What factors account for the shortage of nurses in the National Health Service?

ABSTRACT

The healthcare industry currently faces a crisis that will only continue to deepen in the future. There are too few nurses who can pick and choose among an almost exponentially increasing number of jobs. The aging population and rapid advances in healthcare are providing a wealth of new opportunities for nurses. The NHS has failed to have a proper nurse retention and leadership programme that will help to maintain nursing levels. Almost half of NHS nurses are foreign born with few ties to the UK to keep them in the country when better opportunities beckon. Current needs can be filled, but future planning is vital if shortfalls are not to occur.

CHAPTER 1 - INTRODUCTION

Significance of the Issue

The National Health Service is the largest employer in Europe and it is responsible for the healthcare needs of a great majority of British citizens. Any shortage of a particular type of position, especially one as vital as nurses, may effect the level of service and quality of care provided by the NHS profoundly.

Aims

The general aim of this study is to explore the complex series of reasons that may account for the shortfall of nurses. While obvious ones such as lack of job satisfaction, the pressures inherent within the work, and competition from other professions (and other countries) will be taken into account, some more subtle reasons will also be considered. Thus the question needs to be asked of whether there actually *is* a shortfall of nurses in the NHS, or whether those that do exist are not being utilized in as efficient a manner as they could be.

The study will aim to quantify the shortfall of nurses, explain why it has occurred, and also point the way towards some possible solutions to the problem. The *how* and the *why* of nursing shortfalls need to be considered before the *what can be done about them* can be tackled in a meaningful manner.

The case-study approach to the nursing shortfall will enable a detailed examination of the specific problems being faced by a particular organization (in this case Kings College Hospital in Denmark Hill). The advantages offered by the case-study will enable broader trends to be identified within the NHS as a whole.

Rationale

The rationale for this study is that nursing shortfalls are a central dilemma for the NHS. The need to provide a meaningful and rewarding job experience for nurses goes hand in hand with a desire for excellent patient care. If nurses are not content on the job, patient care is likely to suffer. This dilemma is of particular interest to anyone entering the healthcare profession, as it will be one of the major dynamics influencing my career path in future years. Knowing as much as possible about nursing shortfalls will enable my own career growth.

Overall Approach

The overall approach to this study will be a mixture of a *literature review* and the *primary research* that will be undertaken through the case-study of Kings College Hospital. The literature review provides the theoretical underpinnings and foundation for the case-study, as well as providing some raw data on the total nurse shortfall within the NHS as a whole. The literature review will also take into account some policies and programmes that have been into place in an attempt to alleviate current problems within the NHS in general, and the nursing shortfalls in particular.

Structure of the dissertation

Chapter 2 will be the literature review regarding the NHS in general and the nursing shortage in particular. This will provide the framework and foundation for the case-study in *Chapter 3*. Methodological issues raised within the previous two chapters will be

discussed in *Chapter 4* while *Chapter 5* will present the findings. *Chapter 6* will provide a summing up and the conclusions that can be drawn from the study: essentially answering the question of what is causing the nursing shortfall. *Chapter 7* will make recommendations for addressing the nursing shortfall.

CHAPTER 2 – LITERATURE REVIEW

There is a large amount of literature on human resource issues, research methods and some available on the specifics of why there has been a shortage of nurses within the NHS. In her seminal book on management and organizational behavior, Laurie Mullins illustrates how the management structure and ethos of any organization will influence both the effectiveness of its activities and the willingness of its employees to stay working within it (Mullins, 2004)

Mullins suggests that matters of particular importance are having a clear vision in place, receptive/nurturing managers who are respected for both their fairness and confidence, as well as well-defined organizational structure that provides routes for promotion. If any one of these is missing, then the whole structure may fall down. Mullins also sees management as what she terms “a core integrating activity” that should apply the principles of “behavioral science” within the workplace (Mullins, 2004).

She provides a contrast to the controlling type of manager as exemplified by the old theories of management. The manger within her vision is someone who is a facilitator for the talents of others rather than a controller. This is an important concept in evaluating how and why nurses might decide to leave the NHS: the management above nurses will be as important as the nurses themselves.

