

Nurses Working in Mid-Life

Final Report

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Context of study

This report presents the findings from the Nurses Working in Mid-life Study funded by the Department of Health in 2004. The work was carried out by members of the Nursing Research Unit at King's College London in two Trusts in London. The research was proposed against a background of concerns about a shortage of a skilled nursing workforce in London and ever increasing numbers of older nurses taking early retirement. The aim of the study was to explore personal, professional and organisational factors that would affect future participation in the workforce of nurses aged 45 and over. The study took place in two different contexts of service delivery, one King's College Hospital London an acute setting and the other, Camden and Islington Mental Health and Social Care Trust an integrated health and social care Trust to explore the impact of organisational policy and practice upon individual commitment. The findings focused on the working lives of both qualified nurses and Health Care Assistants.

The first section of this report draws together the findings from each case study site, in order to capture naturalistic generalisation (Stake 2000). In addition, generalisation of the findings is further discussed in the form of 'middle-range theory', which can provide insights into how and why personal and organisational factors may affect retention in different or similar contexts. The findings from each Trust are presented in appendices 1 & 2, and were initially sent as individual reports to the Trusts for their response and feedback. The initial reports were also sent to the Department of Health.

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Introduction

The shortage of a skilled workforce, especially in London is a key challenge to the modernisation of health care delivery. In nursing, staff shortages are exacerbated by the 'greying' of the workforce, and ever-increasing numbers of older nurses taking early retirement (Buchan et al 2003). In 2004 in England, almost one-third of qualified nurses were aged 45 and over (Department of Health 2004) and levels of retirements are projected to increase (Meadows 2002). Planning for an older workforce has been identified as a key challenge for the NHS in London (Hutt & Buchan 2005). To aid retention of nurses post retirement age, the Department of Health has introduced a flexible retirement initiative (Department of Health 2000c) as part of the human resources framework underpinning the NHS Plan. However, retirement decisions are complex, and individuals' decisions to retire or remain in the workforce can be influenced by a range of factors, personal, professional or organisational. It has become increasingly recognised that people working in 'mid-life' have particular preferences in terms of balancing work, life, health and well-being as well as training needs, which must be addressed to help them accommodate workplace and professional changes (Bowers et al 2003, Hirsch 2000). Knowledge of the needs, values and interests of older nurses can be useful so that organisations can develop policies that may encourage older nurses to remain in the workforce. To this end, the Nurses Working in Mid-life Study explored work and retirement issues of nurses and HCAs nurses aged 45 and over, within the context of a modern human resources framework.

There is a wide variation in age profiles throughout nursing suggesting that different organisations and roles are more favourable to older nurses with proportionately fewer nurses working beyond 55 in the acute than other sectors. Among qualified groups, the oldest are community staff nurses, health visitors and district nurses (Buchan 1999). Because of this and in acknowledgement of the development of different contexts of service delivery, the study took place in two case study sites, one an acute setting and the other an integrated health and social care Trust. This report presents findings by each case study site and across sites.

The policy context

The Government is committed to a modernisation agenda for the NHS and has outlined a range of reforms (Department of Health 1999) (Department of Health 2000a). Key to the modernisation programme is a recognition that the NHS as an employer has a responsibility to develop and support their staff and in 1998, *'Working Together –securing a quality workforce for the NHS'* (Department of Health 1998) outlined the values of fairness, equality of opportunity and recognition of diversity that should underpin the management and development of NHS staff, although age was not specifically mentioned. Other recruitment and retention strategies advocated through the human resources framework underpinning the NHS Plan to increase flexible patterns of work and promote career progression within and across roles neither address specific retention issues nor the needs of mid-life nurses, although NHS employers are required to prove they are tackling age discrimination under the Improving Working Lives (IWL) Standard (Department of Health 2000b).

Under the IWL initiative, NHS organisations have to demonstrate commitment to more flexible working conditions to allow a better work-life balance, such as giving staff more control over their own time, reduced hours options, flexi-time and career breaks. The HR framework in the NHS plan allows room for local initiatives although it states that there should not be unacceptable variations in the ways staff are employed and treated. By 31st March 2006, all organisations were required to meet Improving Working Lives Practice Plus where achievement in all staff groups across the organisation should be demonstrated. Previously, there has been evidence of variation throughout acute Trusts in implementation of these policies (Royal College of Nursing 2002). Where there is a 24-hour service, the majority of nurses work some sort of shift pattern and flexible working may not be readily accommodated. Nurses in community-based services are more likely to work fixed daytime hours and part-time work here may be easier to negotiate. There is also a general perception that flexible working opportunities have

been targeted at nurses with young children rather than nurses with different work-life balance needs or different caring responsibilities, for example, for teenagers, grandchildren or parents (Coyle 2003). It is estimated that 20% of older nurses have caring responsibilities for dependent adults (Buchan 1999).

One IWL initiative which is directed at older staff is the flexible retirement initiative launched in 2000 to encourage older workers to delay retirement by allowing them to work in different ways; Wind Down allows nurses to work part-time instead of retiring completely and Step Down allows them to move into more junior grades. Both of these options do not reduce pension entitlements and may increase overall income in retirement. Nurses can also retire and return to nursing in the NHS under the Retire and Come Back option without affecting their pension (Department of Health 2000c).

The reasons why nurses leave, however, are not just due to rigid work patterns. Research by the Nuffield Trust indicated that the five fold increase in early retirement from 1988 to 1998 was also due to work related stress, attributed to excessive workloads, rising patients' expectations and increasing incidents of violence (Nuffield Trust 1998). The latter is a particular issue in the care of mental health patients. Violence and harassment, stress, overburdening workloads and role boundary issues have been identified as some of the challenges in mental health nursing. Research has identified that acute mental health in-patient settings can be particularly stressful with staff concerned about their personal safety giving examples of violence and drug-dealing on some wards (Genkeer et al 2003). In the acute sector, a Royal College of Nursing (RCN) survey reports that 40% of nurses said they had been harassed or assaulted by patients or relatives in the 12 months prior to the survey, 79% in A&E and 52% on hospital wards (Ball & Pike 2006). The Health and Safety Executive (HSE) reports that nursing has one of the highest prevalence rates of work-related stress (Health and Safety Executive 2005). The RCN identified that the demands of the job and constant change represent the biggest stress factors and that nurses working in hospitals in particular experience high levels of stress. This is significant because a high level of stress is associated with a greater intention to leave nursing (Ball & Pike 2006).

Research in other occupations also stress the influence of workplace structures and experiences of work on women's retirement (Bernard et al 1995). Although there are proportionately more men working in mental health than other specialities, mental health nursing still comprises approximately 70% women. In employment generally there is evidence that promotion tends to diminish rapidly after age 40, especially for women (Loretto et al 2000) and there has been an increasing awareness of the way 'gendered ageism' operates against women (Duncan & Loretto 2004, Itzin & Phillipson 1995). Age barriers to training have been well documented. A review of data from official sources, attitudinal surveys and case studies found that older nurses in the NHS are less likely than younger nurses to apply for courses in continuing professional development, although it is unclear whether this is because of age discrimination, caring responsibilities or whether older nurses are less committed to career progression (Buchan 1999). In one study of older nurses, however, it was reported that continuing professional development was not geared towards their needs and the study identified a need to develop continuing professional development that would help older nurses take on new roles (Watson et al 2003).

The need for equality of access to education, training and development and career development was identified in *'Making a Difference'* (Department of Health 1999). Subsequently, *Agenda for Change* is being implemented introducing a new pay structure and clearer system for career progression (Department of Health 2005). To support personal development and career progression, there is a new Knowledge and Skills Framework (KSF) linked to annual development reviews and personal development plans. It is argued that the guiding principles behind the development of the NHS KSF are those of equality and diversity, whereby all staff use the same framework and have the same opportunities for learning and development throughout their working lives (Department of Health 2004). A review of early implementers of Agenda for Change found that nursing staff hoped that KSF would provide better access to training and development and that this would lead to improved career paths (Review Body for Nursing and Other Health Professions 2004), which could be key to retaining staff.

Finally, the UK has committed itself to legislate against age discrimination in employment this year, highlighting the need for the NHS as the largest employer in the UK to have robust HR systems in place and to promote, monitor and enforce non-discriminatory behaviour. A recent report commissioned by the Department for Work and Pensions found that one in four older people experienced discrimination in relation to an actual or potential job at some point in time (Department of Work and Pensions 2005). The impact of age discrimination on retention of the nursing workforce has yet to be understood.

Until recently, the careers and working lives of mid-life nurses have received little attention. There has been some research into influential factors on retirement decisions of older nurses and NHS staff, both individual, such as finances and health, and structural, in terms of aspects of the NHS, such as lack of resources or too much pressure. With the development of different contexts of service delivery, and the development of new and advanced roles for nurses, it is timely to examine work and retirement issues in different organisational contexts and professional roles, taking into account domestic circumstances and partner's retirement decisions. There is scant evidence on the links between organisational culture and individual expectations and experiences. This research links organisational culture with the workforce by examining the experiences and expectations of older nurses in different professional roles within different organisational contexts to inform evidence-based HR policy.

Literature Review

The general population is ageing. In the United Kingdom in 2004, according to estimates based on the 2001 Census of Population there were over 11 million older people (11,125,000). In 2004, the population of the United Kingdom, based on mid-year estimates was 59,835,000 of these figures 18.6% were over pensionable age: 7,034,000 were women 60 and over of whom 5,488,000 were over 65 and over. The number of people over pensionable age, taking account of the increase in the women's State Pension age, is projected to increase from nearly 11.4 million in 2006 to 12.2 million in 2011, and will rise to over 13.9 million by 2026, reaching over 15.3 million in 2031 (Age Concern 2007).

The National Health Service (NHS) is the largest employer in the United Kingdom (Watson et al 2003). The largest group of employees within the workforce is nurses and midwives (Watson et al 2003). Even though the last five years have seen a dramatic increase in the nursing workforce from 267,000 to 322,00 leading to short term over supply, over the long term, staff shortages are still a potential problem for many Trusts (National Audit Office 2006). At the same time it is becoming increasingly recognised that the NHS has an ageing nursing workforce. Although a growing proportion of nurses are over 50, and a declining proportion are under 30 (Watson et al 2003) the age profile is not uniform throughout sectors. Only 6% of hospital nurses are aged 55 or older, compared with 12% of practice nurses, 19% of bank nurses, and 19% of nurses employed in nursing or residential homes (Department of Health 1997).

Although many nurses over 50 remain in nursing (Watson et al 2003), the links between ill health and retirement are well known. In the NHS, between 1991 and 1997, 33% employees retired on medical grounds at a mean age of 51.6, mainly for musculoskeletal reasons followed by psychiatric reasons and more than 60% thought their ill health was caused by work (Pattani et al 2001). Sickness is a major reason for staff absence in the NHS. In 2001-2002 staff sickness was running at an average of 4.9% across all NHS Trusts, compared with an average of 3.7 % for all public administration, education, and health employees. While there are no reliable estimates of the full costs of sickness absence to the NHS, the Department of Health estimates the annual cost is around £1 billion (Comptroller and Auditor General 2003). There also appears to be a link between ill health and retirement, with the rate of retirement due to ill health in the NHS being higher than in other industries. A recent study has found that retirement because of ill health in the NHS is 5.5/1000 compared to 2/1000 to 25/1000 reported in other UK industries (Pattani et al 2001).

In terms of training, the provision of life long learning and support strategies are essential, but older nurses, compared to their younger colleagues find it more difficult to access training and professional development (Meadows 2002). It has also been reported that training needs are

not geared to the specific needs of older nurses (Watson et al 2003). These are important considerations because job satisfaction has been identified as a crucial factor in retention and in retirement decisions (Robinson & Perryman 2004).

The study

The overall aim of the study was to examine organisational, professional and personal factors that influence perceptions of commitment and participation in the workforce for nurses working in mid-life (aged 45 and over). The study was carried out in 2005-2006 in two different Trusts in London, King's College Hospital NHS Trust and Camden and Islington Mental Health and Social Care Trust, which integrates health and social care in the care of people with mental health problems. It sets out to answer the following questions:

- What is the impact on older nurses of national and local retirement, retention and lifelong learning policies in terms of widening participation, providing flexible working opportunities and career development opportunities?
- Under what circumstances do the policies work in terms of the context of the organisation that facilitate or constrain their success and development?
- For whom do the schemes work? Do they work for some participants and not others?

Briefly, the objectives of the study are as follows:

- To describe human resource policies targeted at older workers in case study sites.
- To examine retirement, pre-retirement and retention policies, flexibility, personal and professional learning opportunities and career development opportunities in case study sites.
- To explore expectations, experiences, aspirations, and commitment of older nurses.
- To identify barriers to innovation of retention and retirement strategies.
- To identify human resources, organisational and professional features that have an impact on commitment and retention of older nurses.

Ethical approval to carry out the research in the two case study sites was granted through Central Office for Research Ethics Committees (COREC). Both Trusts were supportive of the research and key Trusts managers agreed to be interviewed as part of the study. The Trusts also supplied basic aggregate data on nursing staff aged 45+ and key policy documents.

Research Methods

Our original intention was to undertake maximum variation sampling of nurses aged 45+ to take account of gender, ethnicity, different grades and roles as well as part-time and full-time working. However, ethical requirements meant that we could not have access to HR records. We therefore had to rely on nurses volunteering to take part in the study. Both Trusts helped to raise awareness of the study in various ways: a conference stand was provided to publicise the research, senior managers emailed staff and managers inviting them to participate, members of the research team were invited to key service area meetings during a two month period to inform all service managers of the study. The research team designed posters with details of the study and contact details and both Trusts ensured these were displayed in all areas. Flyers were also provided to be handed to interested staff. The research was also publicised by link lecturers from KCL and we set up a website to provide information to potential participants. Members of the research team also visited the wards and handed out flyers. Nurses contacted members of the research team directly and were assured of confidentiality. They were asked if they would like to take part in a focus group or individual interview. All participants were given an information leaflet and signed a consent form before being interviewed. All participants, managers and nurses are referred to by pseudonyms to maintain anonymity.

In both Trusts, we examined policy documents to identify types of continuing professional development, career development, improving working lives, equal opportunities, pre-retirement, flexible retirement schemes and other retention and staff support schemes at national and Trust

level. We also examined human resource systems and processes in relation to: appraisals, personal development plans, supervision and mentoring and identified monitoring systems.

We undertook telephone interviews with managers to identify main human resource concerns and assess views of: deployment of older members of the workforce, policies targeted at older workers and needs of older nurses in terms of flexibility, training and development. The data collected from the managers were continually compared with data collected from the nurses in order to refine the development of categories to assess the organisational and professional barriers and facilitators to policy implementation (see Appendix A for basic schedule). At KCH, we undertook semi-structured interviews with eight key managers including care group managers and at CANDI, the total was nine, including service managers.

We held two focus groups of nurses aged 45+, one at KCH and one at CANDI to assess views of Trust policies in terms of retention strategies, flexibility, training and career development opportunities, organisational and professional barriers to and facilitators of implementation of policies for older nurses (see Appendix A for basic schedule). Each focus group comprised five nurses.

We undertook individual biographical semi-structured interviews with nurses aged 45+. In each interview, the participant completed a lifeline detailing key work and life events starting from the school leaving age until the date of interview. The biographical method is not routinely used in nursing research. In this study the biographical method provided a unique insight into the interrelationship between work and other commitments such as family, childcare responsibilities, and gendered divisions of labour in the home. This was followed by a semi-structured interview to identify perceptions of how Trust and NHS factors and work, career and life events impact on participation and commitment to the organisation and to the NHS (see appendix A for basic schedule). A life course perspective was adopted to capture the diversity work and life experiences, especially of women. The lifeline and some of the questions were based on the schedule developed by Rosemary Crompton et al., in their study, *Organisations, careers and caring* (Crompton et al 2003). Eighteen nurses and HCAs participated at KCH and 19 at CANDI.

In KCH, at the beginning of the study, in March 2005, there were 2196 qualified and unqualified nurses and midwives working at KCH, 89% women and 11% men with 28% (n=606) aged 45 and over. In the study, 17 women and one man took part in the biographical interviews. All five focus group participants were women. Twelve participants described themselves as White British, five as White Irish, one as White other, five as Black British and two as Asian. The median age was 49 years. Two nurses were working on a part-time basis. Of those taking part in the individual interviews, nine participants had partners who lived with them and nine lived alone. Seven participants had no children, eight had grown-up children, some of whom were still at home and three had young children at home. Two of the participants had active caring responsibilities for relatives.

In KCH at that time, 38% of nurses aged 45+ were at grade F and above, with 42% at Grade D and E and 19% were HCAs. However, of nurses who volunteered to take part in the study, the majority, 14 were grade F and over, as were all 5 members of the focus group. Of the rest, one was a health care assistant and three were at D and E grade. This means that the findings may reflect matters concerning more senior staff and there may be different issues for nurses in lower grades and/or health care assistants. Length of time in nursing ranged from 2 – 46 years and length of time at the Trust ranged from 1 to 40 years, with eight of the participants in the biographical interviews employed at the Trust for 15 years or more. Although this sample cannot be considered as representative of all older nurses working in the Trust, it is illustrative of the interrelationship between organisational and personal factors that affect the participation of older nurses in the workforce.

In CANDI, in April 2005, there were approximately 1,260 nurses and support workers of whom 23% (n=286) were aged 45+. We did not have breakdown by gender. In this study, 11 women and eight men took part in the biographical interviews. The focus group comprised two men and three women. The median age was 52 years. Thirteen were working in the community and 11 were in in-patient settings. Eleven of the sample described themselves as white British, 7

were white and not British, 4 were Asian, 1 Black British and 1 Black African. Three nurses were working on a part-time basis. Of those taking part in the individual interviews, 11 had a partner that lived with them and 8 lived alone. Ten participants had no children, 5 had children at home and 4 had grown-up children.

In CANDI at that time, 39% of nurses aged 45+ were at grade F and above, with 31% at Grade D and E and 29% Grade A-C. However, of those who volunteered to take part in the study, the majority, 14 were grade F and over, as were all 5 members of the focus group. Of the rest, two were unqualified and three were at D and E grade. This means that the findings may reflect matters concerning more senior staff and there may be different issues for nurses in lower grades and/or HCAs and support workers. Length of time in nursing for the participants ranged from 10 – 50 years and length of time at the Trust ranged from 2 to 34 years, with 13 participants employed at the Trust for 15 years or more. Because of their length of service, the findings may reflect a greater commitment to the Trust.

All interviews were recorded with the participants' permission and were transcribed and analysed using a qualitative software package, Atlas.ti, using constant comparative method, identifying themes and data patterns (Patton 1987). Data from each case study site were analysed separately (Eisenhardt 1989). Our aim was to generate a theory from two case study sites and illustrate the personal and organisational dimensions of nursing practice in the 45 and over age group. Detailed field notes were written after every face-to-face biographical interview and semi structured interviews with the nurses. The same procedure was carried out in relation to the telephone interviews with managers. By reviewing our field notes frequently, important issues or conflicting answers were identified immediately. The field notes were also useful in revising the interview schedules. During the process of uploading the interview data into the Atlas.ti programme further reflective remarks were added in the form of memos. These stages of analysis generated a deeper understanding of the data. The analysis of the data involved within case analysis and, across case analysis. Data were segmented, coded and arranged into categories, which facilitated insight comparison and the development of theory (Strauss & Corbin 1990).

We examined Trust records to identify types of continuing professional development, career development, improving working lives, equal opportunities, pre-retirement, flexible retirement schemes and other retention and staff support schemes at national and Trust level. We also examined human resource systems and processes in relation to appraisals, personal development plans, supervision and mentoring and identified monitoring systems. Data obtained from the nurses lifelines and interviews were then compared with the data obtained from the interviews with Trust managers and Trust records. Rigour was ensured through audit trails and data verification. This case-study approach produced site-specific findings, reports of which were sent to Trust managers to give them an opportunity to comment on the findings. The findings and comments for each site are included in this report. Findings from both sites are compared and discussed in this report. Comparing data across the two case study sites enhanced naturalistic generalisation (Stake 2000). In addition, the findings can be used to create generalisations in the form of 'middle-range theory', which may provide insights into how and why particular retention strategies might work in different or similar contexts.

