded, with employees being encouraged to nominate their peers for regular performance awards, trust media sharing stories of teamwork or other celebrations of outstanding nursing.
  - D. Units or wards that experience unusually high nursing turnover might benefit from special attention to management-employee relations, and from a trust damage-control intervention to stop employees, stressed by the high turnover, from leaving themselves.
7. Interviewees' concerns of a non-transparent performance management culture need addressing; some staff's poor performance is not perceived to be managed whilst others' excellence is not always recognised or valued. Management of poor performance can be addressed by greater support and training for managers on such

difficult human resource issues, and by transparent and fully implemented guidelines. This may require increased human resource support for managers.

8. Trust managers could compare the **psychological contract** that they are perceived to be offering with the more open and stated conditions of work. This perceived but unstated contract attracts new employees, but as interview 2 showed, high hopes for development and that the trust can provide the best conditions for patient care can lead to later disillusionment and untimely departures.
9. Although **pay levels** were mentioned by a small minority of respondents, if the trust is to continue to offer current compensation while increasing the workload and stress of highly trained staff, it may well face competition from other employers in terms of keeping nurses in post. This may be particularly true with the increasing number of foundation trusts in London that can each set local pay.
10. In this light, provision of coffee, tea and other “**comfort benefits**” such as the transportation options mentioned above could outweigh the cost factors involved in replacing and retraining staff frustrated with perceived deterioration in nursing conditions. Other initiatives to recognise and support nurses, such as subsidised transport for nurses travelling to work on rail and tube, could be explored with the mayor of London’s office.

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# Appendices

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## Appendix 1: Participant information sheet

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## Participant Information Sheet Nurses Joining the Trust

### Study title:

**Employee engagement, turnover and retention in the nursing workforce:  
A case study of an inner London acute trust**

### Dear Nurse

You are being invited to take part in a research study. Before you decide if to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me (details at the end of this sheet) if you would like more information or have any questions. Take time to decide whether or not you wish to take part.

*Thank you for reading this.*

### What is the purpose of the study?

The research project is being carried out at the London School of Hygiene and Tropical Medicine, a post-graduate medical school, and is being undertaken by a nurse researcher. As you may be aware there are nursing recruitment and retention challenges across the whole NHS, and these are particularly pronounced in some cities, especially London. The vacancy and turnover rates in London are higher than in other parts of the UK (twice as high as the NHS average for some occupations) and there is greater reliance on agency and international staff. This trust has been selected as a case study for this work as it represents an average trust in terms of recruitment and retention difficulties in London, and because there are a number of policies being implemented in the trust that may be expected to influence the retention of nursing staff. This study wants to try and understand employee engagement, turnover and retention in the nursing workforce within the trust.

Employee engagement is a term that is used in the business world more than in public services, and it includes employee commitment to the organisation and organisational citizenship behaviour (OCB). OCB consists of a large

group of behaviours, ranging from helping colleagues to conveying a positive impression to others of the organisation.

This research wants to investigate why nurses join a particular trust and why they stay, and why they may leave. Some research suggests that employees will be more committed if there is a good match between what the person is looking for in a job and what the job provides, and the concept of the 'psychological contract' – i.e. what employees are promised and expect, and what is delivered by an organisation – is very important in determining employee commitment and retention of staff. However, we do not know if this is true for nurses, and most research that has been done has been through one-off questionnaires. It is hoped that by offering interviews to staff joining the trust over a two-year period with an independent researcher, then nurses will feel more able to be honest about their reasons for joining and for staying or leaving, and we will be able to determine much more about nurses' engagement and commitment to work. Ultimately it is hoped that this research will contribute to improving nurses' working lives.

Other aspects of this project include interviewing nurses leaving the trust through 'exit interviews' with the researcher and interviewing nurse managers expected to undertake 'exit interviews'.

### **Aim of the study:**

To determine characteristics of employee engagement in the nursing workforce in an inner London trust and the effects of trust and government initiatives upon nursing turnover, intention to leave and retention.

Specific objectives:

1. What keeps nursing staff engaged in an organisation and what influences NHS nursing staff to leave or stay in post?
2. What are the trade-offs that staff make in their assessment and decision to leave or stay?
3. When does intention to leave set in?
4. What effect does met or unmet expectations about a role / job have on people's intentions to leave / stay?
5. What are the effects of trust and government initiatives on employee engagement and intention to leave / stay?
6. To identify:
  - (i) Trust policies that may impact upon retention, employee engagement, and turnover of nursing staff
  - (ii) The retention strategy of the trust

### **Why have I been chosen?**

You have been identified to the researcher by the human resources department in the trust as someone who has just joined the trust or is about to join the trust and who will be attending one of three corporate induction days over the next few months.

The researcher will be attending your induction day and will provide more information about the study then, but wanted you to have the opportunity to

find out more about the research prior to that day, and to see if you were interested in taking part.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your current or future employment in any way.