A whole corpus of work deals with various aspects of human resource management. Some of these, such as Beardwell and Holden (1997) concentrate on some of the more modern perspectives and theoretical approaches to human resources. These include empowerment ideas that allow employees to take control of their own destinies

within their employment, while enabling managers to manage at the same time. There is a always a delicate balance between employee management and empowerment: the former must not subsume the latter, while the latter must not overwhelm the former. They can work together in dynamic equilibrium.

Foot and Hook (2005) adopt a similar approach, presenting the clearest concepts of "the latest developments in areas such as employment law and strategic HR as well as current applications of HR practice in the workplace." John Storey's *Human Resource Management* (2005) adopts a more complex approach, bringing to the fore a number of controversies that exist surrounding the subject. As Storey writes early in the book, "and yet, as the phenomenon of HRM seems to flourish – at least at the conceptual level – it remains, and always has been from its earliest inception, highly controversial." As he continues, there are indeed "numerous questions about its nature, its domain, its characteristics, its reach, its antecedents and its outcomes and impact" (Storey, 2005) These concepts are vital to an understanding of nurse shortfalls within the NHS; as human resource management has only really come to the fore within the British context during the last two decades – the very decades when nurses went from being in a surplus to being in a shortfall. The question must be asked whether human resources are too "managed" in the modern day NHS.

Social research as a discipline also has a number of different perspectives. Alan Bryman attempts to situate "social research in the context of sociology, which in turn means attending to the question of its role in the overall enterprise of the discipline." He shows that a lot of social research is connected with "wider social scientific enterprise"

and that such data is “invariably collected in related to something . . . more usually, a theory” (Bryman, 2004).

The link between research and theory introduces how the question of how far social research should test the applicability (or otherwise) of a theory, or whether it should try to explore actual social concerns, problems and relationships. This is especially the case within a discussion of nursing shortfalls, as many of the management programmes currently in place within the NHS are steeped in theoretical concerns, and based upon studies that were undertaken with theoretical underpinnings.

Turning to literature that deals directly with the nursing shortfalls within the NHS, the study by Aiken et al (2001) points the way to some of the reasons why there may be a nursing shortfall. This study, that analysed the way nurses are organized within five countries (USA, Canada, England, Scotland and Germany) found that “nurses in countries with distinctly different health care systems report similar shortcomings in their work environments and the quality of healthcare”. The study also reports that “resolving these issues, **which are amenable to managerial intervention**, is essential to preserving patient safety and care of consistently high quality.” (my emphasis) It thus becomes clear that the problems faced by nurses (which surely lead to the nursing shortfall) are in fact solvable by the correct type of management. It is this management and leadership, that the NHS is currently attempting to address, that needs to change in order to alleviate the nursing shortfall.

This study utilized a survey approach, together with specific instruments such as the Malasch Burn-out Inventory (MBI) “to measure emotional exhaustion and the extent to which nurse respondents felt overwhelmed by their work.” (Aiken 2001). From

between 30 to over 40% of respondents in all countries reported very high MBI ratings, indicating that they would be likely to leave the profession within the subsequent few years. One of the major reasons for the burnout was the fact that nurses report little to know input into the formulation of their working schedules. A remarkable **75 % of nurses in the UK felt that their pay was inadequate** (Aiken, 2001).

> Regarding the management of nurses, the study had the following finding:
>
> Much of the recent reengineering and restructuring undertaken by hospital management has been designed to emulate industrial models of productivity improvement, rather than to address nurses' concerns. These approaches have had limited success in terms of retaining nurses or improving patient outcomes and have been demonstrated in some cases to yield negative outcomes.
>
> (Aiken, 2001)

Again, it seems as though the management of nurses, in terms of both organization and leadership, is highly suspect. The attempt to introduce industry-like management structures to a caring profession has been fraught with difficulty.

Beck (2000), among many other authors, finds an ambivalent attitude among training and newly-qualified nurses towards their careers. Many still believe in the ideals that drew them into nursing in the first place – caring, healing etc. – but are equally

uncertain as to whether the working conditions, from scheduling to management style, will allow them to actually fulfill these ideals.