Camden and Islington Mental Health and Social Care Trust

Camden and Islington Mental Health and Social Care Trust (CANDI) was formed on April 1st 2002. Services include adult mental health, mental health care of older people, substance misuse services and care for people with learning disabilities. Care Trusts were introduced in 2002 and are a new type of organisation within the NHS. They are part of the NHS but with delegated Local Authority (LA) functions and are a combination of NHS and LA services. The aim is to provide a vehicle for the integration and co-ordination of health and social care services to increase continuity of care and simplify administration (Department of Health 2002). CANDI provide both community and in-patient health and social care across 57 different sites. In the community setting, nurses and social workers work together, often sharing a common

core of overlapping tasks (Kharicha et al 2004). In-patient settings provide more traditional mental health nursing roles and working patterns. Care Trusts, as other NHS organisations, are expected to deliver the HR agenda in terms of IWL and Flexible Retirement.

In line with the Government's equalities agenda, CANDI operates a Valuing Diversity Policy, which includes age and other facets of diversity including gender, sexuality, ethnicity, religion, disability, part-time or fixed term status. Recent equal opportunities initiatives have been directed at promoting the careers of women and black and ethnic minority staff. CANDI has a Workforce Age Action Plan for January 2004-March 2006, which includes promoting flexible working options and flexible retirement options for older workers and auditing uptake as well as exploring the feasibility of the Care Trust being an 'Age Positive Champion' (CANDI 2005).

In terms of flexible retirement, following national policy, CANDI offers Wind Down and Step Down while preserving pension rights earned at a higher level, and Retiring and Coming Back on a part-time basis. Nurses and other medical staff are also offered the option of working only during winter peak times (CANDI 2002).

In line with national policy, staff can request flexible working. However, the request must be considered in relation to the needs of patients and service users and the impact on the team and service. Staff apply to their line manager for flexible working and if the application is refused can then appeal to the Director of Service. Where the service can accommodate it, team-based self-rostering, flexi-time, annualised hours and term-time working are offered. Staff are also entitled to 6 days paid special leave per annum for example, to deal with emergencies or for specialist appointments or to care for dependants and are allowed to take unpaid leave between 6 months and a year for the latter, if necessary. A temporary reduction in hours may be considered which is periodically reviewed. Career breaks of up to five years are offered for personal or professional development purposes (CANDI 2003).

CANDI's Training and Development Strategy aims to ensure individual staff members and teams take responsibility for lifelong learning. All staff are expected to have a minimum of 5 days formal study a year and to provide mentorship to students or colleagues in training. In addition, the Trust encourages teams to set up a multidisciplinary shared learning sessions to explore common themes (CANDI 2003). While the study was taking place, CANDI was implementing Agenda for Change and appraisals should now be yearly and structured using the Knowledge and Skills Framework (KSF) dimensions. All staff should have a personal development plan.

King's College Hospital NHS Trust

King's College Hospital NHS Trust (KCH) is a large London teaching hospital. It provides a full range of local hospital services and serves as a regional and national centre for liver disease and transplantation, foetal medicine, neurosciences, neurosurgery, cardiology and cardiothoracic surgery, haematology, oncology and vascular surgery. KCH was established as a National Health Service Trust in 1991 under the National Health and Community Care Act 1990. The Trust is currently in the process of being re-assessed for qualification to become a Foundation Trust later in 2006.

In line with the Government's equalities agenda, KCH operates a policy of Equality and Diversity in Employment, which includes age and other facets of diversity including gender, sexuality, ethnicity, religion and disability. It operates a Race Equality Scheme and is pursuing a workforce equality action plan (KCH 2005). Progress is monitored against Trust equality targets, in terms of ethnic origin, gender and disability. At the time of study, age was not monitored.

In terms of flexible retirement, following national policy, KCH offers Wind Down and Step Down while preserving pension rights earned at a higher level, and Retiring and Coming Back on a part-time basis. Staff are also offered the option of deferring retirement for a limited time with KCH paying pension contributions on their behalf.

In line with national policy, staff with children aged under 6 years (or up to 18 years if the child is disabled) can request flexible working. However, the request must be considered in relation to 'service needs and financial accountabilities' (KCH 2005). Staff apply to their line manager and if refused can take their request to the next level of manager in the appropriate department through the Staff Complaints (Grievance) Procedure. Where flexible working can be accommodated, under the KingsFlex scheme various options are offered including part-time working temporarily reduced working hours, job share, staggered working hours and annual hours. There is also a personalised annual leave policy that allows staff to increase annual leave (up to 40 days) or 'sell' their annual leave entitlements (up to 5 days) with a commensurate pay adjustment. Staff can also apply for special leave to deal with emergencies or for specialist appointments and in line with national policy, parental leave of up to three months a year. After two years service, staff can apply for a career break of up to two years for travel, education or family care (KCH 2005). KCH has achieved IWL Practice Plus and are commended to other Trusts as worthy working practices for their flexible working schemes, training and development, HR Management and Practices, team working and team relationship and staff involvement project (KCH 2005).

While the study was taking place, KCH had almost completed the implementation of Agenda for Change.

Findings across both Trusts

Profile of sample

Routes into nursing

The data were analysed to examine age of entry and routes into nursing. In terms of age, we found the median age of entry into nursing at KCH to be 19 years, with an age range of 17-50 years (n=18) and in CANDI the median age of entry into nursing of those working in a community setting was 23 years with an age range of 18-36 years (n=11). In the in-patient setting at CANDI the median age of entry into nursing was 36 years, with an age range of 19-49 (n=8). National studies of diplomates have shown that the mean age of entry into mental health nursing is higher than other branches (Robinson et al 2001).

Although the median age of entry into nursing at KCH was 19 years, only 6 participants took direct entry into nursing from school. However, twelve participants worked for a very short while before starting their training and, one participant started nursing in mid-life. Only two of the participants at CANDI took direct entry into nursing from school, 17 of the participants had worked for various lengths of time undertaking various types of employment. Figure 1 shows work histories of two G grades, 1 from CANDI and 1 from KCH to illustrate these two routes.

Figure 1 G grade routes into nursing KCH and Camden

Age	KCH G grade nurse	Work History
16		
17		Left school
18		Gap year
19		SRN training
20		
21		
22		Full-time Staff Nurse
23		
24		
25		
26		Degree nursing
27		
28		
29		Full time Junior Sister
30		
31		
32		
33		
34		Voluntary Redundancy
35		Full time G grade-Fixed term contract
36		Full time E grade – different setting
37		
38		
39		Full time F grade – different setting
40		
41		
42		Full time G grade - promotion
43		
44		
45		
46		

Age	Camden G Grade	Work History
16		Left school
17		Full time work administration
18		
19		Full time various jobs
20		
21		
22		
23		
24		
25		Degree non-nursing
26		
27		
28		Full-time work media
29		
30		
31		
32		
33		
34		Voluntary work
35		
36		Nurse Training P2K
37		
38		
39		Full time D grade
40		Full time E grade - promotion
41		
42		
43		Full time F grade - promotion
44		
45		Full time G grade - promotion
46		
47		
48		

	Nursing
	Nurse Training
	Degree
	Unemployed
	Non-nursing work
	Maternity Leave

As discussed, age of entry into nursing in CANDI was higher than at KCH. We found that at KCH, there was a more traditional route into nursing, with nursing qualifications gained shortly after leaving school, whereas at CANDI the participants started their nurse training after gaining a wider life experience by for example, working in other sectors or travelling. National studies have also found that mental health nursing has contained a substantial proportion of nurses with previous experience in other occupations (Robinson et al 2001).

Summary points

- More traditional route into nursing in acute sector
- Greater diversity of life experience prior to entry into mental health nursing

Routes through nursing

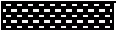

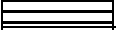



It might be expected that traditional entry as evidenced in KCH would reflect a traditional vertical career yet this was not the case, and promotion by grade was found to be setting specific. At KCH we found instances and were told of disrupted career progression, where nurses had reached G grades but these senior posts were subsequently 'disestablished'. This meant that nurses continued working in the same role but at a more junior, usually F, grade. In CANDI, none of the participants had been downgraded. Nurses working in the community are mostly employed on G grades or their Agenda for Change equivalents to reflect the responsibility nurses have for their own caseload. Figure 2 illustrates the differences between the two sectors. The nurse in CANDI was not only a late entrant to nursing but had progressed in her career fairly rapidly despite working part-time.

Figure 2 Routes through nursing – F grades in Camden and KCH

Age	F Grade nurse at Camden	Work History
16		Left school
17		Full time study
18		Full time administration
19		
20		Travel/work
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		Full time administration
32		
33		
34		
35		
36		Part time unqualified nurse
37		P2K training
38		
39		
40		Full time D grade
41		Full time E grade - promotion
42		Maternity Leave
43		Part time E grade
44		Part time F grade - promotion
45		
46		
47		
48		

	Nursing
	Nurse Training
	Degree/full time study
	Unemployed
	Non-nursing work
	Maternity Leave

Age	F Grade nurse at KCH	Work History
16		Left school
17		Unemployed
18		
19		SRN training
20		
21		Full time Staff Nurse D grade equivalent
22		RSCN Training
23		Full time General nurse
24		
25		Full time Staff Nurse - promotion
26		Full time relief Sister - promotion
27		
28		
29		Full time G grade - promotion
30		
31		
32		
33		Full time F grade – G post disestablished
34		
35		
36		Full time G grade - promotion
37		
38		
39		
40		
41		Full time F grade – G post disestablished
42		
43		
44		
45		
46		

	Nursing
	Nurse Training
	Degree/full time study
	Unemployed
	Non-nursing work
	Maternity Leave

Summary points

- More rapid grade progression in CANDI
- More disrupted careers at KCH

Retirement decisions

In the wider literature it has been demonstrated that retirement decisions are complex. For older nurses, as with other groups of workers, finances and pension entitlements have been identified as operating either as an incentive to continue working or as an incentive to retire (Watson et al 2003). Women's pension entitlements are also heavily influenced by their previous employment patterns, usually to the detriment of women with work histories of part-time working and career breaks for childcare (Ginn & Arber 1993). Other factors identified in attitude surveys across a range of employers are health and job satisfaction (Boaz et al 1999). Low morale linked to job dissatisfaction has been documented among nurses generally (Nursing Times 2001).

Many of the participants in both Trusts had not really considered retirement plans until the interview and used the interview as an opportunity to discuss their plans. This suggests that provision of mid-life/pre-retirement planning courses would be beneficial. Retirement predictions at KCH were as follows:

Table 1 Retirement plans at KCH

Retirement plans	Gender	Grade	Time at Trust years	Time in nursing years
retire at 55	F	F+	9	29
retire at 60	F	D-E	15	37
retire at 60	F	F+	6	25
retire at 60	F	F+	40	40
retire at 60	F	F+	16	29
retire at 65	F	F+	21	27
retire at 65	F	F+	4.5	25
retire at 65	M	F+	5	42
retire at 65	F	F+	10	27
retire at 65	F	F+	2	30
work past retirement	F	D-E	29	34
work past retirement	F	D-E	26	36
work past retirement	F	F+	20	29
work past retirement	F	F+	2	28
no plans	F	F+	12	27
no plans	F	A-C	2	2
no plans	F	F+	16	29
no plans	F	F+	1	46

At CANDI Mental Health nurses who joined the NHS pension scheme prior to 1995 are entitled to Mental Health Officer Status (MHO). An MHO with at least 20 years MHO membership may retire with benefits from age 55 and count each year of MHO membership over 20 years as 2 years for benefits purposes. As shown in Table 2, retirement predictions were as follows:

Table 2 Retirement plans at CANDI

Retirement plans	Gender	Grade	Time at Trust years	Time in nursing years
retire at 55	F	F+	2	27
retire at 55	M	F+	16	23
retire at 55	M	F+	18	18
retire at 55	M	F+	20	30
retire at 55	M	F+	22	28
retire at 55	F	F+	20	34
retire at 55/65	F	F+	15	28
retire at 60	M	A-C	12	16
retire at 62	F	F+	20	33
retire at 65	F	D-E	2	10
retire at 65	M	D-E	24	29
retire at 65	F	D-E	30	30
retirement depends on partner	F	A-C	12	12
work past retirement	F	F+	29	29
work past retirement	F	F+	15	21
no plans	F	F+	7.5	12
no plans	M	F+	12	12
no plans	F	F+	29	50
no plans	M	F+	34	34

In both Trusts age related health issues were raised as important factors in retirement decisions. Although nurses working at CANDI and KCH mentioned physical symptoms such as backache, nurses at KCH reported more levels of stress:

The workload is for 3.5 full time equivalents, we're only 2 full time, so our timetable is crammed and overflowing and there is not one bit of time to do anything else. I've been trying to provide an audit for the general manager since August. You know its, pressure being poured upon you all the time and you have no control over it, that's the other thing, we have no control over what we do. We agreed to this timetable, we haven't had a choice in the timetable. We're told what we're going to be doing; we're told how many patients there are. We're told when you've got to change something. So huge pressures, huge stress.

Melanie, F Grade

At CANDI we found evidence of nurses planning to continue to work after retirement, but not in nursing. They were looking forward to a new challenge; they had the enthusiasm and drive to try a range of different occupations including new business ventures. This was not the case for nurses working at KCH:

Int:
And what would you imagine doing, if you worked past 55?

What I'd love to do is.... I mentioned that I like my garden. And I'm into Bonsais, and if you could make that, if I could make that a little business, or if I could go and work in a Bonsai nursery or something like that!

Sam H grade CANDI

Int:
Are you planning to continue nursing until retirement age?

Yes, unless my husband wins the Lottery.

Int:
So are you planning then to retire at 65?

Is it 65, I thought it was 60?! I'm heading for 60, I don't know about 65! I know. At the moment I've got my sights set on 60. I'm out of here at 60

Int:
Will you work after you have retired?

No! Absolutely not

Pamela H grade KCH

In both Trusts we also found evidence of nurses with dual caring responsibilities, which could have a bearing on retirement planning. The 'sandwich generation' has been conceptualised as those mid-life adults who simultaneously raise dependent children and care for frail elderly parents (Grundy & Henretta 2006). Adults particularly women, in late-middle age are the most likely to face these two way commitments. Wider economic pressures such as university tuition fees are also likely to burden the sandwich generation further. These, in turn, have increased the demands on dual carers who must also safeguard their financial resources for their own retirement (Grundy & Henretta 2006). As one nurse at KCH said:

You're actually going to be shelling out shed loads of money for their university. So you know, 'I won't be able to retire.' I'm thinking I'll have to go full time which is just at the wrong time of your life really. You know, you're tired, you're just getting a bit of life back. And you've got to go full time to pay for your kids.

Alicia G grade

The population as whole is ageing and members of the sandwich generation are set to increase. An ageing nursing workforce poses a serious challenge to human resource managers and workforce planning. Recent research has suggested that only one in eight nurses is under 30, compared to one in four 10 years ago, and almost one quarter of registered nurses (24%) will be eligible to retire in the next five years (Scott 2002). Even though we found little evidence of retirement planning, we also found that nurses showed very little inclination to remain in nursing after retirement. It has been predicted that an ageing nursing workforce will inevitably lead to more and more nurses leaving the NHS in the next 10 years as they reach retirement age. The NHS is dependent on reasonable numbers of nurses who are 45 and over staying past retirement age. In addition, older nurses who continue to work are less likely to work full-time and special consideration will need to be given to their age-specific health needs. Flexibility within the NHS needs to be maintained as it can be a source of encouragement to nurses to remain in nursing (Royal College of Nursing 2005).

Summary points

- Little evidence of retirement planning
- Provision of pre-retirement and retirement planning courses would be beneficial
- Nurses aged 45 and over a members of the 'sandwich generation' which is set to increase
- Ageing nursing workforce poses a serious challenge to workforce planning
- Flexibility within the NHS could be a key factor in the retention of older nurses

Personal dimensions of nursing

The data contained many examples of the emotional content of career. At CANDI we found examples of professional identities under threat, and at KCH we found examples of potential stressors and 'role conflict' (See Appendix 2). The analysis of the personal dimensions of career revealed that the notion of career is complex and involved many tensions. This section explores some of these tensions further through a discussion of meaning of nursing, commitment to nursing and professional identity.

Commitment

Commitment and identity are under-theorised concepts in nursing. Yet, employee commitment is a key concern in human resources management mainly because of its perceived association with job performance (Corley & Mauksch 1993, Guest 1992, Guest & Conway 1999, Meyer & Allen 1997). In the past twenty years, most studies have focused on organisational commitment and have been based on standardised scales (Mowday 1982) (Meyer & Allen 1997). The Mowday et al 1982 OCQ scale has been criticised for treating organisational commitment as unitary and unproblematic (Guest 1992, Meyer & Allen 1997). Commitment is a multi-dimensional concept and there is a need to distinguish between organisational commitment and

other forms. For example, differences between professional commitment and commitment to the NHS have been highlighted by Guest (2004).

Nurses may have multiple and sometimes competing commitments within and outside the organisation. Some may want to stay in practice but not move into management. From an organisational perspective, they may be viewed as lacking career commitment. Part-time workers are also generally perceived to be less committed to work than full-time workers. Hakim's Preference Theory argues that women who work part-time are committed to their home and family and not to paid work (Hakim 2000). However, recent research by (Davey et al 2005) has shown that nurses returning part-time at their preferred hours were motivated both by their work and their career rather than the other two factors. In the case of nurses, Hakim's theory that women returning part-time are not as committed as women returning on a full-time basis is therefore rejected. The policy implications point to the importance of NHS organisations to provide flexible working, career and training opportunities to retain returnees' commitment. This is a particularly relevant to the nursing workforce, where 90% of the nursing workforce are women and for the majority of women, their working lives may include maternity leave and periods of part-time working.

As discussed in the previous two reports there were many personal and organisational barriers to career. Many of these barriers were made tolerable through expressions of commitment. However, commitment was found to have multiple components, for example to the NHS, to the Trust, to nursing and to patients. We found that sustaining multiple commitments was not easy and there were often tensions between them. Yet, older nurses in both Trusts appeared to be able to overcome these tensions and their resilience is therefore, of value in terms of retaining members of the workforce:

I feel committed to my ward and my patient load. You know, for example, for me to go off sick, I mean I never go off sick and I'm a terrible person, I'll come in here with a streaming cold and I'll say, 'I'll stay in the office because I've got a streaming cold,' and I never go off sick. And if I am off, I feel permanently guilty because I'm not here. I feel, this is - right I've got my family at home, and I've got my family here.

Alicia G grade

Newly qualified nurses are increasingly leaving the profession within the first 3 years and appear to lack the dedicated attitude and commitment towards direct patient care (Kirpal 2003). However, a period of long service is not necessarily a reflection of commitment to the employing institution. As the quote above illustrates, strong commitment can also be expressed at the level of the team or to a particular ward. Employee commitment is pertinent therefore, because identification with a particular ward and or specialism and a strong team spirit are arguably necessary to provide high quality health care and may be crucial to nurse retention.

Identity

Current research suggests that nurses are experiencing a crisis of identity (Buller & Butterworth 2001) (Savage 1992). Although the exploration of identity in nursing research is not new (MacIntosh 2003) (Ewens 2003) it has always been confined and related to the working environment and focused on nursing at the expense of the existence of other equally salient identities. For example, previous research has discussed how organizational context may hinder or facilitate the development of nurses' skills and identity as professionals (Fagerberg 2004) (Kelly 1996) argues that nurse's expectations of themselves and the expectations of others during their professional socialization in the first year of working life is extremely stressful. Equally, the psychological effects of not being able to meet tasks, or rather, feel compromised by them is also well documented (Menzies Lyth 1997).