### **What will happen to me if I do take part?**

If you decide to take part you will be asked to let the researcher know that you are willing to take part (either by returning the attached slip in the FREEPOST envelope, or contacting her by phone or email or letting her know at the induction day). Taking part in the research will mean sharing your views on your decision and reasons to join the trust with the independent researcher named at the end of this sheet. It will also mean ideally meeting with the researcher after you have been in post for between 2 and 4 months, 10-12 months and after 2 years with the trust, or sooner if you decide to leave earlier. You will be asked to reflect on your time with the trust and share your experiences of being a nurse within this trust. This will be done through a series of face to face interviews with the researcher, up to a maximum of 3 times over a two-year period. This is nothing like a job interview and is more like an informal chat about the issues involved.

The interview will be carried out at a place that is convenient and preferable to you, either at your place of work, an independent room within the trust, your home or another quiet place where your views will not be overheard. The interview should last no longer than approximately one hour, and it will be audio-taped with your permission to provide an accurate record of the information you have shared with the researcher. After the interview the audio tape will be listened to and the information on it transcribed by the researcher or research secretary. The transcription of the interview will then be analysed by the researcher.

### **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential and secured against unauthorised access. Any information that is collected will have your name and (where applicable) your address or place of work removed so that you cannot be recognised from it. Other colleagues, including those in human resources and in the nursing directorate, will not know if you decided to take part or not. You will be given an identity code by the researcher which will be used on all forms of data, including tape recordings, to protect your identity and create anonymity for you. Your name, nor the trust name will not be identified in the findings of the research or the final report.

The researcher will explain the study before the start of each interview and you will have the opportunity to ask questions. You will then be asked to sign a consent form agreeing to participate.

### **What will happen to the results of the research study?**

Anonymous results from the study will be presented to key people within the trust such as the Director of Nursing and the Director of Human Resources. You will not be identified in any way and great care will be taken to protect your identity if certain remarks could make identification possible. At the end of the study the findings will be written up into a report which will be submitted to the research funder, The Health Foundation (a charity). The findings will also be published in academic journals and presented at professional and academic conferences. However, neither you nor the trust in which you work will be identified in any reports or papers emanating from the research.

Data from the interviews (anonymous) will be kept for 10 years in accordance with university regulations and then destroyed. In view of this we will need your consent to these arrangements.

### **Contact for further information**

If you have any questions regarding this study, please contact the researcher, Jill Maben, either by telephone (0207 927 2305) or by email ([jill.maben@lshtm.ac.uk](mailto:jill.maben@lshtm.ac.uk)), or by asking at the induction day or by using the enclosed FREEPOST envelope.

Thank you for taking the time to read this information.

Dr Jill Maben  
Principal Investigator

This study has been approved by East London and the City Research Ethics Committee.

Indemnity is provided by the London School of Hygiene and Tropical Medicine

**You can keep this information sheet and you will also be able to keep a copy of your signed consent form if you decide to take part**

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## **Appendix 2: Questionnaire for new nurses administered at Trust induction**

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I.D. Number

### **Employee engagement, turnover and retention in the nursing workforce: A case study of an inner London acute trust**

### **Questionnaire for nurses and midwives joining the trust**

#### **Who should complete this questionnaire?**

Qualified nurses and midwives new to the trust who have received a participant information sheet about the above-named study and who wish to participate in this research project.

#### **Why is the information needed?**

The information you provide in this questionnaire will help the researcher select from those of you who wish to participate, a varied sample with a range of different nursing, midwifery and personal backgrounds and a range of grades and clinical areas for the next phase of the study, which will be face to face interviews.

#### **Completing the questionnaire**

This questionnaire should take approximately 5-10 minutes to complete.

For each question please tick clearly inside one of the boxes using a black or blue pen. In some cases you may be asked to circle the appropriate number.

Don't worry if you make a mistake; simply cross out the mistake and put a tick in the correct box.

**Thank you for your time.**

**Your answers will be anonymous and confidential**

**Data will be coded for anonymity and kept confidential within the research team**

I.D. Number

**Section 1: General Information**

1. Please indicate your gender

Male  Female

2. Please indicate your age last birthday by ticking the relevant box: *(please  one only)*:

16-20     21- 25     26-30     31-35     36-40  
 41 – 45     46-50     51-55     56- 60     61- 65  
 over 65

3. Please state the name of the ward / clinical area in which you will be working.

.....  
.....

4. Please indicate whether you have worked in this trust before.

Yes, I have worked in this trust before

No, I have not worked in this trust before

If Yes, please state when this was and for how long (e.g. 1996-1998)

.....

5. Please state where you obtained your nursing / midwifery qualifications (state/country) and in what year.

.....  
.....

6. Please indicate whether you have previously worked outside of your country of origin.

Yes, I have worked outside my country of origin before

No, I have not worked outside my country of origin before

If Yes, please state **where** this was (country) and for **how long** (e.g. 1996-1998)

.....

I.D. Number

7. Please indicate the type of contract under which you have been employed (please  one only):

Permanent  Under contract for a fixed period

Seconded  Bank or agency  Don't know

8. Please indicate the nursing/ midwifery grade / pay band under which you will be employed once you complete your supervised practice period (please  one only):

D grade  E grade  F grade  G grade  H grade  I grade

Band 4  Band 5  Band 6  Band 7

Band 8 (range 1)  Band 8 (range 2)  Band 8 (range 3)

Band 8 (range 4)

Other (please state)

.....