CHAPTER 3 – THE CASE STUDY: KINGS COLLEGE HOSPITAL IN DENMARK HILL

Kings College Hospital is an NHS Trust that was established in 1993, and currently has 950 beds and about 2075 nursing staff (nursingnet, 2006). It serves an inner city population of around 700,000 in Lambeth, Southwark and Lewisham, and possesses some impressive statistics:

200 million pound annual budget

4200 staff

415,000 patients seen annually

85,000 patients seen in A/E

4000 doctors trained

950 beds

It provides basic medical services, as well as being a regional and national secondary/tertiary centre for liver disease/transplantation, fetal medicine, neurosciences, neurosurgery and cardiology/cardiac surgery. It thus provides a cross-section of medicine, and a whole range of possibilities for nurses.

A cursory glance at the vacancies currently available at the King's College NHS Trust shows a wide range of available positions. There are nineteen positions listed (as of July 26th, 2006), ranging from Trainee Dental Nurses to a Senior Staff Nurse. This would not seem to constitute a shortfall considering the size of the hospital. With roughly 2100

nursing staff these 19 vacancies represent a 1% vacancy rate. However, looking underneath the raw figures reveals some more troubling trends.

A chat-group associated with the hospital supports many of the findings from the literature already discussed:

> I work in an A&E dept in London and we have been working really hard to achieve the famous 4 hour max wait. It's been tough to say the least. **In my experience the priority has sometimes been placed on getting the patients out of the department within the said time rather than on actual care**. This is not a pleasant situation for any of the staff to be as at the end of that day we are there to care for and tend to the needs of the patients not patch them up and send them on their way. On the other hand I have to admit that the scheme has had the desired effect of getting waiting times down and I believe it has given the A&E staff a goal to work towards as regards each patients time. There are definite pluses and minuses on both sides of the argument but my main point is that not all patients can realistically fit into the 4 hour waiting time.
> (nurses4london, 2006)

While anecdotal in nature, this nurse brings up a serious issue that may point towards some of the dissatisfaction that is probably brewing at King's Hospital. If adherence to the 4-hour rule is becoming more important than actual patient care then priorities are starting to become reversed. This 4-hour goal is essentially an industrial-type productivity aim that does not take into account the reality of the variance that will inevitably occur on particular days and with particular cases.

A post from a nurse at King's Hospital shows how some nurses are looking for work beyond the UK. Thus on a discussion board titled "Living and Working in London" the first post, somewhat ironically, reads:

> Hi. Please can anyone tall me how I would go about relocating as a midwife to Seattle WA. The quickest route possible. Thanks.
> (www.nurses4london.co)

At the other end of the scale are those seeking to come into England, such as the post "hi I am a qualified nurse from the phillippines I need some sponsor who can help me get job in London." (sic) Two points here: first, communication would probably be difficult due to the simple (and often incorrect) English grammar, of this poster; and second, it seems likely that she would be looking for remunerative employment in another country soon after she arrived in the UK. The revolving door policy is as in place at King's Hospital as it is elsewhere within the NHS.

One of the major problems at King's (as with hospitals everywhere) is the fact that, as Justin Hewitt (CEO of Nestor Healthcare Group) puts it, "we could actually place every single … individual in healthcare, probably two or three times over." (bbc,2003) The task of hospitals such as King's is to make their particular work situation as attractive as possible: if nurses do not like it they will go elsewhere because there are so many available jobs. Fiona Hunter, who is head of nursing recruitment at King's, claims that:

> ". . nurses from all over the world have been able to integrate very well into the nursing culture at King's
> . . . a patient with renal failure in Australia is the same as a patient with renal failure here, and the

> nursing care of that patient will be the same, the nursing skills are very transferable, and of great value to us."
>
> (Hunter, 2003)

This begs the question of whether the treatment of *nurses themselves* is common throughout the world. Renal failure is a biological process with specific features, outcomes and treatments that are more or less uniform throughout the world; management practices are more complex and more variable.