Instead of confining our analysis of identity to the working environment we recognise that a work place identity is one of the many identities experienced, negotiated and sustained within the

social and working world. We also acknowledge that nurses negotiate their identities within competing public cultural and political discourses. These social and political discourses do not offer nurses universal subject positions; rather they illustrate their multiplicity. For example, some discourses may position nurses with status and power and construct nursing as a profession, whereas others will position nurses as primarily carers and construct nursing as a vocation. These contradictory subject positions and discursive constructions of nursing serve to illustrate that a range of possible nursing identities can be constructed in the negotiation of competing discourses (Weedon 1987). Likewise, the social and personal discourses of nurses are equally contested and add another dimension to who nurses are and what they do.

Including theorisations of identity in workforce research provides another layer of analysis of career decisions especially for those who try to balance their work and home life. For example, the adverse impact of combining work and family on career progress for nurses and retention of staff for employers has long been known. This is especially so for nurses returning to work after maternity leave (Davey et al 2005). Previous research has also shown the negotiations required in securing a personally fulfilling identity in and between competing discourses have an affect upon psychological well-being and subjective experiences of women especially mothers (Bennett 2004). Therefore, the tensions between nursing and personal identities (such as a mothering identities) require careful consideration. This is important given that the nursing workforce comprises approximately 90% women (Davey et al 2005).

The analysis of interprofessional working at CANDI gave rich examples of nurses negotiating professional identity as well as examples of their identities under threat (see page 49), which was not evident in the KCH data.

So wards take up the things that all of the other services don't take, and people have criteria they don't meet. And they pick up all the things that OT's and psychologists don't do rather than having a really very strong sort of identity of what their particular skill is. And I, when I was younger, I felt I was much clearer about what a nurse was and what a nurse did, than I am now.

Sue, focus group (Camden)

I mean it's adjusting to that really, and different disciplines at times. I mean, we've had to sort of gel into a multi professional team when I worked in the community. And there's a lot of norming and storming that happened before we could gel as a team. And it's the understanding where, you know, where the disciplines are coming from. And I think, I think, I don't know who just said it, but nursing these days is lots and lots of things that other people do not do. And yet, I think that's where they undervalued comes in to it - we're still struggling to see what do nurses do

Rose, focus group (Camden)

Perceptions of role

Role theory (Super 1980) was used to underpin the discussion of stress within the KCH report (see page 78). Role theory can also help to illustrate and deepen our understanding of the importance of multiple and competing identities and commitments and their relevance to the workplace. Donald Super made links between career and personal life over 25 years ago. He defined career as 'The combination and sequence of roles played by a person during the course of a lifetime' (Super 1980). Similarly, (Law et al 2002) argues that work is an emotional issue, especially when career identities are shifting and more links must be made between career and

other life-role-relevant learning, so that a person's life as a worker can be understood in connection with life as a partner, a parent, a consumer, a volunteer and a citizen. From this vantage point theorisations of career can begin to engage with the many nuances and meanings of career throughout the life span (Super 1980). But meanings of career and identity are differently constructed in different discourses (Law et al 2002) and the links between the two are rarely acknowledged. To engage with the subtleties and nuances of career requires an acknowledgement of the interrelationship between the 'professional' and 'private' self. By doing this it becomes clear that the 'professional' and 'private' self can never be completely separate from one another. This is because, as Super (Super 1980) argues, our role in any given situation can never be acted out in a vacuum; remnants of other roles will always be present and in conflict with one another.

Role conflict is particularly relevant to nurses who try to balance the tensions between the role of the nurse with other equally important roles. According to (Super 1980) role conflict occurs because roles are never played out in isolation from one another, they will always coexist with other roles. The conflict occurs when roles exist or at least cannot be absent from seemingly irrelevant areas. So, whilst the roles pertinent to private or social life may not be relevant to the workplace it would be impossible to just 'turn off' any given role in any given situation or environment. Roles, competing or otherwise will always be in existence, and therefore, in possible tension with the role of a professional nurse.

I am basically the sole breadwinner in my nuclear family, so I am dependent upon financially, which is hence why I sometimes do more hours than other times by my two sisters. One sister is not at all well, and my mother is very elderly, in her 80's, and a younger sister who has learning difficulties and therefore is in and out of very low paid work, so I'm the sole breadwinner.

Sally, F+ grade (KCH)

Equally we have highlighted the tensions between professional roles in the workplace. This was especially so for managerial nurses in KCH and we discussed these tensions as potential stressors for nurses who try to balance the tensions between the role of manager and the role of nurse. Even though patient contact may remain important to managerial staff, a managers' role requires a very different set of skills. These include ensuring that junior staff provides a high standard of care while maintaining an environment in which people can work well, all of which must be achieved within a set budget. Clearly the role of manager and the role of nurse are coexistent, but each is very distinct and requires certain skills.

Yes, I'm more of a manager now, so I'm not so much of a nurse. I do run a clinic, which is fine, it's hands on and I've got full responsibility for it. So I don't have any problem with that at all. Sometimes, I do so much bed management; bed management takes up most of my time. So it's sort of making decisions, which are not maybe necessarily therapeutic for patients, directly therapeutic, but you know, just having to get by.

Brian, G grade in-patient (Camden)

A lot of the issues that older nurses have are not age specific. Role ambiguity for example, may be linked to attrition, but not necessarily to age or experience (Takase et al 2006). However, older nurses may be inclined to stay in nursing because of perceived fewer opportunities for alternative employment or because they have less time until they retire. Nevertheless, the link between stress and role ambiguity are well documented and can occur at any point of a career. In 2001, a report was published which examined the stressors identified by ward managers (Allen 2001). The major source of stress among ward sisters and charge nurses was their anxiety about whether, how and by whom their wards and units were to be staffed each day.

They had serious concerns about the competence of unknown agency nursing staff. Much of their stress was caused by organisational and managerial factors, which they felt to be beyond their control. Many of their problems related to the infrastructure of the organisation - unreliable support services, old and poorly maintained equipment and inadequate IT and administrative support. They were particularly concerned about patients who were in the wrong place at the wrong time, which they identified as an organisational bed management problem beyond their control. The findings presented here in this report concur with these findings and we have found that middle managers are vitally important to the process of maintaining communication between Trust and Ward level. Their skills and ability to manage competing roles simultaneously could be hugely influential in the retention of staff. Strategies to support managers working in stressful environments need to be explored through mentoring or other support schemes. Under the forthcoming Age Discrimination Act it would be discriminatory to offer confidential voluntary health checks just for nurses aged 45 and over. KCH already operates a pre-employment occupational health screening service, and offer advice and support requested by management in order to address individual sickness problems. This 'open door' policy not only works well within the Trust, but also, avoids any discrimination on the basis of age and any association of surveillance in terms of role and performance.

Summary points

- Commitment is important in terms of retention
- Organisational and personal factors can threaten commitment
- Interprofessional working can pose a threat to professional identity
- Nurses with managerial responsibilities may perceive conflicts within their roles
- Role conflict can be a stressor

Organisational and political dimensions of nursing

There is no standard definition of organisational culture although there would probably be agreement that it is holistic, historically determined and socially constructed (Hofstede 1991). Much of the research drawn upon here suggests that some organisational cultures are unfavourable towards women and/or ethnic minority nurses and in this context; organisational culture could perhaps be more usefully understood to mean tradition and current custom and practice. Although NHS organisations are expected to implement national policy initiatives, the sometime frequent gap between policy and practice is well-known (Buchan 1999) (Northrop 1999). Moreover, Trusts devise and implement their own policies and examples of good practice have been found (Watson et al 2003). As with employers in other sectors, studies have found that many NHS employers undervalue older workers but that others are supportive of the continued employment of older nurses (Buchan 1999) (Watson et al 2003). The study of healthcare staff in London found that there was sometimes a resistance to implementation of national policy initiatives (Meadows 2002) and the study of older nurses found that greater flexibility was offered to younger rather than older nurses (Watson et al 2003).

Agenda for Change

The key principle behind Agenda for Change (AfC) is to pay staff on the basis of the work they do and the skills and knowledge they apply (NHS Employers 2006). At the time of the study CANDI and KCH were at the implementation stage of Agenda for Change so these findings may change over time. Nevertheless, nurses in both Trusts reported that they were unhappy with certain aspects of Agenda for Change, these were: a perception that Agenda for Change did not value or recognise experience, grade structure and promotion prospects.

I feel aggrieved, if that's not too strong a word, about how younger people are coming in and your experience is overlooked. I have been nursing for over 20 years! [...] The younger people need the training to bring them up, but actually what they're doing is, as you say, they are blocking your development, which is not good. I feel valued in the way that housewife feels valued; that's how I feel!

Sheila F grade

I'm lumped with the G grades [...] in theory I'm a H grade, and what we're doing in this Trust is, we're lumped with the G grades. So in actual fact, a nurse I supervise could creep up the band and overtake me if need be. That's a possibility and that's a contentious issue at the moment. And although I have got a lot more responsibility in the team and responsibility to the Trust, the banding doesn't reflect what I do, because I'm lumped in with my colleagues.

Danielle, G grade outpatients (Camden)

I prepare people for interviewing now, when a nurse comes to a certain age they feel they ought to be promoted. And they're very caring nurses and you know on the whole, and are very committed, but if they haven't got the background of educational development and haven't, they're not very dynamic under management then they do miss out on being promoted. And then, then ... so I'm aware of ... older nurses, I mean when I say older kind of over 45, that have not been promoted and have not had their career structured in a way that they felt that they were valued.

Bridgette, G grade (KCH)

As mentioned above, both KCH and CANDI are at the implementation stage of Agenda for Change so these findings may change over time. In terms of the organisation, Agenda for Change provides an opportunity to collect a wealth of information about the workforce. In terms of the personal, Agenda for Change signalled an introduction of a new pay system to ensure fair pay and a clearer system for career progression. Finally, Agenda for Change simplifies the creation of innovative and unique roles and services by separating pay and terms and conditions from professional titles by enabling the development of jobs based purely on the skills and competencies required. The findings across both case study sites have found that few nurses viewed Agenda for Change positively and wider research has reported similar findings (Ball & Pike 2006). There are however examples of Agenda for Change being used to bring about positive outcomes. In Cambridge University Hospitals Foundation Trust for example, staff are considering a comprehensive change programme to integrate system redesign and workforce development using Agenda for Change pay and careers framework (NHS Confederation 2006). Avon and Wiltshire Mental Health Partnership has been very successful in implementing Agenda for Change and found it had a significant number of benefits for staff (NHS Confederation 2006).

Summary points

- Dissatisfaction with the implementation of Agenda for Change
- Perception that Agenda for Change fails to recognise experience of older nurses
- Dissatisfaction with grade under Agenda for Change
- Dissatisfaction with career progression and promotion under Agenda for Change
- Dissatisfaction with Agenda for Change could increase attrition

Education and Development

To support personal development and career progression, there is a new Knowledge and Skills Framework (KSF) linked to annual development reviews and personal development plans. It is argued that the guiding principles behind the development of the NHS KSF are those of equality

and diversity, whereby all staff use the same framework and have the same opportunities for learning and development throughout their working lives (Department of Health 2004). The Knowledge and Skills Framework formally requires employers to ensure that every member of staff is aware of the knowledge and skills required to carry out their job

The provision of further education and training were reported as being excellent at KCH and very good at CANDI. We did, however, find apparent constraints to access to further training in both Trusts. At KCH access to further training was hampered by staff shortages and at CANDI by time constraints, with short courses more accessible than longer courses.

A common theme between CANDI and KCH was nurses in both Trusts felt that courses were out of date for experienced staff with many years of service.

I think the courses the Trust runs, are very repetitive. And if you've been around as long as I have, you tend to run out of what the Trust is offering on courses. So I mean, if I go through the training manual now, I've done all the courses that are in there, you know - dementia care, Alzheimer's, elder abuse, everything that's in there, I've done. And so, what would I be doing them again for?

Marion, HCA, in-patients (Camden)

And a nurse at King's College Hospital said:

The courses I've been on, some of them, you go to sleep halfway through because you know those. They don't, they're preaching at you, and then you, you just think I've heard this so many times before.

Melanie, F grade (KCH)

Provision of further education and training is important for experienced nurses. At the moment under Agenda for Change, value is measured by qualifications. This raises the question, 'Are qualifications worth more than experience?' The answer is open to subjective interpretation, but the measure and benchmark we have at the moment (i.e. Agenda for Change) is not. Yet, we found that managers and less experienced nurses appreciated the experience that older nurses may have:

So I think, I think it is more experience and life knowledge and skills that they bring.

Barbara Trust manager (KCH)

We also found that younger less experienced nurses appreciated the skills of older nurses:

I think it's [experience] is a valuable resource to have, and I think, for the younger nurses, it must be useful having older colleagues around that they can approach, [...]

Trevor grade 7 nurse (Camden)

Wider research has found that that nurses who perceive career development opportunities are more likely to stay in nursing and are more committed. Encouragement of professional commitment is important, as it has been shown that the more nurses are committed to their profession, the greater commitment they show to the organisation (Jauch et al 1980). We found in both Trusts, that older nurses with more experience demonstrated a professional

commitment, intrinsic to which was the possession of an intuitive expert practice (Benner et al 1992, Benner et al 1997), which develops over time and which in their view, nurses with less experience who were typically younger did not possess. This quality was found to be of benefit to younger less experienced staff as well as patients in terms of quality of care. However, training courses need to be continually updated to meet the needs of older nurses, and to give them equal career progression.

THE Knowledge and Skills Framework lies at the heart of the career and pay and progression strand of Agenda for Change. Life long learning and continuing professional development for staff is integral to the development of a modern health service and the implementation of the NHS Plan. A competent and committed workforce is a key requirement of a quality service. Safe patient care, motivation, updating and the extension of knowledge and skills are essential outcomes of education and training (NHS Modernisation Agency 2007). Much can be learned from the commitment and strong occupational identities of experienced nurses and, they have a wealth of experience to offer the NHS, patients, and their less experienced colleagues. It is important therefore, that any training and education anomalies are rectified.

Summary points

- **Courses can be repetitive for older, more experienced nurses.**
- **Courses need to be updated for older, more experienced nurses.**
- **Experience of older nurses is a valuable resource to organisations and should be utilised.**
- **Any training and education anomalies should be rectified to ensure full and successful implementation of Agenda for Change.**

Improving working lives

The findings of this research suggest that the nature of nursing poses many challenges to the implementation of flexible working, with some organisations or organisational structures more facilitative and supportive than others. There was little evidence of poor access to or implementation of, flexible working at CANDI where nurses either worked days in the community or earlies or lates. We did, however, find that a joint working setting did generate a perception by nurses that social workers have greater access to flexible working.

In July 2000, the government launched the *NHS Plan* in which it set out its agenda for the development of health care services over the next 10 years. This included the *Improving Working Lives (IWL) Standard*. The IWL is a commitment by NHS employers to create 'well managed, flexible working environments that support staff, promote their welfare and development, and respect their need to manage a healthy and productive balance between their work and their life outside work (Department of Health 2000b).

This research found some difficulties in the implementation and take up of flexible working at both case study sites.

At CANDI we found different working practices between nurses and social workers generated a perception of unequal access to flexible working:

One of the social workers who went away to have her second baby. And she did sort of two days a week and one day from home, three days a week. She did three days' working, but her third day she spent and worked from home. I wonder whether that would happen in nursing, probably not, you know, that's a kind of a 'social work thing' - which I think was quite good for her really.

Kathy G grade (Camden)

We also found differences between in-patient and outpatient settings, with outpatient settings having easier access to flexible working:

I do, I actually do work in a different way. My hours are slightly different because of living in Brighton. And again that's something that they've done for me. I avoid travelling in the mad rush hour. So I finish at 4. The service closes at 5. That's to avoid the big rush hour. I start at 8, granted. But that's my choice. The service opens at 9.

Sam H grade community nurse (Camden)

At KCH we identified a range of barriers to the implementation of flexible working (see page 83). The difficulties of flexible working in a 24-hour setting are well known (Brooks & Swailes 2002). Working patterns for example, appear to either facilitate or hinder the implementation of flexible working. At KCH long days are part of the regular shift patterns and, they appear to be a particular barrier to the implementation and take up of flexible working:

King's very much sees themselves as employers who give flexitime to their staff. But I think within that, you know, there are certain restrictions. [...] When I was actually working as the F grade on that side and I wanted to work flexitime, the shift patterns were different because then they did earlies and lates, so I could, whereas now we only do long days.

Pamela, H grade (KCH)

At KCH we found that there were differing perceptions between Trust and ward level staff regarding the accessibility and implementation of flexible working. At the level of the Trust there was a perception that it was fully operational:

I mean we've had our King's Flex scheme now for, I don't know, 5 years or so, and you know the onus very much is on managers to sort of try and accommodate what is required. Now it's a scheme that's open to everybody so you don't have to have a family, you don't have to have, be a carer, you know you can want flexible working purely because you want it. And it's made as easy as possible so you know the individual goes and talks to their manager and their manager tries to accommodate it. Obviously if everyone wants to have Friday off that's going to give everyone, you know or do a 4 day week that's going to give somebody a problem, but you know you're encouraged to work around it, and perhaps Monday off would be you know just as good type thing. So yes I don't think it is difficult to get flexible working in any area of the Trust. In some areas it is more difficult than others, but I think that boils down to staffing numbers rather than the sort of you know who you are, whether you're a nurse or a secretary or whatever.

Laura, Trust manager (KCH)

We found however, at KCH that access to flexible working was more influenced by working in care-groups rather than the Trust:

Not necessarily the Trust but our care group is not family friendly. If people want to go part-time they won't guarantee them days, and they want them to be flexible about what days they work and all that sort of thing, which I don't think is family friendly. [...] If you have to arrange childcare you need to have it on specific days.

Linda, G grade (KCH)

Access to flexible working at KCH was also linked to seniority as one H grade nurse said:

Well mainly in my position, I'm quite fortunate that I can work 9 to 5 most days. I don't have to do weekends and I don't have to do nights. So that does help. And I'm quite lucky. There are days when I do work long days, but again, I tend to fit that in with where my children are and what they need to be doing. So if they've got after school activities and I can't work a long day, which would finish at half past eight, and I would then, if I needed to work a long day, I would fit that in with a day when, you know, my daughter can be at home or my husband's at home.

Pamela, H grade (KCH)

We also found that ward managers at KCH were key in implementing flexible working:

With my previous manager, it was very easy. She had been in post quite a few years. She worked in informal sort of ways, but we became overspent in terms of money, people weren't performing well. But she was very friendly towards you and if you needed time, you could guarantee you got it. Now we're being more efficiently managed by a new manager, she's always looking to how this will affect the service. That's what her job is. So it's now much more difficult to get time. And if you want to change your hours, the bottom line is always service. So somebody could say, 'I need to be with my children, I need to work 9 to 5, I can't do this on call burden that you're giving me, I can't get childcare provision'

Sylvia, G grade (KCH)

One of the advantages of an age diverse workforce means that flexible working can be more easily implemented within teams. In in-patient settings, the absence of childcare responsibilities means that older nurses are more likely to work 'traditional shift patterns'. Conversely, those with childcare responsibilities adhere to less traditional and inflexible shift patterns. Although the findings suggest that both Trusts appear to benefit from an age diverse workforce, flexible working may inadvertently produce an inflexible workforce. As one manager said:

A quite a high proportion of our workforce are young people with families who do flexible working. If they're a nurse they might be doing say 3 long days so they've got a big chunk of you know sort of time to sort of you know spend with the family or doing whatever they're doing, or they might be having an annual hours contract which is working term time only. So I don't necessarily see that you know it's the older, the older person that's doing more of the part-time working. And in fact I think you would probably find that that wasn't the case now because you know there is so much flexible working that happens because people want to fit it in more with their younger families that I think perhaps that switch has changed.