7. What will be your job title in this trust?

.....

.....

8. What are your reasons for coming to work at this trust? Please give as much explanation as you can.

.....

.....

.....

.....



.....

I.D. Number

**9. Please indicate if you would be willing to take part in the next phase of this research study:**

Taking part in the next phase of the research means the researcher would like to speak to you when you have been working in the trust for around 2-4 months via a face to face one to one interview. You will be asked to share your views on your time in the trust and your experiences of being a nurse in the trust. Ideally the researcher would like to speak to you again after 10-12 months and again after 2 years, but agreement to participate now will not be binding in the future and you will be free to withdraw at any stage. The interview will be undertaken at a time and place convenient for you and will with your permission be audio-taped. Each interview should last no longer than 1 hour.

- I would be interested in taking further part in the research study
- I am not interested in taking part

If you are interested in taking part or in discussing this further please complete the following details which will help us contact you at a convenient time:

Your name:

.....

Your telephone number.....

Your email address

.....

Best times to contact me are:

.....

If you have any questions or queries please do not hesitate to contact on 0207 927 5203 or at [jill.maben@lshtm.ac.uk](mailto:jill.maben@lshtm.ac.uk)

**Many thanks for your time and co-operation in completing this questionnaire**

Jill Maben, Lecturer, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT.

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## Appendix 3: Participant Consent form

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### London School of Hygiene & Tropical Medicine

(University of London)  
Department of Public Health and Policy  
Health Services Research Unit  
Keppel Street, London WC1E 7HT

Tel: +44 (020) 7927 2305 (Direct)

Fax: +44 (020)7580 8183

Email: jill.maben@lshtm.ac.uk



**Study Number: 05/Q0512/48**

**Participant Identification Number for this study:**

## CONSENT FORM

**Employee engagement, turnover and retention in the nursing workforce: A case study of an inner London acute trust**

**Name of Researcher: Jill Maben**

Please initial box

1. I confirm that I have read and understand the information sheet dated June 2005 (version 2) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my employment or legal rights being affected.
3. I agree to the audio taping of any interview in which I participate and to the data being used for research purposes.
4. I agree to the data being kept for 10 years and then being destroyed and understand that all identifying information about me will be removed to protect my identity.
5. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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**Appendix 4:****Table 11: Time of interviews after first starting in the Trust**

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<b>Interviewee</b>	<b>Interview 1 (months after start in trust)</b>	<b>Interview 2 (months after start in trust)</b>	<b>Adaptation undertaken (IRNs)</b>
ID007	3 months	9 months	
ID009	6 months	X	
ID010	4 months	15 months	
ID011	4 months	17 months	
ID013	4 months	15 months	
ID019	3 months	15 months	
ID021	3 months	15 months	
ID030	6 months	17 months	* completed by interview 1
ID059	7 months	18 months	* completed by interview 1
ID072	7 months	15 months	* completed by interview 1
ID073	3 months	17 months	
ID076	6 months	17 months	
ID077	7 months	17 months	
ID078	6 months	16 months	
ID079	3 months	14 months	
ID080	5 months	16 months	
ID083	4 months	14 months	
ID084	3 months	14 months	
ID086	2 months	14 months	
ID087	3 months	X	
ID088	2 months	14 months	
ID090	5 months	16 months	
ID092	2 months	X	

ID094	7 months	15 months	* completed by interview 1
ID095	6 months	16 months	* completed by interview 1
ID097	5 months	16 months	* completed by interview 1

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**Appendix 5: Table 12: interview dates, order and months between interviews**

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Participant ID codes	Interview 1 order	Interview 2 order	Interview 1 date	Interview 2 date	Months between interviews
ID007	2	1	5.10.05	19.4.06	6
ID009	18	X	20.1.06	X	X
ID010	9	16	9.11.05	6.12.06	13
ID011	10	21	9.11.05	19.12.06	13
ID013	11	7	9.11.05	12.10.06	11
ID019	4	6	13.10.05	11.10.06	12
ID021	7	3	21.10.05	10.10.06	12
ID030	21	17	31.1.06	6.12.06	11
ID059	25	23	1.3.06	25.1.07	11
ID072	24	11	24.2.06	23.11.06	9
ID073	6	15	20.10.05	6.12.06	14
ID076	17	22	17.1.06	19.12.06	11
ID077	23	13	7.2.06	6.12.06	10
ID078	19	10	24.1.06	21.11.06	10
ID079	12	4	18.11.05	10.10.06	11
ID080	16	19	17.1.06	13.12.06	11
ID083	14	9	19.12.05	24.10.06	10
ID084	13	5	22.11.05	11.10.06	11
ID086	1	2	3.10.05	6.10.06	12

ID087	8	X	3.11.05	X	X
ID088	5	8	17.10.05	19.10.06	12
ID090	20	18	25.1.06	13.12.06	11
ID092	3	X	6.10.06	X	X
ID094	26	12	1.3.06	30.11.06	8
ID095	22	20	3.2.06	18.12.06	10
ID097	15	13	11.1.06	4.12.06	11