It is clear that a recruitment head who at least claims that common treatment can lead to a common experience and quality of nurses is perhaps a trifle too rose-tinted or naïve in her outlook. While persons in such positions obviously need to assuage the public regarding the qualifications of foreign-born and trained nurses, they also need to tackle the very real dilemmas that such nurses face. The rapid movement of nurses into and then out of the NHS is a cause for concern, even though they do have the same basic level of education and skill sets.

Hunter graphically illustrates the often chaotic, haphazard but essentially energetic approach towards the hiring of nurses at King's Hospital. She states that "people can paste their CVs across and we can select them, choose to interview them and hopefully mobilize them across to nurse in King's" (Hunter, 2003). It seems clear that the nurses choose King's rather than King's choosing the nurses. This is perhaps the reality of the current healthcare industry where the job market is so tight for employers and so open for employees.

A nurse has skills that are marketable throughout the world, and he/she will be even more in demand as the population ages and as the number of healthcare workers does not keep pace with those needed in years to come. King's Hospital, one of the premiere healthcare institutions in the UK, represents a facility that does not have a current shortfall of nurses, but one that may have one in the future if current trends continue.

CHAPTER 4 - METHODOLOGICAL ISSUES

The research method employed within this study of nursing shortfalls in the NHS is that of the *case study*. This is essentially *qualitative* in nature, although some studies (as in the University of Southampton study) have tried to combine a multiple case-study approach with quantitative analysis. According to Herndon and Kreps (1993), case studies,

> "are a type of qualitative research that offer a specific technique for collecting, organizing and analyzing data. . . researchers father systematic, in-depth information about each case under examination. A case study comprehensively describes and explains the variety of contemporary phenomenon with its real-life context."

Another common feature of the case study is the *holistic approach* (Marshall and Rossman) associated with it. Because the case study seeks to capture individuals as they experience everyday circumstances, it can offer a researcher empirical and theoretical gains in understanding the relationship between the individual NHS employee and the type of leadership that is occurring within the NHS.

The case-study approach offers several advantages. These include (but are not limited to) the discovery of hidden forms of behavior, the exploration of causal mechanisms linking phenomena, the revelation of a critical case and the explanation of variations (Leedy & Omrod, 2005). The case-study approach also provides a way of studying human events and actions in their natural surroundings (Babbie, 2003).

The nature of *human resource management, nurse* retention and leadership are by nature complex and thus may actually be revealed in the “forms” of what people do, forms that are best evaluated within the natural surroundings of the actual world rather than within the more cohesive, but perhaps less proximate to reality world of the model or theory.

Perhaps most importantly, case studies tend to be selective, concentrating on one or two issues that *are fundamental to the system being studied***.** There are also profound differences between the *qualitative* and *quantitative* approaches to research:

Qualitative researchers:

- reject the idea that social sciences (such as education and training) can be studied with the same methods as the natural or physical sciences;
- feel that human behavior is always bound to the context in which it occurs; therefore, behavior must be studied holistically, in context, rather than being manipulated;
- employ an "insider's" perspective; this makes qualitative research an intensely personal and subjective style of research.

Quantitative researcher:

- argues that both the natural and social sciences strive for testable and confirmable theories that explain phenomena by showing how they are derived from theoretical assumptions;
- reduces social reality to variables in the same manner as physical reality;

- attempt to tightly control the variable in question to see how other variables are influenced.

(SDSU 2006)

The differences between these two types of research are of profound importance to the study of leadership within the NHS. The qualitative approach suggests that human reality is infinitely more complex and subtle than that of the physical sciences. Thus "leadership" needs to be considered within a deeply humanistic paradigm that recognizes the uniqueness of every situation.

By contrast, the quantitative approach (and this is the one that seems to have been adopted by the NHS) suggests that human relationships and dynamics are as measurable as any other data. Thus "leadership" can be studied and defined in much the same way as a physical phenomenon within nature. Employees can then be slotted into a leadership programme. The problematic nature of this approach is considered later.

There are a number of ethical issues surrounding the research that is occurring on NHS retention and leadership. One major one is the assumption that there is only one way of viewing both how a leader should be made and how he/she should act within a particular situation. A good example of this is the diversity training programme which, behind what might be termed the "mumbo-jumbo" language is essentially seeking to inculcate a single view of diversity within the workplace. Ironically, diversity training seeks diversity in all areas of the workplace except in discussion of diversity: in that area absolute acceptance is expected.