Laura, Trust manager (KCH)

Older nurses may be happy to work regular shift patterns. However, there needs to be awareness that the availability of flexible working to younger nurses does not impose a burden on older nurses, many of whom may have increasing health problems or just cannot work at the level of a younger nurse. As one Trust manager said:

But I must admit I do think sometimes, you know, can you reasonably expect somebody who is 45 plus, of age, to be charging around an orthopaedic, 32 bedded orthopaedic ward, answering every buzzer and giving every bed pan out, as sprightly as I used to do when I was 24, 25?

Josephine, Trust manager (KCH)

This section has illustrated some of the operational difficulties in implementing a national policy at local level, that suggest flexible working initiatives may be too uniform and prescriptive to suit the needs of older workers. Both CANDI and KCH have achieved practice plus status, yet the findings across both Trusts have revealed a number of barriers to the successful implementation of flexible working. The variation in perceptions of access to, and implementation of, flexible working is an issue that needs further exploration, which is not within the remit of this research. There is, however, an important question to be raised, if there is such variation in the implementation of flexible working, how are decisions made? Our findings have already highlighted that ward managers can be burdened by the stress of maintaining a service. Our findings have also found that ward managers are key to the implementation of policy. Under the present system, it is not unusual for ward managers to decide who can have flexible working and who cannot.

Summary points

- **Implementation of flexible working is setting specific**
- **Long days are a particular barrier to implementing flexible working**
- **Access to flexible working can vary by care group and seniority in the acute sector**
- **Flexible working awareness sessions could prove to be very beneficial**

Discussion

The following outlines the **research questions** and our interpretation of the findings.

Under what circumstances do the policies work in terms of the context of the organisation that facilitate or constrain their success and development?

Middle managers were instrumental in the implementation of policy at ward level. However, organisational constraints such as poor communication between Trust and ward level, staff shortages and resources were significant barriers. At CANDI poor communication was found to foster interprofessional misunderstanding and at KCH too much communication was found to be a barrier to understanding policy. Staff at CANDI could benefit from interprofessional team building workshops where participants could discuss the expectations they had of each other. The multiple means of communication at KCH needs to be reduced. At present nurses at KCH feel burdened by 'too much information' and they could become indifferent towards it.

What is the impact on older nurses of national and local retirement, retention and lifelong learning policies in terms of widening participation, providing flexible working opportunities and career development opportunities?

Retirement

The findings suggest there is a need for a structured local policy with clear, well thought through opportunities and benefits for nurses to encourage them to stay in nursing after retirement age.

It is well documented that the UK nursing workforce is ageing. Only one in eight nurses is under 30, compared to one in four 10 years ago, and almost $\frac{1}{4}$ of registered nurses (24%) will be eligible to retire in the next five years (Scott 2002). Although retirement predictions were fairly mixed, we found very little evidence of retirement planning. The lack of retirement planning could have implications in terms of national retirement policy, it could be useful therefore, to provide an advisor and encourage pre-retirement planning at local level.

In both Trusts age related health issues were raised as important factors in retirement decisions. Although nurses working at CANDI and KCH mentioned physical symptoms such as backache, nurses at KCH reported more levels of stress. A recent qualitative study found that stress was a major influence in retirement decisions for older nurses but there was some indication that when measures to reduce stress were adopted, they were effective (Watson et al 2003).

In both Trusts we found evidence of nurses with dual caring responsibilities. The 'sandwich generation' has been conceptualised as those mid-life adults who simultaneously raise dependent children and care for frail elderly parents (Grundy & Henretta 2006). Adults particularly women, in late-middle age are the most likely to face these two way commitments. Wider economic pressures such as university tuition fees are also likely to burden the sandwich generation further. These, in turn, have increased the demands on dual carers who must also safeguard their financial resources for their own retirement (Grundy & Henretta 2006).

Education and Development

In both Trusts we found that older nurses were dissatisfied with the availability and suitability of current courses. The Knowledge and Skills Framework strand of Agenda for Change is designed to ensure that nurses are equipped to work within the modern NHS. It is essential therefore, that older experienced nurses are provided with suitable training courses that expand their knowledge and skills rather than courses they do not need or have already undergone. To do otherwise, may be de-motivating and jeopardise their future career progression and pay.

For whom do the schemes work? Do they work for some participants and not others?

This research has found some problems with the implementation of flexible working. In the absence of active caring responsibilities, flexible working can be an extra burden for older workers. Many nurses reported that their working patterns had to accommodate the flexible

working requirements of those with caring responsibilities, which can have the effect of producing an 'inflexible workforce'. We also found that the implementation of flexible working was often the responsibility of ward managers, which can be a source of stress and anxiety and an extra burden for middle managers. In terms of setting, this research has found that flexible working can falter in the acute sector. In KCH, access was linked to seniority, with senior staff having greater access. In CANDI, we found access to flexible working was easier in the community. However, at CANDI nurses reported social workers have greater access to flexible working in in-patient settings. At the time of the study, CANDI was in the process of implementing self-rostering in their 24-hour settings, and this could be a way forward for KCH.

Promotion by grade was found to be setting specific. At KCH we found instances of disrupted career progression, where nurses had reached G grades but these senior posts were subsequently 'disestablished'. This meant that nurses continued working in the same role but at a more junior, usually F, grade. In CANDI, none of the participants had been downgraded. Nurses working in the community are mostly employed on G grades or their Agenda for Change equivalents to reflect the responsibility nurses have for their own caseload.

Conclusion

This case-study approach produced site-specific findings. The case study findings were sent to Trust managers to give them an opportunity to comment on the findings. The findings and comments for each site enhanced naturalistic generalisation (Stake 2000). In addition, the findings can be used to create generalisations in the form of 'middle-range theory', which may provide insights into how and why particular retention strategies might work in different or similar contexts. Data from each case study site were analysed separately. The joint findings were divided into two sections, the personal dimensions of nursing and the organisational and political dimensions of nursing. Although it is not possible to disentangle the personal from the organisational, this study presents the following main conclusions.

Older nurses are increasingly important to the current nursing workforce and will be a substantial part of the future nursing workforce. Investment needs to occur now. This research suggests that nurses haven't really thought through their retirement plans so there appears to be an opportunity to influence their choices through the local implementation of retirement initiatives. These initiatives need to be attractive and must emphasise the benefits of remaining at work after retirement, whilst at the same time conveying value to the individual. For example, initiatives could be communicated effectively by ward managers as part of individual professional development plans.

In both case study sites commitment was high. This is an important factor, which could be used in devising strategies to encourage older nurses to stay beyond retirement. Although there are similarities in the working lives of nurses at all ages (e.g. role conflict), the findings across both case-study sites suggest that older nurses have specific needs that are not the same as other nursing staff. For example, middle/ward managers can be burdened by the task of implementing policy within the constraints of staff and resource shortages. These experienced members of the nursing workforce could be key figures in ensuring that communication between the level of the trust and the ward are maintained, but they will require support and guidance in order to be able to work effectively. Another example of the specific needs of older experienced nurses was found in the data about education. Age did not seem a barrier to access training, but the limited range of courses did limit the professional development of older nurses. Similarly, this study found widespread dissatisfaction with the implementation of Agenda for Change and career progression and grade structure under Agenda for Change.

Further research

Flexibility needs to be maintained within the workforce and is a key component of retention. The findings suggest that flexible working is an important area worthy of further investigation. First, the role of middle/ward managers in the implementation of flexible working could benefit from

further investigation. In essence the findings suggest that the role of middle/ward managers may become increasingly important in the future.

In terms of retirement, further qualitative research that explores the usefulness of current retirement initiatives may help to develop strategies that will encourage nurses to stay in nursing after retirement.

Recommendations

Nurses require pre-retirement planning to discuss their pension forecasts and future options.

Improve communication strategies by reducing the volume or by targeting information strategically. This is important because it conveys value and supports key members of staff particularly middle managers.

Older experienced nurses have different education and development needs compared to younger less experienced nurses. Courses need to be up-dated and tailored to their needs. This is particularly pertinent to the Knowledge and Skills strand of Agenda for Change.

Flexibility in the NHS needs to be maintained, and if necessary improved in order to retain nurses after retirement age.

Strategies to support managers working in stressful environments need to be explored through mentoring or other support schemes.

Learning from Trusts that have successfully implemented Agenda for Change could benefit both CANDI and KCH.

Majority of participants were in senior grades and the views of older nurses in lower grades and those new to the Trust need to be explored.

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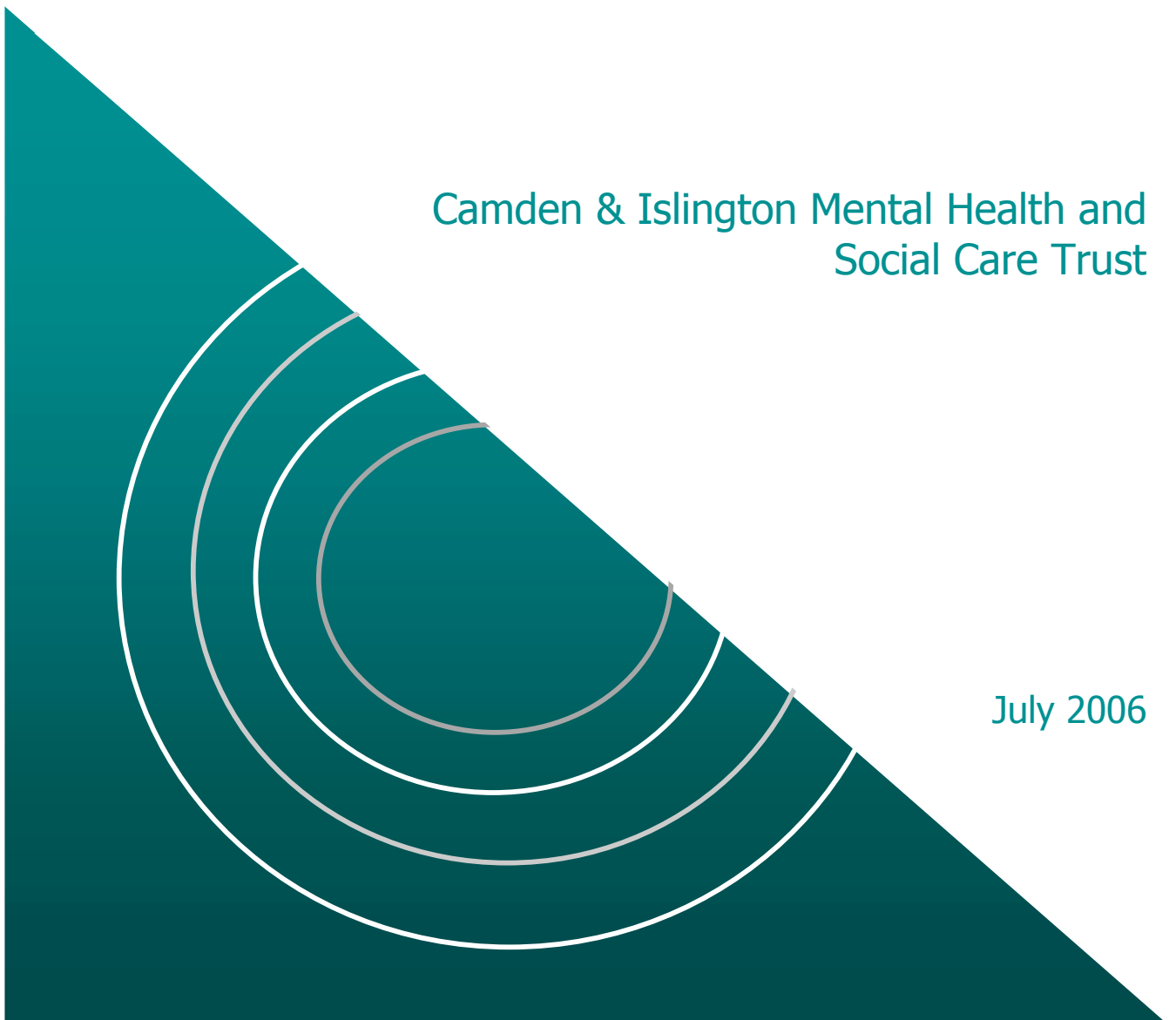
**Appendix 1: Camden & Islington Mental
Health & Social Care Trust Report**



Nurses Working in Mid-Life

Camden & Islington Mental Health and
Social Care Trust

July 2006



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2006

Camden and Islington mental Health and Social Care Trust

This findings presented here were originally sent to Camden and Islington Mental Health and Social Care Trust, for their response and feedback. The document was used as part of the feedback process to the Trust and served as a background to a consultation with the key managers, whose views were used to refine interpretation of the findings in the final report.

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Summary of findings

There were many positive comments especially from participants in senior grades about working for Camden and Islington Mental Health and Social Care Trust, in terms of training opportunities, career development and a pleasant working environment. The majority of participants are committed to and feel valued by the Trust and we found no evidence of ageism in terms of policy or practice.

The majority of participants had no firm retirement plans but many felt that health reasons would play a part in their retirement decisions and the physical and emotional nature of Mental Health nursing, particularly in the more volatile settings meant that older nurses may wish to transfer to other settings.

Managers considered older nurses a source of stability and continuity in an NHS under constant change. Although resilient to change, some older nurses found that working in multi-disciplinary teams had an effect upon the nursing role and challenged their professional identity. There was some dissatisfaction with the perceived unequal career development opportunities and different working practices and entitlements between social workers and nurses.

The participants in the study expressed a high level of commitment to service users and to nursing. Nurses expressed that the positive aspects of joint working were better client care, opportunities for cross-professional learning and opportunities for role reflection. Some participants would forego further promotion so that they could maintain clinical contact, although they would still welcome new training opportunities.

Identifying training needs is important. Some older nurses felt that they had exhausted the curriculum. In terms of age and experience, experienced nurses have a lot to offer the education and training needs of less experienced nurses. Many were interested in mentorship roles, also identified by some managers as a potential key role for older nurses. There seems to be some variation in implementation of yearly appraisals, where training needs would be identified, possibly owing to the burden of work experienced by managers.

Middle managers also have a key role in disseminating Trust policies. Ineffective communication of policies can lead to misunderstanding or scepticism. While flexible working in some in-patient settings was not fully implemented, some participants were unaware of their entitlement to flexible working and felt policies were directed at younger nurses with children. There was also some evidence of misunderstanding flexible retirement policies and how they would work in practice.

Age diversity in teams can improve the implementation of flexible working but there needs to be an awareness that older nurses may carry the burden of the 'inflexible' flexible worker. To avoid inflexible shift patterns, which may become increasingly difficult with age, older nurses in in-patient settings may transfer to the community.

Findings

Working for CANDI

There were many positive comments about working for the Trust:

I've had a great career and this Trust has served me personally very well. You know, and I think I've given it back, but, so you know, I've had a great time. [...] I definitely enjoy what I do.

Sue, Focus Group

Participants in senior positions spoke of innovative training, good career development opportunities and a pleasant and supportive working environment:

But this Trust has always had a reputation for, which I'm not sure whether it's diminishing or not, but quite innovative training and yes giving people a chance to do that, so. I'm not sure what the situation is now, but there's loads of us here, quite a few CPNs here did it, so.

Paul, Community G Grade

I think the Trust has always been very good in terms of funding the training courses, and they're very keen on that sort of thing, so I've benefited a lot from that. And I think the Trust do try their best to make working within the Trust an enjoyable experience. I've certainly enjoyed it. And I mean, most of my colleagues in the older people's service, we've all been around for years and years, you know.

Trevor, In-patient G Grade

I have felt very supported. I have given, I have been given a lot of freedom of developing the service. My views and ideas and implementations of different things have always been 'go ahead and let us know what you need or we'll support you,' or whatever.

Beatrice, In-patient I Grade

A valuable workforce

Not only did the majority of participants give positive views about the Trust, there were also many expressions of the value Trust placed on older nurses. Previously, the NHS Confederation observed that there has been a long history of age discrimination (Buchan 1998). However, since the IWL initiative, NHS employers have to prove they are tackling age discrimination. Our analysis of the data at CANDI has revealed no expressions of ageism by the Trust either in terms of policy or practice. Neither were there any expressions of ageism in managers' views. None of the staff interviewed reported discrimination on the basis of age in relation to training and career development opportunities. Managers considered members of the older workforce to be a source of stability and continuity in an NHS under constant change, able to pass on expertise to less experienced nurses. Some older nurses too saw a role for themselves as a 'wise family member', expressed a strong identification with nursing as 'part of

who I am', and still found nursing very rewarding. By implication this meant that some patients appreciated the experience and maturity of older nurses:

- and being older helps actually, with patients. They may say, 'Oh I don't mind you. I don't want these little girls.' Or one lady said to me recently, 'Would you give me a bath later, because you're a nice big girl.' [...] And I find that's an asset, being a bit older and a bit motherly.

Marian, In-patient B Grade

There was also evidence of enduring commitment, which was expressed at several levels. In terms of a commitment to nursing, many of the sample wanted to 'leave nursing in a better shape than they found it', had very high standards in terms of delivery of care and in some instances would forgo promotion if it meant losing patient contact. Commitment to colleagues was expressed as a desire to pass on their skills to less experienced nurses. In terms of the Trust and the organisation, commitment was expressed by length of service. Commitment was further demonstrated by intentions to work after retirement with 13 of the sample stating intentions to work post-retirement in either a vocational or voluntary capacity. On this basis, it could be argued that nurses nearing retirement may be persuaded to stay rather than leave.

Although enduring commitment was evidenced, current work in the Nursing Research Unit has shown that commitment can be threatened during the course of a career. These threats may originate from the organisation, but also from the personal/social sphere. Nurses at the beginning of their careers can for example, experience high levels of dissonance between demands between personal and organisational pressures, which can make it very difficult for young people to remain in nursing (Bennett forthcoming).

This sample has overcome the previous threats to career posed by childcare responsibilities. This could be because part-time nurses returning to work after maternity leave are no less committed than their full-time colleagues (Davey et al 2005). Whilst the demands of 'hands on childcare' are less, some of the participants said that the financial burden of paying for their children's university tuition fees had played a part in their decision to continue to work.

Summary – key points

- No evidence of ageism in policy or practice
- Older nurses valued as a source of stability and continuity
- Majority of participants positive about working for the Trust
- Many positive comments about training opportunities and career development
- Participants committed to nursing and to delivering a high standard of care

Retirement

Mental Health nurses who joined the NHS pension scheme prior to 1995 are entitled to Mental Health Officer Status (MHO). An MHO with at least 20 years MHO membership may retire with benefits from age 55 and count each year of MHO membership over 20 years as 2 years for benefits purposes. Yet, many of the participants had not really considered retirement plans until the interview and used the interview as an opportunity to discuss their plans. It could be the provision of mid-life/pre-retirement planning courses would be beneficial. Nevertheless, as shown in Table 1, retirement predictions were as follows: four participants said that they had made no plans to retire, six said that they may take advantage of their MHO Status and retire at 55 years of age, six participants said that they would probably retire between the ages of 60 and 65 years of age, two thought they would carry on working past retirement age, one said that she would retire at the same time as her husband and that they had not made a decision.

The findings show that links between personal and work factors affect retirement decisions in the same way as they do throughout the course of a career. The following sections outline the main organisational and personal push/pull factors that affect participation in the workforce. We suggest possible solutions to encourage continued service and make suggestions where policy might be developed.

Table 1

Retirement plans	Gender	Grade	Time at Trust years	Time in nursing years
retire at 55	F	F+	2	27
retire at 55	M	F+	16	23
retire at 55	M	F+	18	18
retire at 55	M	F+	20	30
retire at 55	M	F+	22	28
retire at 55/65	F	F+	15	28
retire at 55	F	F+	20	34
retire at 60	M	A-C	12	16
retire at 62	F	F+	20	33
retire at 65	F	D-E	2	10
retire at 65	M	D-E	24	29
retire at 65	F	D-E	30	30
retirement depends on partner	F	A-C	12	12
work past retirement	F	F+	29	29
work past retirement	F	F+	15	21
no plans	F	F+	7.5	12
no plans	M	F+	12	12
no plans	F	F+	29	50
no plans	M	F+	34	34

Communicating retirement

The majority of participants had made limited plans or preparations for retirement and indeed explored their retirement options and intentions through the interview process. This suggests that NHS and Trust policies may influence retirement intentions and encourage retention. However, policies need to be communicated effectively to staff and the findings suggest that sometimes participants had limited awareness of policies perhaps associated with difficulties in communicating to staff in 57 sites and there were comments from participants in some settings that the Trust was 'over there'. This feeling of distance can be exacerbated by a lack of communication and there were several comments that not all staff were able to access electronic information. As one manager said:

communication, you know, we're 57 different sites, God knows how many different professions and we're not all linked to the Internet. So it is a challenge.

Carol, Manager

Communication has been linked to achieving strategic goals within organisational and professional contexts (Ticehurst & Ross-Smith 1998). There is a need to overcome the treatment of communication as a superficial aspect of organisational life; rather it needs to be seen as a core organisational process with multi-dimensional aspects. It is clear that although professional communication can be defined as a functional concept in an organisational setting, its understanding and practice cannot be separated from, and is dependent upon, other communication activities in the organisation.

Communication is also a means by which an organisation can express the value it places on staff. This is important because although the majority of participants in this study did feel valued by the Trust, staff can feel devalued by ineffective communication. One nurse gave an example of how communication would have helped her to feel valued by the Trust:

Yes, something. I mean they must know your age and that you're coming up to that. You know, like you get, from insurance companies, 'happy birthday, you're 60 next week, how would you like ...?'

Marian, In-patient B Grade

Other staff said they would feel valued by the organisation if they were contacted personally prior to their retirement age, outlining flexible retirement options. This would not only communicate the value placed on the member of staff by the Trust but also help to avoid misunderstandings about eligibility, as expressed by one HCA:

I don't think they're aimed at me, I think essentially they're aimed at qualified nurses because they're so short of nurses and so desperate. I may be wrong, but flexible retirement it's like the workplace childcare isn't it, get the mums when they've had their kids, get them back in part-time if they're starting a family. And if they're thinking of early retirement why take that qualification with them, let's have them back on a part-time. But me, I can't honestly see them wanting me back. Because they'll fill this post won't they?

Peter, In-patient C grade

More effective communication detailing how retirement policies may work in practice may also be useful. Some participants were sceptical or fearful as to how flexible retirement options may work, especially in terms of Step Down. As one nurse said:

The other thing is about going down a level, although I think, I think it would be quite difficult. Would it be difficult for somebody to come in and be the manager and I've been the manager and become the deputy? Would that be very hard? Who would want to do it?

Anne, Community G grade

Clearly, staff at all levels need to be able to understand policies and their implications and service and team managers have key roles as 'professional communicators' of all Trust policies to staff. Some managers have developed their own strategies to communicate policies to staff more effectively:

We always want to believe that the nurses have access to all the policies. On every board in our service, we have a folder, a Policy Folder, because I still believe, and I know that not everybody is IT proficient. And there are quite a lot of discussions and ... about directives ... believe that we should do away with folders and that everybody should be able to use IT skills. And I felt quite fearful about it, because many of the healthcare assistants, or even sometimes the ... staff, are not able. [...] So we do have policy folders. When we have to renew a policy, they are sent around for a group of the staff to comment. That hasn't always happened, but that's what we do. And we expect comments and we try and encourage everybody to discuss policies with the team.

Jill, Manager

Many participants wanted to be informed directly about retirement policies from the Trust and the majority of participants wanted one person they could talk to about their current finances and their future options either to carry on working or to retire:

Yes I would like to know that this person that works only with pensions and I could access information. You know, sitting like we are, on a one to one. And go through it.

Rebecca, Community I grade

I would really like to know, to find out from someone what kind of pension I can expect and what is, when I could actually retire.

Fran, In-patient E grade

Summary – key points

- Individual communication from Trust can make staff feel valued
- Policies not always communicated effectively
- Middle managers key to effective communication
- Pre-retirement and pension planning policies needed

Personal and professional factors

It is well known nursing can be both physically and mentally tiring and research shows a link between health issues and retirement decisions (Disney et al 2004). In the NHS, between 1991 and 1997, 33% employees retired on medical grounds at a mean age of 51.6, mainly for musculoskeletal reasons followed by psychiatric reasons and more than 60% thought their ill health was caused by work (Pattani et al 2001). A recent qualitative study found that stress was a major influence in retirement decisions for older nurses but there was some indication that when measures to reduce stress were adopted, they were effective (Watson et al 2003). As previously discussed within this paper, retirement decisions are subject to a range of personal and professional factors. As health issues were one of the main themes in the findings this section will focus on understanding the relationship between health and plans to remain at work post-retirement. Some nurses felt that physical demands of their role would influence whether they would remain in nursing:

Because of my age I don't think my body will be able to go with this pace of nursing. Nursing nowadays you really have to be very quick, be vigilant with everything. Tina, In-patient D Grade

Older nurses compared themselves to younger nurses in terms of feeling more tired and needing more time to rest:

Interviewer: You were saying you get more tired.
Yes I just think you just get a bit more tired on the wards. You need a bit more 'me' time, I think, than younger people do, because they're going out and partying until 3 o'clock in the morning and can still wake up and come in for the half past seven shift, and I can't.
Fran, In-patient E Grade

The findings suggest that heavy physical work associated with the care of older people is particularly arduous. This is a situation of increasing relevance with an increasingly ageing population requiring health services and an increasing ageing workforce. Conversely, staff working in settings with younger patients (i.e. drug rehabilitation services) reported that caring for violent and/or aggressive patients was emotionally stressful.

You're here to treat people, to help people, you know, to try, to do our best for people. And people are saying, 'Well I don't want you to do your best for me, I don't want you to help me, I am going to continue to take crack cocaine whether you like it or not,' and bring it on to the ward and give it to other patients as well, I don't think that we should have the responsibility.
Fran, In-patient E Grade

Some of the participants have chosen to work in particular sectors preferring to take on heavy workloads rather than working in potentially harmful or volatile areas of nursing:

Maybe that's why we have the older nurses here with us. You know, when you go on the ... wards and it's quite hectic and there's more - more volatile and, you know, it does, there comes a time when they feel that A & E is not for them.
Robert, Manager

Even though some staff choose to work within less volatile settings, the combination of the demanding nature of mental health nursing, age and health factors for some older workers remains a concern for some managers:

I think, really drive the next phase of radically looking at different components of the workforce, including the over 50s. But, all the obvious things about being over 50, in a physically demanding and emotionally demanding role. The emotional labour in Mental Health nursing is perhaps greater. I wouldn't necessarily camp in that because I think my colleagues in Acute Care expend a great deal of emotional energy with their patients as well, but by the very nature of Mental Health, that can be a very exhausting component.
Elizabeth, Manager

One way of alleviating the physical and emotional burden of mental health nursing may be through the creation of 'new roles' for older nurses. The experience that older nurses and HCAs have to offer in mentoring or training less experienced staff is something that has been mentioned by Trust managers and older nurses. Offering these roles as part of their working week and reducing the 'heavy' care of nursing may have a positive impact on retention while also developing capacity at ward level.

But it would probably support our relatively ageing workforce if we were to bring in, you know, a group of younger people. Then again there would be another role, you see, for our older nurses in having a group who could particularly mentor and support for the first year of their career in Britain, those nurses, to let them have a soft landing and feel really welcome and wanted on the wards.

Elizabeth, Manager

I'd love to do that. But that's up to management, because I mean you don't, I don't necessarily have to be an RMN. I don't think I could mentor students but I mean I could certainly give advice to less experienced staff.

Peter, In-patient C Grade

The diversity of the patients accessing mental health services also means that staff offer a wide range of experience, for example in terms of cultural and ethnic health needs:

I'm quite interested in cultural things. And that's useful because now we're seeing people from many cultures. Before, it was the people looked after their - ethnic minorities looked after their own elderly, but now we're seeing more and more. And there are things like that I would like to be interested in.

Interviewer: But at the moment, they're not available in the Trust?

No. And that's quite important because, you know, simple things like Afro Caribbean's, need to be creamed every day. Now, we wouldn't dream of creaming our - but that's really important and part of their care and treatment. And that's never recognised, you know. [...] And just dietary, you know. Their needs like maybe they wouldn't drink this or eat that. So it's a two-way thing. But I think it's important and I'm very interested in cultural ...

Marian, In-patient B Grade

The creation of 'new roles' is integral to continuing personal and wider career development for both qualified nurses and HCAs. Yet at Trust level, there appears to be a range of conflicting views among managers about the equality of further training opportunities:

That I can say quite categorically. The more you've got, [training] the more you'll get. Non qualified has been neglected.

Carol, Manager

I think there are issues, particularly for people who haven't studied very much in the course of their careers and that's certainly what we're finding - what we found in recent years with much more proactive Training and Development Strategy, including setting up an NVQ Assessment Centre, is that we're probably now targeting groups, particularly in the non qualified end of the workforce, that have possibly not been given those opportunities and not been sufficiently encouraged.

Pamela, Manager

Some staff at ward level believed that they had made the most of opportunities available to them and were in need of new or different courses:

But I think the courses the Trust runs, are very repetitive. And if you've been around as long as I have, you tend to run out of what the Trust is offering on courses, you know. [...] So I mean, if I go through the training manual now, I've done all the courses that are in there, you know - dementia care, Alzheimer's, elder abuse, everything that's in there, I've done. And so, what would I be doing them again for? And there isn't anything else.'

Marion, In-patient B Grade

While the data suggest that some teams are following Trust requirements for teams to set up a multidisciplinary shared learning sessions to explore common themes, communication between staff at ward level, middle managers and the Trust is key, which has been recognised by some managers who are developing stronger communication strategies:

there's positive things going on, on every ward, and the idea is to try and get them to be shared between the wards, in an easy sort of way without it having to be part of some grand cause.

Interviewer: That does happen at the moment.
Yes, well it does, yes. And we've got plans in place for development for Charge Nurse Development Plan to actually take place from January to April where they will have some management sessions like absence and disciplinary things because they are the sort of deputies to the ward managers. And some more practice things about risk and - and the ward managers will take on each of those offered - an afternoon each and run it as a session. So sometimes it will be your manager running a session, sometimes it will be someone else's. And then the idea is that they rotate to other - each charge nurse will rotate on to a different ward for three days, and bring back something positive from that ward to their own ward.

Sue, In-patient I Grade

Personal and professional influences in retirement decisions are closely associated. This is especially so in terms of age/health issues. As the data above show, increasing health/work related ailments could be reduced whilst maintaining patient contact. Creative thinking around 'new roles' may provide a partial solution to retaining an older workforce and supporting less experienced staff.

The creation of 'new roles' requires an identification of education and training needs of staff. One of the requirements of Agenda for Change is the implementation of yearly appraisals. Some participants had not had appraisals within the previous year. This was mainly because of time constraints of managers with large teams. One manager pointed out the difficulties:

I manage six people all the same, [...] It's harder when you manage a team like ... do because it's an establishment of twenty. So you have to cascade. You can't do 20 appraisals, because you know, you'd be doing one every single fortnight, all the time, all year round. So, you know, I think it is quite difficult. And then cascading it down is quite difficult because then you've got to keep track whether other people have done it right.

Sue, focus group

At the time of the study, CANDI was implementing Agenda for Change, and it may be that these issues have subsequently been addressed. The analysis suggested that the absence of appraisals may jeopardise training and career development opportunities which in turn may lead to an 'individualised career' that is a career pursued by the individual rather than supported and guided by the organisation. The consequences of an individualised career may mean that staff can feel overlooked and to a certain extent de-motivated. As one participant said:

And it's kind of, you know, it's where your own individual responsibility ends and where the person that manages you, starts. And, you know, it's unusual, people don't normally push for their own appraisal. You expect your manager to tell you, 'This is when you're going to have it.' Things like that.

Sue, focus group

The lack of defined career pathways for nurses prior to Agenda for Change is well known. It remains to be seen whether the implementation of Agenda for Change will improve career development for nurses.

Summary: key points

- Health issues are key consideration in retirement decisions
- Some settings are more attractive to older nurses
- Capacity building – new roles for older nurses: mentoring and teaching
- Older nurses may have different education and training needs
- Absence of appraisals and individualised career

Retaining a valuable workforce

Improving Working Lives

In July 2000, the government launched the *NHS Plan* in which it set out its agenda for the development of health care services over the next 10 years. This included the *Improving Working Lives (IWL) Standard*. The IWL is a commitment by NHS employers to create 'well managed, flexible working environments that support staff, promote their welfare and development, and respect their need to manage a healthy and productive balance between their work and their life outside work (Department of Health 2000b). However, the findings suggest that the implementation of flexible working is particularly challenging within a clinical setting:

There's a whole range of Flexible Working initiatives, so you can work part time, you can do annualised hours, which means you do the same number of hours over the year. Some people do, say, one long day a week and then other shifts, so they have an extra day off a week. But with nursing, I do think it's quite limited because nurses need to go to handover. If you're working in a clinical setting, you need to go to the handover at the beginning of the shift and then you need to handover at the end of the shift.

Anna, Manager

Even though it is clear that the Trust are dedicated to the ethos of flexible working with the majority of the participants believing the Trust to be accommodating, there are gaps between policy development, implementation and take-up. The findings suggest that some managers are aware that staff can misunderstand who can take advantage of IWL initiatives:

'We try and encourage the idea that it's not just about accommodating people with children, but it's difficult to know whether there could still be an element of staff perceiving it to be that way. I think also, workers over 45 and upwards, perhaps when they were younger, there was less around, and they may not be as used to the culture of flexible working as, say, newer entrants would be, where it's more or less understood that, at some point, everyone has this entitlement.'

Harriet, Manager

Older nurses may feel that flexible working only applies to staff with young children: As one nurse said:

I know my partner had a very bad knee and often I would help him get down the stairs and leave him there because it was very painful, he was going for operation soon, but for a long time he couldn't walk very much. So I'd help him downstairs and kind of get all the things so that he doesn't have to move too much in the daytime. And then I would come in to work and then go home and then help him, or he would stay in bed for a long time and I'd go home and I'd help him. But I never, ever took time off work as a family person would do.

Danielle, Community & Grade

One of the advantages of an age diverse workforce means that flexible working can be more easily implemented within teams. In in-patient settings, the absence of childcare responsibilities means that older nurses are more likely to work 'traditional shift patterns', whilst their 'flexible' colleagues adhere to less traditional and inflexible shift patterns. Studies of other workforces have shown that managers' perceptions about the inflexibility of the flexible workers has been a barrier to implementation (Edwards & Robinson 2004). Flexible working may inadvertently produce an inflexible workforce at the expense of the flexibility of the older workforce. As one manager said:

I think our Trust is very good. C and I are very good, very supportive to flexible working. But then the consequences of that is that if you are not having children, you don't have a family or the family is grown up, you will be in the team whereby all your colleagues are working flexibly, working condensed hours, so the burden may well be on those people who are more mature and then having to provide the cover.

Alex, Manager

Older nurses may be happy to work regular shift patterns. However, there needs to be an awareness that the availability of flexible working to younger nurses does not impose a burden on older nurses, many of whom may have caring responsibilities for parents or grandchildren. Some participants had moved to the community to work regular day-time hours and shift patterns can become increasingly difficult with age. One nurse said:

I feel that once you reach the age of 50 your sleep pattern changes. Your sleep pattern changes, you get up earlier and quicker rather than when you were young at the age of 20 or 30 you find it difficult to get up in the morning. But now you get up early and you really don't find it difficult to get up. But the sleep pattern is very erratic ...

Tina, In-patient D Grade

Summary – key points

- Older nurses may find changing patterns of shift working more difficult
- Flexible working in some in-patient settings not fully implemented
- Some older nurses unaware of their entitlement to flexible working
- Age diversity in teams improves implementation of flexible working
- Older nurses may carry the burden of the 'inflexible' flexible worker.

Joint working

We did not ask participants specific questions about joint working but several nurses, mainly working in the community, expressed their views. The aim of joint working is to provide seamless integration and co-ordination of health and social care services to provide continuity of care for service users. There has been a wealth of literature focusing on advantages and disadvantages of co-located working. Close working relationships is one of the main advantages of joint working. In this study, views were expressed that joint working was an opportunity to learn from others:

But for me, it's perfect, because I think we learn so much from each other really. I actually like the fact that we, as nurses, it's probably our training, but you kind of worry and care in a different way. And you sort of worry about, 'Have I done enough for clients in the community, have I missed anything?' Social workers are much more boundaried. They're much better at saying, 'Let's look at this, let's examine this,' and they're quite good, even for a one to one, if you're sort of worried about somebody, to say, 'Well what have you done?' and look at it. And they're kind of more political than we are. And I actually I think that's very helpful to us really, as nurses on the team as well. So, yes, I think it's really, really good.

Kathy, Community G Grade

The tasks have changed, but then there's also the other things you're still doing anyway. But, to me, in many ways it makes it more interesting as well. [...] But the nice thing about it is there's someone else in the team who has, or there's an experienced social worker who has been in the team for quite a while and can help you in, you know, help you out or tell you what to do, what you need to do.

Kathy, Community G Grade

Joint working was also seen as an opportunity to reflect on the nursing role and practice. One manager said:

I think the - because we work in such an actively multi-disciplinary way, I think we do have to think hard about what is your own profession's unique contribution in a multi-disciplinary set up. And I think that's a good discipline for all the disciplines. We all have to question our practices.

Lionel, Manager

Although it was felt that better care was provided by multi-disciplinary working, several nurses working in the community expressed concerns about the challenges of joint working, in terms of role change and working practices. As one nurse said:

This collocation. I mean I think it's important to say that in client care, it's possibly a lot better, they get one person who has all the knowledge rather than, you know, people feeding into them with different bits and two workers not knowing that's what's going on with the client. But I suppose from the nurses' point of view, it's been hard to take all that's been expected.

Rebecca, Community I Grade

The literature conceptualising the difficulties of joint working has discussed differences in occupational culture, including professional identity and status. Some participants said that they had entered nursing in order to practise therapeutic care, but joint working had to some extent had eroded their nursing role and to some extent their professional status:

Well, I think what's happened is, that, as other professionals come in, like OTs and psychologists, in particular, the more therapeutic aspects of the work has taken ... And certainly in Mental Health, there's always like the therapeutic side of it and the counselling and the therapy side of things, and there's an awful lot of risk assessment and holding and containing, if you like, social policing. And it does seem that nurses get moved into that bit. And I find that there isn't really a strong culture in the nursing profession for us to stand together and say we can or cannot do.

Sheila, Community G Grade

And they [nurses] pick up all the things that OTs and psychologists don't do rather than having a really very strong sort of identity of what their particular skill is. And I, when I was younger, I felt I was much clearer about what a nurse was and what a nurse did, than I am now.

Carmel, Focus Group

Now? I don't feel like I am a nurse. I've worked for a number of years in this sort of setting here which is this, we're co-located with Social Services. And it feels like we're all expected to know each others' jobs really. So you come with a nursing background but you're expected to know about housing and benefits and all sorts of things that I think nurses struggle with really, and resent doing.

Rebecca, Community I Grade

It has been argued that interprofessional differences need to be skillfully bridged and exploited (Spratley & Pietroni 1994). Research has found that communication between professionals was improved following workshops where participants could discuss the expectations they had of each other. Key factors were the involvement of representatives from all levels of service provision (Bond 1998).

Other challenges included differences in working practices between nurses and social workers, and differences in career opportunities. In terms of the former, travelling within the community to visit patients is one example where some nurses were dissatisfied that they have to use their own travel cards to pay for journeys where social worker do not. As one nurse said:

I use my card, which I pay to go and see my patients. [...] Last year the social workers have been given card for Zones 1 and 2. But if they come in a car, or they ride a bicycle or they live around the corner, even if they don't want a card, they are given a sum of money to cover Zone 1 and 2, to put in to the bank account. My colleague, my manager comes in on a bicycle, he doesn't claim, but he gets the money put in his bank and he can use it.

Danielle, Community G Grade

There were also reported differences in access to flexible working opportunities between nurses and other professionals:

And we refer to recent examples on the ward really. You know, if, if you are another discipline, then you need to start your shift at the same time as the nurses do, you know, 9 o'clock, well we've all been in since half seven. You know, that's, I think that's why I sometimes wonder about

Charlotte, Focus Group

The differences between career development opportunities between nurses and social workers was mentioned:

A deputy manager can be a nurse. But a team manager has to be a social worker.

Interviewer:; Oh really?

Even if I wanted the team leader's post, I could not apply because it was earmarked for a social worker.

Danielle, Community G Grade

Summary – key points

- **Perceived positive aspects of joint working**
 - Better client care
 - opportunities for cross-professional learning
 - opportunities for role reflection
- **Perceived negative aspects of joint working**
 - Erosion of nursing role and professional identity
 - Dissatisfaction with different working practices
 - Dissatisfaction with different career development opportunities

Discussion

The following outlines the **research questions** and our interpretation of the findings. There were many positive comments about working for the Trust and, in many ways the length of service and the commitment of staff reflect this. This document has shown that retirement issues for this sample are subject to a range of organisational and personal factors that cannot be considered in isolation. For some staff the interrelationship between age and health means that certain settings are more attractive than others.

Under what circumstances do the policies work in terms of the context of the organisation that facilitate or constrain their success and development?

Communication was found to be key in terms of disseminating policies and that misunderstanding can mean that staff do not take advantage of policies. In recent times the notion that communication simply reflects organisational realities has been rejected and replaced by a view that understands communication as a formative process, which creates and represents the processes of organising (Putnam et al 1996). In this contemporary view, organisations are structured and sustained through the articulation of meaning produced in communication. Organisational realities are established through these formative communication processes, power structures are developed and maintained, and organisational outcomes determined. Personal and targeted communication is a way the Trust can draw staff's attention to key policies and express the value it places on staff.

Research has found that communication between professionals was improved following workshops. The provision of the latter for all levels of staff where professionals' roles and identities and can be openly communicated is a means through which nurses can reaffirm and gain recognition for their unique contribution to a multi-disciplinary team. Harmonising working practices and entitlements between nurses and other professionals is also a means by which the Trust can express its appreciation and recognition of nurses.

What is the impact on older nurses of national and local retirement, retention and lifelong learning policies in terms of widening participation, providing flexible working opportunities and career development opportunities?

There were many positive comments especially from participants in senior grades about working for CANDI, in terms of training opportunities and career development. Although nurses were keen to access further training, some felt they had exhausted the training curriculum. This document has also discussed that older nurses may be key in providing support and training to new or less experienced staff. The innovation of 'new roles' in terms of providing this support may reduce the burden of physical and emotional labour associated with mental health nursing. In addition these roles could provide managers with extra layer of support within the team structure. New roles could provide career development for older nurses, some of whom would normally forego promotion in order to maintain client contact. Career development can only take place effectively with a regular appraisal system. Without organisational support, nurses have to take control and develop their career pathways which can lead to an 'individualised career'.

For whom do the schemes work? Do they work for some participants and not others?

Although resilient to change, some older nurses working in multi-disciplinary teams were dissatisfied with the perceived unequal career development opportunities and different working practices and entitlements between social workers and nurses.

Flexible working in some in-patient settings was not fully implemented. Setting may impact on implementing some flexible retirement requests. Generally, nurses working in the community have more autonomy and may more easily be able to work or retire flexibly. There may still be a perception that flexible working policies are directed at younger nurses with children. Where younger nurses are taking advantage of IWL policies, age diversity in teams can improve its implementation.

Recommendations

Nurses require pre-retirement planning to discuss their pension forecasts and future options.

More direct and targeted communication needed with clear information detailing how retirement policies will work in practice for individuals.

Personal communications about retirement policies and opportunities from the Trust would express the value the Trust places on older nurses.

Offering older nurses 'new roles' as part of their working week in the form of mentoring, supporting or developing skills of less experienced nurses may be a way to alleviate an increasingly heavy burden of mental health nursing.

Providing opportunities for staff to work in other settings may alleviate age and health related issues.

Providing workshops for all levels of staff where professional roles and identities can be openly communicated is a means through which nurses can reaffirm and gain recognition for their unique contribution to a multi-disciplinary team.

Working arrangements and entitlements between social workers and nurses need to be harmonised.

Majority of participants were in senior grades and the views of older nurses in lower grades need to be explored.

Trust feedback

Since the study took place, the Trust has achieved IWL Practice Plus. We have been advised that an HR Flexible Retirement Lead has now been nominated. The Flexible Retirement Lead contacts people due to retire to discuss their retirement and working options. The Trust has also provided sessions and workshops for both staff and managers where issues flexible working and retirement and pensions are discussed. In terms of career development and training, the Trust are in the process of identifying nursing staff who can act as career advisors to other nurses within the Trust.

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**Appendix 2: King's College Hospital NHS
Trust Report**



Nurses Working in Mid-Life

King's College Hospital NHS Trust

September 2006



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King's College Hospital NHS Trust

This findings presented here were originally sent to King's College Hospital NHS Trust, for their response and feedback. The document was used as part of the feedback process to the Trust and served as a background to a consultation with the key managers, whose views were used to refine interpretation of the findings in the final report.

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Summary of findings

We found no evidence of ageism in terms of policy or practice, and access to training was excellent. Although there were some positive comments from participants about working for King's College Hospital NHS Trust (KCH), we did however, identify a perception of disharmony between Trust managers and ward staff. This is not uncommon (Jinks & Daniels 2003) and we do not believe it to be particular to KCH.

The majority of the participants had made limited plans for retirement, sometimes due to the limited awareness amongst staff regarding their retirement options. We also found that wider factors such as future health and financial situation are important factors in retirement decisions, but the financial implications of retirement appear to take precedence over health.

KCH is nationally recognised in terms of its training, expertise and range of specialisms. As a working environment KCH offers many opportunities for nurses to develop their skills and experience. However, there was concern among the participants about the probability of being overlooked for promotion in favour of younger less experienced diplomate and graduate nurses. Most participants had qualified via the certificate route and were unhappy that Agenda for Change appeared to value nursing qualifications over experience. This is likely to be a wider issue within the NHS.

We found that ward managers were particularly susceptible to stress. The main stressors appear to be caused by balancing the tension of 'being a nurse and a manager' simultaneously as well as being key in the implementation of policy, in particular flexible working. Although KCH operate a policy of reflective practice linked to clinical competencies, we found limited evidence of formal supervision in practice, the implementation of which can go some way to alleviating stress.

Kingsflex is a very positive improving working lives policy. However, we found differences between Trust managers and ward staff, in perceptions of availability and access to flexible working. The data suggest that the implementation of flexible working is setting specific and subject to factors such as age and seniority. Again, this is likely to be a wider problem across the NHS acute sector.

Findings

Working for King's College Hospital

The data contained positive comments about working for King's College Hospital. Many participants described a culture particular to King's that was both friendly and supportive and having a 'family atmosphere':

You just fall in to that King's culture, which is lovely in terms of friendliness; again I could not say anything wrong, friendliness is fantastic here.

Julia, G Grade

I like working here because I like the patients. There's nothing like the King's patients, there's nothing like them.

Melanie, F Grade

There was also some evidence of staff feeling valued by middle and senior management and appreciative of the support of their colleagues:

Fantastic, yes. And the freedom to kind of, nobody's looking over your shoulder. There's a lot of trust, which I really value. A lot of trust you know. I mean yes brilliant, brilliant kind of relationships you know that you feel trusted; you feel that your opinions and your views count and that they actually value that. Yes I've always felt that.

Sally, F Grade

There was however, also a pervasive feeling that the Trust does not value or support its staff in some aspects of work for example, dealing with cases of abuse from patients:

I don't feel that we get support from the managers; you know somebody comes and shouts at us and then we just get on with it really. Whereas if you ended up turning round and shouted at a patient not that you would, but if you shouted at a patient there'd be all hell to pay.

Int:

So if that does happen then you do nothing?

No, I mean I've known nurses that have been punched here, and you know they're expected to be back at work and look after that patient!

Grace, G Grade

Others believed that Trust managers did not appreciate or understand the pressures experienced by staff working at ward level:

I find that management will come along and they always seem removed, from the pressures that are going on every day. Now occasionally they may acknowledge the pressures that one's under or whatever, but it's never, it's never honestly dealt with you know. Because they're covering themselves, they're saying we're putting the processes in place for you to allow you to do X, Y and Z, and you, excuse me what processes are we talking about here you know.

Julienne, G Grade

Yet interview data from managers at Trust level revealed extensive appreciation for older workers. This was expressed in terms of their ability and reliability, life skills and experience:

Our turnover is a lot lower for older staff.

Int:

Oh right.

And that's borne out of the staff attitude surveys as well. When the questions are asked around you know are you thinking of looking for a job, etc., etc., etc., our, it's quite clear older staff are much less likely to move on than our younger staff.

Rick, Manager

Well I think they bring life experience, which is really important. They often bring stability. And often they have, well they have different pressures, they might not have the same pressures where they would have young children and you know so they need time off for some of those things, given it's a predominantly female profession, but of course as people get older they have more carer's responsibilities as well often. So I think, I think it is more experience and life knowledge and skills that they bring.

Barbara, Manager

Although the Trust use multiple means of communication in the form of staff forums, the Trust's Daily Bulletin which is emailed daily, hard copies of the monthly King's News which is circulated to all clinical areas, regular Director Road Shows and Themed Open Days we still found a perception of a lack of communication between some the staff and the Trust. It would appear that there is a lot of information for nurses to process, and it maybe helpful for nurses if these multiple means of communication were streamlined and or reduced. This is an important issue because although the majority of participants in this study did feel valued by the Trust, some staff felt devalued by ineffective communication. Given the perceived dissonance in communication between ward and Trust level and the potential it may have to foster 'bad feelings', we deemed it important to bring these to the attention of the Trust. However, it is also acknowledged that a perception by staff of disharmony between trust and ward level is not uncommon, and therefore, we do not believe it to be particular to King's (see for example, (Jinks & Daniels 2003).

Summary - key points

- Staff feel that King's College Hospital is a mainly friendly supportive working environment
- Some older nurses are not aware that they are valued by the Trust

The older nurse

Previously, the NHS Confederation observed that there has been a long history of age discrimination (Buchan 1998). However, since the IWL initiative, NHS employers have to show they are tackling age discrimination. Our analysis of the data at King's College Hospital has revealed no expressions of ageism by the Trust either in terms of policy or practice. Neither were there any expressions of ageism in managers' views. None of the staff interviewed reported discrimination on the basis of age in relation to training and career development opportunities. We found that Trust managers are more than prepared for the forthcoming age legislation and are already preparing for implementation:

I am probably like a lot of HR professionals; I'm particularly interested in age discrimination legislation. I think what that might flag up is perhaps some issues around indirect age discrimination, we haven't really sort of considered before. [...] And of course, one of the things that - you know, there's now been some talk, they've spoken about it in terms of this legislation, is around the use of terms. So the terms that might disproportionately impact on sort of older workers, because you are using perhaps terms such as, 'young, energetic, enthusiastic' - those are all terms, which clearly would have an impact on older workers.

Gerald, Manager

Several Trust managers raised their concerns about age related health issues. Their concerns were not about the level of sickness of older nurses, but rather, recognising illnesses can be a part of a natural ageing process:

We do have issues around sickness, in that you get knee replacements, hip replacements, hysterectomies, those kinds of illnesses, which you know, are a good six months off sick. But it's six months off sick and then the problem is gone type of thing.

Valerie, Manager

We also found examples of managers recognising their responsibility for developing health intervention and monitoring strategies:

The fact they're just tired. I think nursing is a very demanding role; it's still so very physically a demanding role.

Josephine, Manager

It's our responsibility as well to identify when there is a problem rather than just thinking oh she's off again with flu sort of thing, thinking well could this be something more, or you know could the headaches be something more, or could this be indicative of, you know, diabetes or high blood pressure or whatever. So I think, I think it's about sort of identifying the problem and making sure we intervene early, which is the same for everybody, and is sort of good sickness management. We do have, you know we are quite; well there is quite a lot of emphasis on managing sickness anyway. So, yes so I think it's on identifying that there is a sickness issue and then dealing with it in a supportive way, and you know we do try and be as flexible as we can.

Jean, Manager

Remaining with the theme of age, we do not take the view that age can be conflated with experience. However, the data does suggest that the older nurses possess life experience, which can enhance nursing practice. Most of the nurses in this study trained via the certificate route and views were expressed that they were better able to provide care that considers the wider psychosocial needs of the patient. Although this was described, as having a 'common sense' attitude it in itself is an interpretation of the skills of older nurses might have in assessing patient needs:

I find the older nurses seem to have a common sense attitude to what's going on, so they seem to be able to pick up when a patient is not well by just looking at them, [...] They just seem to be able to pass the patient ... and know they need to do something that something is not quite right. Where as I've found the way the new nurses seem to be trained is very much dependent on technical feedback. And I find the older nurses use a lot of visual cues to do kind of continual assessments. They just seem to be able to pass the patient and know what they need to do that something is not quite right. But I think the older nurses seem to be trained differently, you know visual cues and listening to patients seems to be much higher in their assessment skills. *Brigitte, G Grade*

The Dreyfus model of Skill Acquisition (Benner et al 1992) describes the five stages of expert development. This is a useful model with which to consider the range of experience and qualifications of the nursing workforce and, how it develops overtime. In a further study (Benner et al 1997) have shown how clinical practice develops in dialogue with others and, a well-functioning team requires effective communication of experiential learning and a social climate that supports sustained vigilance and care. Experience and expertise is developed over time and cannot be taught. Experience therefore, should be both prized and utilised in the development of practice and quality of care.

The majority of this sample also attached a great deal of meaning to being a nurse, with many expressions of job satisfaction at a professional as well as emotional level:

Oh where would you like me to start? I love a challenge [...] I love introducing developments and making things better, improving things for both patient care and nursing skills and all that sort of thing.

Emma, F Grade

Emotional satisfaction I think more than anything. It is really nice to be able to watch somebody getting better and go out.

Jane, E Grade

There was also evidence of enduring commitment, which was expressed at several levels. In terms of a commitment to nursing, many of the sample felt committed to supporting the professional development of up and coming student nurses, to patients and to colleagues. In terms of the Trust and the organisation, expressions of commitment were mixed although this could be the result of faltering communication within which, there is (as previously discussed) the potential for nurses to be unaware of how much they are valued by the Trust:

I like it here I don't think it's because of the way the Trust works, I like it because it's got specialist services but it also serves the local population as well, and I like that aspect of it. I like the variety of work that you get here and I like the variety of people and I like that it's a teaching hospital because you have to keep, you know, innovative work keeps coming in. I like that part of it. But, you know, I just think, person wise; the Trust are not particularly supportive.

Alicia G grade

Nevertheless, there were some very positive comments:

I think we do provide a good service and I think we look after our staff quite well, and I know people don't always see it that way.

Pamela, H Grade

I feel like this is the first job I've had really that they look after me as well as me working hard for them. [...]. I just feel if they're going to give me a good life so I intend to work hard and be loyal to them really. Yes, well since I got this job I knew I'd be here until the end of my working life.

Donna, HCA

Although enduring commitment was evidenced, current work in the Nursing Research Unit has shown that commitment can be threatened during the course of a career. These threats may originate from the organisation, but also from the personal/social sphere. Nurses at the beginning of their careers can for example, experience high levels of dissonance between demands between personal and organisational pressures, which can make it very difficult for young people to remain in nursing (Bennett forthcoming).

This sample has overcome the previous threats to career posed by childcare responsibilities. This could be because part-time nurses returning to work after maternity leave are no less committed than their full-time colleagues (Davey et al 2005).

Summary – key points

- No expressions of ageism in terms of policy and practice
- Nursing practice can benefit from life skills and experience
- Commitment is important in terms of retention
- The Trust are aware of and monitor the health of the older workforce

Retirement

Many of the participants had not really considered retirement plans until the interview and used the interview as an opportunity to discuss their plans. It could be the provision of mid-life/pre-retirement planning courses would be beneficial. Nevertheless, as shown in Table 1, retirement predictions were as follows: four participants said that they had made no plans to retire, one planned to retire at 55 years of age, four said that they would probably retire at 60 years old and five would retire at 65. Four participants planned to work past their retirement age.

Table 1

Retirement plans	Gender	Grade	Time at Trust years	Time in nursing years
retire at 55	F	F+	9	29
retire at 60	F	D-E	15	37
retire at 60	F	F+	6	25
retire at 60	F	F+	40	40
retire at 60	F	F+	16	29
retire at 65	F	F+	21	27
retire at 65	F	F+	4.5	25
retire at 65	M	F+	5	42
retire at 65	F	F+	10	27
retire at 65	F	F+	2	30
work past retirement	F	D-E	29	34
work past retirement	F	D-E	26	36
work past retirement	F	F+	20	29
work past retirement	F	F+	2	28
no plans	F	F+	12	27
no plans	F	A-C	2	2
no plans	F	F+	16	29
no plans	F	F+	1	46

The findings show that links between personal and work factors affect retirement decisions in the same way as they do throughout the course of a career. The following sections outline the main organisational and personal push/pull factors that affect participation in the workforce. We suggest possible solutions to encourage continued service and make suggestions where policy might be developed.

Communicating retirement

The majority of participants had made limited plans or preparations for retirement and indeed explored their retirement options and intentions through the interview process. This suggests that NHS and Trust policies may influence retirement intentions and encourage retention. At the level of the Trust we found that there were systems in place to inform staff of their options prior to retirement:

We run pre retirement courses on a regular basis. We look forward on the payroll, as it were, and you see people who are coming up to retirement age, and you do this about 12 months in advance, so it's a 12 month rolling review. And you write to them and you say you know you are due to retire on X. There are lots of options available, we invite people to our pre retirement courses because the thing that concerns most people is A) you know, if I do X what's going to happen to my pension, and secondly well, you know, what options are available if I want to continue working. So they come along and you know the session is generally led by our Payroll Manager who happens to be also our pensions expert, but we get in an external organisation to actually talk about the finances and how people manage their money and what the issues might be once somebody does retire, and what does your mortgage look like, and do you know that sort of thing. So, basically we give people some food for thought and some, useful contacts.

Int:

And do most people attend them?

Yes.

Laura, Manager

We run retirement courses, and I can't remember the details, but I think we write to everybody when they're 55 and so we can talk about it. I mean it causes some difficulties for us because of course we're trying to encourage people to, to be very, very open about older applicants for jobs we find ourselves recruiting people who are about 55 and then tell them about their retirement options.

Rick, Manager

However, communication appears to be faltering between Trust and ward level, and the findings suggest that some participants had limited awareness of policies, and were unaware of when and how they could retire:

What age can you retire?

Well I don't.

They seem to keep changing it don't they.

Yes.

Is it 68 now isn't.

Well you can, you can have early retirement at 55.

I think it's.

I think it's according to the year you were born I think, and then it goes, it goes up, because they're planning to put the age up.

I heard it was 70, but now I think it's going down to 68, yes.

But, but years ago they told me that I could go at 60.

60 years.

And that's what I'm doing, I'm going at 60.

I thought 55 ... 55.

Yes.

nurses could finish at 55.

nurses can finish at 55 if they want to.

Focus Group

There was also a lack of awareness of retirement options, and strategies to develop the communication of retirement policies to staff need to be explored. A lack of awareness was illustrated by several participants, with many sceptical or fearful as to how flexible retirement would work or would not work:

Int: Do you feel fully informed about the flexible retirement initiatives in your pension plan?

Not really. Mind you I did go and investigate because I'm now paying, a little more attention and I need to make sure that by the time I retire I get the most that I can. But I can't honestly say I'm au fait with the ins and outs of it now to be honest.

Int:

Right. Have you had any kind of consultation about your retirement options?

Oh no, anything that I've ever done I've had to go and find out.

Int: You do it yourself?

Yes

Julienne, G Grade

Communication between Trust and ward level could be improved by introducing a system whereby all members of staff are contacted about their retirement options regardless of age. Although there was a general perception of a lack of awareness of retirement policies we did interview one very proactive and progressive ward manager who helped staff with their retirement plans and preparation. In the absence of the support and guidance of ward managers, an older worker advisor may prove useful as a means of informing staff of their options pre-retirement:

I've retired two nurses, when they were coming up to retirement, I got in touch with Payroll Liaison and I asked them if there was anything in place. And lo and behold, I was amazed, they had Retirement - Plan Your Retirement Study Days, which I sent the nurses off to, and they found it incredibly informative.

Pamela, H Grade

It is well known nursing can be both physically and mentally tiring and research shows a link between health issues and retirement decisions (Disney et al 2004). The findings of this report have also found that health is one of the most important factors in retirement decisions and although health issues may be isolated they can coexist with other important considerations such as finances. Therefore, it is possible that older nurses, despite failing health will continue to work because of financial reasons:

I don't know whether I'll be able to retire at 55. I mean ideally I would like to. I mean I know that in terms of my back injury and my knee injury that it's a bit of a struggle sometimes, so yes I mean I suppose ideally I would prefer to work less, but.....

Int: Would you retire at 55 if you could afford to?

Yes

Iris, E Grade

In the NHS, between 1991 and 1997, 33% of employees retired on medical grounds at a mean age of 51.6, mainly for musculoskeletal reasons followed by psychiatric reasons and more than 60% thought their ill health was caused by work (Pattani et al 2001). A recent qualitative study found that stress was a major influence in retirement decisions for older nurses but there was some indication that when measures to reduce stress were adopted, they were effective (Watson et al 2003).

Another important factor in the retirement plans of some of this sample, was the continued burden of child support in terms of university fees:

I was talking about this, this morning, with my children, when I was 18, I went off to the School of Nursing and it didn't cost my parents a penny. Whereas now, when they hit 18 and you're usually in your forties you're actually going to be shelling out shed loads of money for their university fees. So then you think, 'I won't be able to retire.' I'm thinking I'll have to go full time, which is just at the wrong time of your life really. You know, you're tired; you're just getting a bit of life back. And you've got to go full time to pay for your kids.

Alicia, G Grade

Summary – key points

- Majority of participants had made limited plans or preparations for retirement
- Personal factors such as health and finances are important in terms of retirement decisions

- Continuing child support in terms of university fees of children feature in retirement planning
- An older worker advisor could be useful in terms of retirement planning

Education and Development

In terms of education and training there was a widespread appreciation for the excellent provision of further training and courses:

I think the opportunities that we're given for education and courses are very good. You get quite well supported.

Grace, G Grade

Managers reported that access to courses is universal regardless of age, experience or working patterns:

There's no difference made in terms of our study leave policy and our equal opportunities policy for nurses who are around about 22 age and those who are over, there's no difference. If you're a member of staff here, you are entitled to your full allowance for mandatory training, such as Moving and Handling and Basic Life Support and Advanced Life Support and mandatory equipment training etc., all the things that you would expect to have, plus, on top of that there is an allowance which is also giving pro rata to part timers, so that you can undertake formal education in line with our HEI that has our post reg contract, in accordance with the corporate objectives of the Trust and the needs of the care group, as well as the individual's own personal development. *Josephine, Manager*

The findings did suggest however, that both nurses and managers are aware that older nurses can be disadvantaged by Agenda for Change. As one Trust manager said:

Well I think the fact that Agenda for Change, take this as a case in point, we had to look at all the job descriptions across the Trust [...] some of those job descriptions were way above what we needed. And I think that then starts to exclude people. You're going to be in a situation if you make these criteria too high you won't get anyone applying for the jobs because you'll have tightened it so much. Now if a nurse has been working in an environment for a long time and has been at a certain Grade it may be that they'll just take one look at some of the new job descriptions and think well I clearly don't fulfil the criteria here, even though they have the qualification or experience. [...] So I think that's definitely the Agenda for Change process.

Phyllis, Manager

With a nurse at ward level expressing similar concerns:

I prepare people for interviewing now, when a nurse comes to a certain age they feel they ought to be promoted. They're very caring nurses and you know on the whole, they are very committed, but if they haven't got the background of educational development and haven't, they're not very dynamic under management then they do miss out on being promoted. I'm aware of ... older nurses, I mean when I say older kind of over 45, that have not been promoted and have not had their career structured in a way that they felt that they were valued.

Brigitte, G Grade

The data also suggests that some staff felt they needed to be overly pro-active in their careers, seeking their own contacts and opportunities, which can lead to an individualised self-pursued career rather than a career developed in conjunction with the support of the Trust:

I don't know, if you're always striving to be something, you always have to have the next step ready. I suppose if I was really career minded I wouldn't have sat on my F grade for the past few years, I would have been out there fighting my way type of thing, I'd have been more proactive.

Kathryn, F Grade

I think what's helped me is that I am very assertive, and I'm very good at networking and I think often in nursing it's about who you know and how you sell yourself. I think I've had opportunities because of the people I know, I've been able to sell myself quite well. And I think that does help because I sit on lots of little committees and things where you hear things all the time about people not being able to develop and not being given opportunities. And I think sometimes it's just because they don't know the people to go to, to get those opportunities. So I think, it's a Trust where there are opportunities, where you can get opportunities if you want to. But equally I do feel, on the negative side you could be kind of lost in the wilderness in King's if you're not assertive and you don't push yourself forward.

Pamela, H Grade

Career progression is an important element in encouraging staff to remain with their employer. The RCN's annual employment survey found analysis by grade revealed that E grade nurses (representing 35%) of the NHS nursing workforce with between 11 to 15 years' experience are less positive about progressing in their careers, and are more likely to be negative in general about other aspects of their careers and working lives (Ball & Pike 2004). In terms of this study, several nurses, many of who qualified via the certificate route, reported that they were unhappy that Agenda for Change appeared to value nursing qualifications over experience. They were most concerned about the probability of being overlooked for promotion in favour of younger less experienced, but more qualified nurses.

Summary – key points

- Staff felt that access and provision of courses and further training was excellent
- No evidence of direct ageism in terms of further training
- Majority of participants positive about accessing training opportunities in the Trust
- Agenda for Change is perceived to sometimes disadvantage older nurses by valuing qualifications over experience
- The potential for staff to develop individualised rather than collective supportive careers within the Trust

Role conflict and stress

The data suggest that there are a range of specific stressors associated with working in a 24-hour acute setting. Stress is important not least in terms of health, but also in terms of posing a threat to commitment, and by implication retention. The findings suggest that nurses working in managerial posts at ward level are working in a particularly stressful environment. Below is a detailed discussion of how nurses' experience working in a stressful environment and how stressful situations are produced, experienced and negotiated.

Trust managers are required to run an efficient service, within budget, and NHS targets. Equally, at ward level, managers are required to work within budget and in accordance with national and Trust policies. This is an enormous balancing act, which is difficult to maintain at all levels. One of the major outcomes of balancing national, Trust and local needs is that many of the managers we interviewed at ward level articulated signs of working in a stressful environment. Stressful situations are known to produce a range of outcomes including a negative impact upon professional pride.

A recent document by the Health and Safety Executive defines stress as an adverse reaction people have to excessive pressures or other types of demand placed on them (Health and Safety Executive 2006). Stress associated with a 24-hour setting is well known. In 2001, a report was published which examined the stressors identified by ward managers (Allen 2001). The major source of stress among ward sisters and charge nurses was their anxiety about whether, how and by whom their wards and units were to be staffed each day. They had serious concerns about the competence of unknown agency nursing staff. Much of their stress was caused by organisational and managerial factors, which they felt to be beyond their control. Many of their problems related to the infrastructure of the organisation - unreliable support services, old and poorly maintained equipment and inadequate IT and administrative support. They were particularly concerned about patients who were in the wrong place at the wrong time, which they identified as an organisational bed management problem beyond their control.

The research by Allen showed that ward sisters and charge nurses felt that management imperatives and targets were imposed on them with insufficient consultation or consideration of how they were to be implemented. They found it particularly difficult to get their voices heard. The report makes 22 detailed recommendations and argues that if the modernisation agenda of the NHS Plan is to be implemented it is time to tackle the underlying organisational, inter-professional and professional causes of stress among key members of NHS staff.

The principles of nursing practice are underpinned by a code of conduct as set out by the Nursing and Midwifery Council (NMC). The NMC does not offer any specific guidance on the accountability of nurse managers other than clause 8.4 in Code of Professional Conduct, which states that: 'When working as a manager, you have a duty towards patients and clients, colleagues, the wider community and the organisation in which you and your colleagues work. When facing professional dilemmas, your first consideration in all activities must be the interests and safety of patients and clients' (Nursing and Midwifery Council 2004). In this study the data contained many examples of balancing the needs of the organisation with the needs of the

patients and staff. One example was role conflict produced by the financial pressures associated with managing a ward:

There are lots of pressures. And yes ultimately a lot of it comes down from the top in terms of budgets, in terms of, you know, the Trust. So I think, when you get to this level, it's really more about recognising what the issues are within your Trust where you work. And it's not just about the issues on your ward. There's always the bigger picture.

Pamela, H Grade

Role conflict was further evidenced in relation to staff shortages. Lack of appropriate staff is a key stumbling block to the provision of effective nursing care (Adams & Bond 2003). This was a recurrent message in interviews with nurses in a wide range of acute hospitals (Adams & Bond 1995, Adams et al 1998). Research about service restructuring tends to focus on the workplace (Buchan 1999) whereas our research is concerned with the interrelationship between organisational and personal factors and workforce participation. The majority of nurses interviewed expressed their concerns the effects of staff shortages on nursing practice:

Last year when we were told we had to take healthcare assistants, I had to then go and say to the staff, 'Look, don't kill the messenger, but we have to take healthcare assistants.' And I knew there was going to be enormous uproar. It was going to be, 'Well who's going to look after them, who is going to train them, what are they going to be able to do?' [...] But, you know, it was then getting the rest of the staff to take that on board and to accept that that was very much a fait accompli, and no matter how much I went out there and stood my ground, I wasn't going to be able to say, 'No we can't have them,' because it was a Trust directive, and therefore, coming from the Trust, there was nothing I could do.

Pamela, H Grade

The workload is for 3.5 full time equivalents, we're only 2 full time, so our timetable is crammed and overflowing and there is not one bit of time to do anything else. I've been trying to provide an audit for the general manager since August. You know its, pressure being poured upon you all the time and you have no control over it, that's the other thing, we have no control over what we do. We agreed to this timetable, we haven't had a choice in the timetable. We're told what we're going to be doing; we're told how many patients there are. We're told when you've got to change something. So huge pressures, huge stress.

Melanie, F Grade

You know we run on bare minimums. One F Grade, the rest are D Grades. I cannot leave the ward. I haven't got time to just disappear off for an hour or so and do that. Once you're here you're here until you've handed over to the next one. It's very rare we've got another, I have another member of staff on with me who is an E or an F that you can just disappear off the ward for a bit, even to go down and get a drink.

Jane, F Grade

Role conflict could be of enormous importance to the NHS because it has much higher rates of sickness absence and lower morale than many smaller independent organisations. The recent Royal College of Nursing report, *At breaking point? A survey of well being and working lives of nurses in 2005*, found that 'psychological wellbeing' for nurses as measured by the CORE Outcome Measure - has decreased since 2000 and stress is now nearly twice as high as for the general population. The survey also found that nurses find working in NHS hospitals more stressful than independent hospitals in terms of workload demands, employee control, workplace support, working relationships, understanding of role in work and communication of organisational changes at work. 'Psychological wellbeing' of nurses working in the independent sector is a quarter higher than those working in the NHS according to the Core Outcome Measure (Ball & Pike 2006). The Healthcare Commission's review of ward staffing, published in 2005, found very high levels of sickness absence for nurses. The average time lost to sickness equated to 16.8 days per staff member. This amounts to an annual cost of £275 million (Healthcare Commission 2005). This is very high compared to other public sector workforces. In 2004, the Cabinet Office found that the average sickness absence across seven sectors (Civil service, local government, police, teachers, social services, health and the prison service) is only 11.3 days per employee, which is substantially lower than that found for the ward workforce (Health and Safety Executive 2004)

We are aware of the 'crisis of affordability' faced by Trusts throughout the UK (Bosanquet et al 2006). Nevertheless, KCH has implemented a range of development programmes. KCH has supported 45 ward managers over a 5-year period through the RCN Clinical Leadership Programme, staff also undertake a King's Fund Leadership Development Programme, and there is a Development Programme designed to enhance management and leadership skills.

Developing strategies to address the health needs of the National Health Services (NHS) workforce are of concern to many health care managers (Jinks & Daniels 2003), and developing strategies to support ward managers working in isolation from their peers could also prove to be of overall benefit to staff as well as the Trust. The flexible working options provided by KCH can help alleviate feelings of fatigue and stress, however, although 8 hour shifts are available many nurses chose to work 12-hour shifts. Nevertheless, strategies to support managers working in stressful environments need to be explored through mentoring or other support schemes. Under the forthcoming Age Discrimination Act it would be discriminatory to offer confidential voluntary health checks just for nurses aged 45 and over. KCH already operates a pre-employment occupational health screening service, and offer advice and support requested by management in order to address individual sickness problems. This 'open door' policy not only works well within the Trust, but also, avoids any discrimination on the basis of age and any association of surveillance in terms of role and performance.

Summary – key points

- **Role conflict is a potential stressor for nurse managers**
- **The implementation of policy at ward level is a potential stressor for ward managers**
- **Mentoring and support strategies to support ward managers would be useful**
- **An 'open door' policy of occupational health screening avoids any association between role and performance**
- **Inadequate breaks for staff is a patient safety issue**

Supervision

The role of the NHS in supporting qualified nurses is important for the development and retention of staff. Since the 1990s in the UK, clinical supervision for nurses has been endorsed by the Department of Health (DoH), nursing professional bodies and nursing academics. Clinical supervision is extensively perceived as an important process for professional development within a supportive environment, which can lead to better patient care. Despite

this, there is a perception that the implementation or uptake of supervision is low. However, evidence of participation in supervision is limited to small-scale studies. Similarly, research on nurse perceptions of clinical supervision is limited to small-scale studies that have focused on perceptions in general terms or have focused on mental health rather than other branches of nursing practice (Davey et al 2006).

Clinical supervision related to developing clinical competences has been ongoing at KCH for many years. The first clinical supervision strategy was developed in 1997/8. From this KCH developed clinical competence documents and the practice development nurses role with the aim of supporting staff and taking this strategy forward.

We specifically asked the participants about their experiences of clinical supervision however, as discussed above, King's use the term 'reflective practice' so the following responses may reflect the different use of terminology, and therefore, understanding:

Int: Can you tell me about your current experience of supervision?

Clinically I do yes.

Int: So you give clinical supervision.

No, well it depends what you mean. No I don't run sessions, I mean I used to ... No what I mean is, I supervise other students, you know medical students, student midwives, student nurses, and to a certain extent junior doctors.

Linda, F Grade

What do you mean by supervision? Do I receive, I mean my [manager] is my direct professional senior. [...] we have a good working relationship, but you know, if I'm worried about anything, if I want advice, you know.

Int: So it's a continuous kind of ad hoc thing?

Yes.

Ted, I Grade

We also found that some nurses believed that supervision is important in terms of alleviating stress and absenteeism:

Int: And are you supervised on a regular basis?

No.

Int: No, would you like to be?

I have had this period of sickness, I've been off with stress, and I think it could have been avoided.

Int: Is there a system in place for you to receive clinical supervision?

No. You can go and find a list of names and la, la, la, but there's nothing in place that you can easily access. You have to be proactive and go out and find it, and if you want to do that, you probably can find it, but it's the time constraints and do I really need it, you know.

Alicia, G Grade

Particularly when there's difficult patients ... but when there's a patient who they're finding difficulty managing ... it can cause a lot of sickness and absenteeism. And ... gives the best benefit on and whose ... But it's not that acknowledged that clinical supervision could make that much more manageable.

Brigitte, G Grade

However, an evaluation of a local clinical supervision scheme for practice nurses found that many felt clinical supervision was not necessary because of the availability of existing peer support (Cheater & Hale 2001). At KCH we also found several instances of nurses appreciating and valuing the support of their colleagues and family during periods of stress:

Int:

How are you supported through those emotional times?

Mostly you're supportive with each other. If we need it, if we have say a traumatic death or something like that then we'll do reflection sessions [...]. So if you feel that you know you really need to talk to somebody you can go and talk to her. We don't have anything formal; mostly it's support from your family and support from colleagues.

Jane, F Grade

Nursing is both an emotionally and physically demanding profession (Davies 1995) and the literature suggests that nurses may perceive benefits from clinical supervision (Williamson & Dodds 1999). At KCH reflective practice is well embedded in some clinical areas, and it is the aim of the Trust to embed reflective practice sessions across all clinical areas, and therefore the work is ongoing. The apparent misunderstanding of our use of the term 'clinical supervision' could be because we interviewed staff in clinical areas where reflective practice has yet to be developed. In the meantime, given the apparent benefits of informal support networks, these could be formalised as a means of support for nurses.

Summary - key points

- Research staff were not aware of the use of the term 'reflective practice' at KCH
- Regular supervision could alleviate absenteeism due to stress related sickness
- In the absence of formal supervision staff will seek support from colleagues and family
- Informal support networks could be formalised

Improving working lives

In July 2000, the government launched the *NHS Plan* in which it set out its agenda for the development of health care services over the next 10 years. This included the *Improving Working Lives (IWL) Standard*. The IWL is a commitment by NHS employers to create 'well managed, flexible working environments that support staff, promote their welfare and development, and respect their need to manage a healthy and productive balance between their work and their life outside work' (Department of Health 2000b).

The implementation of flexible working is subject to a range of interrelated factors. In terms of access to flexible working, the findings suggest that some Trust managers do not agree on whether King's Flex is either fully available or workable. One trust manger said that the size and variety of settings with King's enabled more flexibility:

In actual fact because of the sheer size of the place the bigger the units the more flexibility we can offer. Yes, and generally speaking it isn't such a problem. Our biggest problems are probably in the areas where lots of people work 9-5, like for example theatres, but there's an on call requirement. Obviously people are attracted to the 9-5 environment because perhaps they've got children or other commitments, but they find it difficult to do the on call requirement on top of that, because obviously we run emergency theatres as well.

Rick, Manager

Whereas, another manager expressed a different view and was concerned with the level of requests for flexible working:

I think that that has been more problematical in the last year or so in that there is a missed perception in that King's Flex means that the staff can do whatever they want to do and nobody can tell them different. When actually, we have sort of had to pull back a bits say, 'Well no, you can't all work 9 to 5, because we have a service to cover.' So I think that there are some misconceptions around that, which we're trying to work around. And that does create some issues, because obviously it can create some degree of bad feeling as well as having a workforce that doesn't meet the needs of the work really.

Valerie, Manager

At ward level the availability of flexible working was mixed, with relatively equal amounts of nurses expressing negative and positive views:

There is now term time working available, whereas there wasn't when I started. I think I might have taken advantage of that. School holidays are such a headache. And I think, you know, they are taking on, within this department anyway, quite a few more 9 to 5 staff as well as the other staff on long days. I just think they are much better than they used to be.

Alicia, G Grade

Yes, I think there's a lip service to say that this is what we're doing, but I don't know whether it actually exists. I mean it wasn't a problem for me, but I know for other nurses on the unit, I suppose people with childcare arrangements and things like that you know maybe wanted to work just certain shifts for a period of time or something like that and they weren't allowed to do it so they ended up leaving or going to another area where they could do that.

Iris, E Grade

In terms of resources, staffing levels were found to be a barrier to flexible working. As one trust manager said:

So yes I don't think it is difficult to get flexible working in any area of the Trust. In some areas it is more difficult than others, but I think that boils down to staffing numbers rather than the sort of you know who you are, whether you're a nurse or a secretary or whatever.

Laura, Manager

Access to flexible working was also linked to particular care groups rather than the trust:

Not necessarily the Trust but our care group is not family friendly. If people want to go part-time they won't guarantee them days, and they want them to be flexible about what days they work and all that sort of thing, which I don't think is family friendly. [...] If you have to arrange childcare you need to have it on specific days.

Linda, F Grade

Access to flexible working was also linked to seniority. As one trust manager said:

I mean one of the issues I think is about; the King's Flex seems to be used more by senior members of staff and less by the ward staff. Now I can understand why that's the case because if you have a workforce on a ward and everyone was on King's Flex you wouldn't be able to run the ward. So there is an issue.

Phyllis, Manager

And the link between seniority and flexible working was evidenced at ward level:

Well mainly in my position, I'm quite fortunate that I can work 9 to 5 most days. I don't have to do weekends and I don't have to do nights. So that does help. And I'm quite lucky. There are days when I do work long days, but again, I tend to fit that in with where my children are and what they need to be doing. So if they've got after school activities and I can't work a long day, which would finish at half past eight, and if I needed to work a long day, I would fit that in with a day when, you know, my daughter can be at home or my husband's at home.

Pamela, H Grade

One of the advantages of an age diverse workforce means that flexible working can be more easily implemented within teams. In in-patient settings, not having any childcare responsibilities means that older nurses are more likely to work 'traditional shift patterns'; whilst their 'flexible' colleagues with childcare responsibility adhere to less traditional and inflexible shift patterns. Flexible working may inadvertently produce an inflexible workforce at the expense of the flexibility of the older workforce. As one nurse said:

So somebody can say, 'I need to be with my children, I need to work 9 to 5, I can't do this on call burden that you're giving me, I can't get childcare provision' - apart from the fact that has a knock on effect on the other staff, I can't say that because I don't have young children increasingly they're looking at service, what service needs.

Sylvia G grade

Older nurses may be happy to work regular shift patterns. However, there needs to be an awareness that the availability of flexible working to younger nurses does not impose a burden on older nurses, many of whom may have increasing health problems or just cannot work at the level of a younger nurse. As one Trust manager said:

But I must admit I do think sometimes, can you reasonably expect somebody who is 45 plus, of age, to be charging around an orthopaedic, 32 bedded orthopaedic ward, answering every buzzer and giving every bed pan out, as sprightly as I used to do when I was 24, 25?

Josephine, Manager

The variation in perceptions of access to, and implementation of, flexible working is an issue that needs further exploration, which is not within the remit of this research. There is, however, an important question to be raised, if there is such variation in the implementation of flexible working, how are decisions made? Our findings have already highlighted that ward managers can be burdened by the stress of maintaining a service. Our findings have also found that ward managers are key in implementing policy. It could be that under the present system ward managers are being left with the difficult decision of deciding who can have flexible working and who cannot.

Summary – key points

- Flexible working can falter in an acute setting
- Staffing levels are a potential constraint to flexible working
- Nurses have expressed mixed views about accessing flexible working
- Access to flexible working is perceived to be easier for senior staff
- Older nurses may carry the burden of the 'inflexible' flexible worker.

Discussion

The following outlines the **research questions** and our interpretation of the findings, which will serve as a basis for discussion with the Trust. There were both positive and negative comments about working for the Trust and, in many ways the negative comments were generated by a lack of understanding and communication between staff at Trust and ward level. This document has shown that retirement issues for this sample are subject to a range of organisational and personal factors that cannot be considered in isolation.

Under what circumstances do the policies work in terms of the context of the organisation that facilitate or constrain their success and development?

In recent times the notion that communication simply reflects organisational realities has been rejected and replaced by a view that understands communication as a formative process, which creates and represents the processes of organising (Putnam et al 1996). In this contemporary view, organisations are structured and sustained through the articulation of meaning produced in communication. Organisational realities are established through these formative communication processes, power structures are developed and maintained, and organisational outcomes determined. Personal and targeted communication is a way the Trust can draw staff's attention to key policies and express the value it places on staff. Communication was found to be key in terms of disseminating policies and that misunderstanding can mean that staff can feel de-valued or do not take advantage of policies. Even if there is a comprehensive communication strategy in place, staff may need support in processing the volume of information received.

What is the impact on older nurses of national and local retirement, retention and lifelong learning policies in terms of widening participation, providing flexible working opportunities and career development opportunities?

There were many positive comments about working for King's College Hospital, in terms of training opportunities and career development. Although nurses were keen to access further training, some Trust managers believed that ambition and further training could tail off with increasing age. Dissatisfaction with Agenda for Change was also noted. Many experienced nurses who trained via the certificate route had a perception that Agenda for Change values and rewards degrees and qualifications over experience.

Meeting the needs of the Trust and the needs of the ward can be stressful for ward managers. Strategies to support managers working in stressful environments need to be explored. Developing strategies to support ward managers working in isolation from their peers could be of benefit to staff, the Trust and patients. Clinical supervision is called 'reflective practice' at KCH and it has been going on at KCH for many years. Although it is well embedded in some clinical areas it is not fully implemented, and the work is ongoing. Some of the participants made links between regular supervision and better patient care, the alleviation of stress, and the reduction of absenteeism due to sickness.

For whom do the schemes work? Do they work for some participants and not others?

In line with the Government's equalities agenda, KCH operates a policy of Equality and Diversity in Employment, which includes age and other facets of diversity including gender, sexuality, ethnicity, religion and disability. It operates a Race Equality Scheme and is pursuing a workforce equality action plan (KCH 2005). Progress is monitored against Trust equality targets, in terms of ethnic origin, gender and disability status. At the time of study, age was not monitored.

In terms of flexible retirement, following national policy, KCH offers Wind Down and Step Down while preserving pension rights earned at a higher level, and Retiring and Coming Back on a part-time basis. Staff are also offered the option of deferring retirement for a limited time with KCH paying pension contributions on their behalf.

In line with national policy, staff with children aged under 6 years (or up to 18 years if the child is disabled) can request flexible working. However, the request must be considered in relation to 'service needs and financial accountabilities' (KCH 2005). After two years service, staff can apply for a career break of up to two years for travel, education or family care (KCH 2005). KCH has achieved IWL Practice Plus and are commended to other Trusts as worthy working practices for their flexible working schemes, training and development, HR Management and Practices, team working and team relationship and staff involvement project (KCH 2005).

Views about access to, and take up of, flexible working were mixed, and there was evidence to suggest that IWL initiatives can falter due to the demands of a 24-hour acute setting. Another barrier to the implementation of flexible working was found to be staffing levels, with little access to flexible working in areas of high vacancy rates. The findings suggest that access to flexible working is linked to seniority, and ward managers were able to manage flex working without detriment to their workload. Flexible working may inadvertently produce an inflexible workforce at the expense of the flexibility of the older workforce. This situation needs to be explored further in light of increasing health issues with age.

Recommendations

Strengthen and develop further the support schemes for ward managers

Direct communication with clear information would convey value to staff at ward level

Clear communication strategy throughout the Trust, with clear concise and consistent information would improve understanding of how policies work in practice

Implementing mentoring and support strategies for managers could facilitate policy implementation at ward level

Developing training schemes in implementation of flexible working for ward managers could reduce inequalities in access

Develop ways for older workers to access the King's Flex policy and if necessary include the particular commitments and circumstances of older employees

Trust feedback

The Trust would like it to be known that they have an established and comprehensive communications system. In terms of mentoring and support strategies, KCH has supported 45 ward managers over a five-year period through the RCN Clinical Leadership Programme. In 1997/8 KCH replaced clinical supervision with reflective practice, which is linked to clinical competencies. This system is embedded in some clinical areas, and the aim of the Trust is to establish this system in all clinical areas, therefore, the work is ongoing. In terms of flexible working, the Trust have an independent assessment panel, (staff independent of the particular care group involved who are all ACAS trained grievance assessors) who deal with any allegations of unfairness about how King's Flex is working in certain areas. The Trust is consulting with staff to review how King's Flex works in practice. Following this consultation the Trust might consider rewriting the King's Flex policy to highlight how King's Flex can be accessed by older employees, including nurses, to take account of their particular commitments and circumstances.

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Appendix A: Interview schedules

Trust Id:

Nurses Working in Mid-Life: Organisational and Personal Perspectives

Trust Managers Schedule

(not all questions will be relevant depending on the position of the interviewee)

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Nursing Research Unit
King's College London
James Clerk Maxwell Building
57 Waterloo Road
London SE1 8WA

Tel No: 020 7848 3064

The Nurses working in Mid-life Study is concerned with identifying organisational, professional and personal factors, which influence the participation and commitment of older nurses in the workforce. We will be interviewing nurses aged 45 and over to gain their views. But we are also interviewing Care Trust managers with responsibilities for developing and implementing key HR policies in terms of personal and career development, work-life balance and education and training. We are particularly interested in your views as to how these policies translate for older nurses and the issues that arise that may be similar or different to those for younger nurses or for different staff groups, especially those in social care

First, could you outline your roles and responsibilities in terms of the workforce in this Trust?

In this Trust, what are the main issues for human resources in relation to older nurses?

Are there particular specialities or settings in which you are more likely to find older nurses?

Are there any age discrimination policies in place?

Could you outline how policies for nurses are developed in the trust?

Are nurses involved in policy development?

Is age a factor that is considered in policy development?

What factors would encourage recruitment and retention of older nurses?

What factors act as a disincentive for older nurses to stay?

How are nurses through the Trust informed of new HR policy development?

How are nurses given opportunities to identify their needs for flexible or other forms of working?

Are flexible working opportunities the same for older nurses as younger ones?

Generally, what are the flexible working requirements of older nurses?

Do older nurses have the same career development opportunities as younger nurses?

Do older nurses face any particular barriers to career development?

Do older nurses take advantage of flexible working opportunities in the same way as younger nurses?

Is there a formal system whereby take up of different policies is monitored?

In terms of professional development opportunities, are there formal support structures available to older nurses offering supervision or mentoring schemes? Is this the same or different to schemes available to younger nurses?

Are there any schemes in place whereby older nurses could support or mentor younger nurses or students in training?

Are there any other issues you would like to discuss?

Thank you – if there are any other issues that arise through the interviews, could we contact you again?

Trust Id:

**PARTICIPATION OF OLDER NURSES IN THE WORKFORCE STUDY
(POW)**

FOCUS GROUP INTERVIEW SCHEDULE

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Introduction:

As part of the Participation of Older Nurses in the Workforce Study we are interviewing nurses aged 45 and over. We are interviewing nurses of all grades throughout the Trust. The interviews are designed to gather your views on the Trust in particular their policies and how they are implemented. All the information given to us will be treated in the strictest confidence, no names will be used and no-one will be identifiable in any reports.

The interview will take a maximum of two hours. We would like your permission to tape record the interview as this increases accuracy in recording your responses and speeds up the process. If at any point during the interview any of you would like the tape recorder to be switched off, or there are any questions you do not want to answer, please say so.

Do you have any questions before we start?

Start time:

--	--	--	--

Date of interview :

--	--	--	--	--	--	--	--

Facilitator:	BD	1	FR	2	JB	3	Other (write in):
Assistant:	BD	1	FR	2	JB	3	Other (write in):

Are you aware of any policies that are directed specifically at older workers in the NHS, for example retirement initiatives or flexible working?

How are these national policies implemented within the Trust?

How does the Trust inform staff of new policies?

Is there any way that staff can make their views known to the Trust in relation to policy?

Does the Trust have any policies that are directed specifically at older workers in terms of:

- Flexible working
- Continuing professional development
- Career development opportunities
- Pre-retirement
- Flexible retirement schemes.

Would you call this Trust 'family friendly'? By 'family-friendly' we mean how easy does your employer make it for people to balance their work and family responsibilities, not just for young children but teenagers, grandchildren and other caring responsibilities?

Are the continuing professional development opportunities for older nurses (say aged over 40) the same as for younger nurses?

Are there any organisational factors that encourage or discourage older nurses in accessing continuing professional development or any training course? Are they the same or different for younger nurses? Are they the same or different for older nurses in different grades?

Is professional support available formally through supervision or mentoring schemes?

If there are, how do the schemes work?

If not, what would be useful and why?

Are there any pre-retirement or other initiatives you feel the Trust could implement to encourage older nurses to remain in nursing?

Are there any particular issues or initiatives absent from the Trust specifically for older nurses or older workers, which you feel, need to be addressed?

Are there any other issues you would like to discuss?

Thank you very much (and reassure of confidentiality)

May we contact you again?

If so, check that the contact details are correct.

Practitioner Id:

Nurses Working in Mid Life: Organisational and Personal Perspectives

**INTERVIEW SCHEDULE FOR
QUALIFIED NURSES**

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London SE1 8WA

Tel No: 020 7848 3064

Nurses Working in Mid Life: Organisational and Personal Perspectives

Introduction:

As part of this study, we are interviewing nurses aged 45 and over. We are interviewing nurses of all grades throughout the Trust. The interviews are designed to gather information on your work, career and life events, in a sense your life story, as well as your views on the Trust and the NHS. All the information given to us will be treated in the strictest confidence, no names will be used and no one will be identifiable in any reports.

The interview will take a maximum of two hours. You will be asked questions about your career and working life and your future work plans. We will ask you to complete a lifeline outlining key events in your home and work life. We would like your permission to tape record the interview as this increases accuracy in recording your responses and speeds up the process. If at any

point during the interview you would like the tape recorder to be switched off, or there are any questions you do not want to answer, please say so.

Do you have any questions before we start?

Start time:

--	--	--	--

Date of interview:

--	--	--	--	--	--	--	--

Researcher: BD 1 FR 2 JB 3 Other (write in):

First of all, can I just check a few personal details?

How long have you been with this trust?

What is your job title?

Are you full-time/part-time?

What is your grade?

Does that grade reflect your roles and responsibilities?

What is your highest educational qualification?

Nursing/other

Do you have a partner? Yes/No

Do they live with you?

What year were you born?

(Gender: Male/Female)

Can I just ask you some questions about your current caring responsibilities?

Do you have any children?

Yes

How many and how old are they?

Do they live with you?

How do you manage childcare? *Working definition of child <14 years.

If there are childcare responsibilities and a partner identified:

How is your partner involved in caring responsibilities?

Do you have any other caring* responsibilities (parents, grandchildren spouse/partner, other relative, friend), either currently or in the past? Yes/No

'Caring' means that you are in some way responsible for another person. This might include day-to-day care, as in the case of young children or a disabled person, but it could also doing the shopping for an older person or visiting someone regularly to check on their welfare.

Can you tell me more about it?

Who for

What are involved/ hours per week?

impact on your work?

Work/Life History

Have you received a copy of the example lifeline? If not show the interviewee the example.

Can we fill in your lifeline summarising your work and home life and key events.

There is a line for each year of your life from the age you left school and in the next column we would like to fill in family events such as; a) when you got married or divorced (or any changes

in household status); b) when your children were born; c) major geographic moves; d) any other important life event.

In the next column, we would like you to fill in our employment history: a) when you studied or worked outside the home and whether it was full-time or part-time; b) any career breaks, such as maternity leave.

Key: WFT= work full-time SFT = study full-time H= Home
WPT= work part-time SPT = study part-time U=unemployed

There is a column next that for job changes either within the same organisation or a move to another, change in grade, promotions, etc. Please indicate when you show a job change, whether this was a move at the same level, a promotion or a downward move using the following key.

Key: S = Same level D = downward move P = promotion

If participant has a partner:

There is also a column for partner's job moves. We are asking about that because we are interested if any job change that your partner has made has had an effect on your work history.

Would you like some time alone to complete the lifeline? I will be in xxx if you need any help or guidance. Or if you prefer, we can fill in the lifeline together.

Perceptions and experiences of nursing and a nursing career

Now I would like to ask you some questions about your experience of nursing.

What made you decide to become a nurse?

What does being a nurse mean to you?
(Prompt if necessary)

Have those meanings changed over time?

Are there any challenges and pressures of being a nurse in your job? Is anything different if you are older?

Prompt: workload, staffing, resources, younger nurses with degrees, health problems, discrimination from patients/colleagues/managers

Do you see yourself as a career person?

Could we explore what a career means to you?
Prompt: contrast with job,

Did you have expectations from nursing as a career and has it lived up to expectations?
Prompt: changed for better/worse, challenges, relations with patients/staff

Would you like to go further? (Would you have like to go further?)

Workplace

Now a few questions about your workplace

Do you think that career opportunities are the same for you as for younger nurses in this Trust?
What about in the NHS generally?

Has there been anything that has particularly helped your career in this Trust?
What about in the NHS generally?

*Has there been anything that has hindered your career in this Trust?
What about in the NHS generally?*

How often do you have an appraisal and what is covered in it?

Do you think that continuing professional development and training courses are the same for older nurses as younger?

*Could you tell me about the last course you attended?
When was it?*

*Are you interested in further training?
Reasons why/why not, relevance of course, challenges, support*

*Can you tell me about your current experience of supervision and/or mentoring?
What form does it take/how often/who with/how useful is it?
If none received what would be useful and why?*

Do you mentor or supervise other staff?

*Would you call this Trust 'family friendly'? By 'family friendly' policies we mean how easy does your employer make it for you to balance your work and family responsibilities?
Prompt: how easy it to take time off for caring/domestic reasons.
Team/line manager/organisation support*

What is your pattern of working?

*Is that what you prefer or would you like to work a different way?
If prefer to work differently, why is that not possible?
Preferences changed over time?*

What factors would make it easier for you to balance your work and home life?

Commitment

Do you feel valued and supported by this Trust and NHS?

Could we explore what the term 'commitment' means to you in a work context?

*Would you say that your commitment has changed throughout your working life?
Nursing
career*

Are there any tensions between your work and home commitments?

Do you feel committed to the Trust and NHS ?

What do you like or dislike about working for this Trust?

*A few questions about your retirement plans
What are your views on retiring?*

If not already retirement age:

At what age do you think you will retire from nursing?

If respondent has a partner:

Do you and your partner plan to retire at the same time?

Are domestic or caring responsibilities a factor in your plans for retirement?

Are there any professional factors that would influence your retirement decision?

*(roles, hours of work, setting, workload)
organisation (team, colleagues, managers)*

Are there any organisational factors that would influence your retirement decision?

(team, colleagues, managers)

What are the factors that would (or have) encourage(d) you to continue nursing after retirement age?

*Prompt: personal factors (e.g. pay, lifestyle, financial commitments, partner's retirement decisions, lifestyle);
professional factors (roles, hours of work, setting, workload)
organisation (team, colleagues, managers)*

Do you feel fully informed about the flexible retirement initiatives in your pension scheme?

e.g. wind down, step-down

(Wind down: allowing members to reduce their hours without significant detriment to their final pension. Step down: taking a less well-paid job with significant detriment to final pension)

How were you informed about the options available?

e.g. Have you attended any pension seminars at the Trust?

Prompt: reasons why/why not; usefulness, how it could be improved

Are you planning (or are you taking) advantage of any of the flexible retirement initiatives that are available? For example, 'wind down' or 'step down'.

Would you like to see the trust address or introduce any particular initiatives that would help you in your retirement planning?

Given your understanding of your flexible retirement options, do you think you may return to nursing after retirement?

If yes: Would this be for the NHS, the private sector, or agency work?

If no: Would anything change your mind?

Is there any other work you would consider after you have retired, and if so what types of work would you be prepared to do?

Looking back over the things we have talked about, is there any thing you would like to add? Do you think we have left anything out?

Could you tell me why you wanted to take part in the study?

Would you mind telling me your financial contribution to the household income?

For example, do you contribute 50%?

To which ethnic group do you consider yourself to belong:

White – British.....
White – Irish.....
Other White background.....
Black British – Caribbean.....
Black British – African.....
Other Black background.....
Asian British – Indian.....
Asian British – Pakistani.....
Asian British – Bangladeshi.....
Other Asian background.....
Chinese.....
Mixed Other Ethnic background.....

Thanks you very much (and reassure of confidentiality)

May we contact you again?

If so, check that the contact details are correct.