Thus if a leader in the NHS holds a deep bias against, for example, men under 5'8" tall, but this has no effect upon how he treats his employees (including men under 5'8"), should his bias be regarded as a detriment to his leadership qualities? Present NHS policy would seem to suggest that the answer is a firm "yes", and that the leader should be removed from his position.

Ethical questions also arise around what is essentially the use of human subjects within experimental leadership and retention programmes. While these programmes are not directly experimental in nature (in the way of the famous 1960's experiments on authority and leadership) they do involve what might be termed as a kind of "soft experimentation". Thus if one leadership model is adopted in a Trust and another in a neighboring trust, then the employees at each one will have essentially different experiences that may effect their future performance and promotion. Great care needs to be taken that enthusiasm for a particular programme does not lose sight of what "leadership" within the NHS is aimed at: providing excellent care for patients and a good working environment for employees. Any programme that threatens either of these two overriding ends should be stopped. The rub, of course, comes in trying to identify which these programmes are.

The central ethical issue of retention programmes and leadership development within the NHS revolved around two questions: whether an employer can train (or a government legislate) the content of someone's character: the secret biases, fears, hopes etc. that they contain with them? If they can, should they do so? There is no firm answer to these questions.

A review of methodological issues will be divided into a number of sections, each of which is aimed to provide a background for answering some fundamental questions: Perhaps the major methodological question is to consider whether there is a nursing shortfall within the NHS.

What is perceived as the current shortfall in nurses within the NHS stems from policies during the 1990s when "there was no problem in retaining nursing staff" (Hancock, 2001). By the late 1990's a number of changes had occurred. First, non-NHS demand for nurses had expanded rapidly, while the intake of nurses into colleges was still being dictated by NHS trusts. The English National Board found an intake of about 15,000 new students in 1997, some 30% less than a year before (Board, 1998). An improving economic climate and a general tendency to choose other careers that were seen as more prestigious has led to a decrease in the number of people wanting to become nurses.

By the early years of this century, it became clear that Britain would need to rely upon an increasing number of foreign nurses to fulfill the needs of both the NHS and the burgeoning non-NHS healthcare industry. A 2005 study found that "in the past four years almost 60,000 international nurses have registered with the Nursing and Midwifery Council . . . this represents four in ten of all the 'new' nurses registering to practice in the UK." (Buchan, 2005).

Buchan (2005) also found that 63% of Filipino nurses working in the UK (and this nationality makes up a majority of the foreign nurses working in Britain) are considering leaving for another country, mainly the USA. As Buchan succinctly puts it, "this represents a significant potential outflow of nurses." Together with the rising demand for healthcare, this number alone illustrates that there is indeed a shortfall of

nurses, at least of *reliable nurses who are likely to stay in the United Kingdom*. 'Reliable' does imply skill level; indeed many of the nurses surveyed claimed that they were underpaid and/or deliberately placed at a lower grade level than their actual work would imply. Rather, it is difficult to make a coherent play for a health service whose employees are seeking to leave the country. The features of the shortfall in terms of demographics, type of nurses and numbers will now be considered.

As already stated, the shortfall in nurses within the National Health Service stems mainly from the fact that too few "English-born" people want to become nurses, causing instability among the workforce. One of the major shortfalls occurs because many nurses come into the system and then move through it very quickly. These can be divided into those nurses who come into the system but become disillusioned with their employment conditions and service, and those who come from abroad and who always intended to move on after a short to medium amount of time anyway.

Both groups illustrate the fact that planning with such demographics is rather difficult: some stability is needed within the workforce for both meaningful management and meaningful change in that management to occur. Plans for self-empowerment, changes in management, programmes that are designed to transform leadership – all of these presuppose a workforce that can both participate in and benefit from their changes. If that workforce is constantly changing this is unlikely to occur.

It is now relevant to consider what attempts have been made to alleviate these problems and how successful have they been. Two major programmes have been instituted that have attempted to alleviate the shortfall in nurses by making leadership within the NHS

more accountable, more reactive and also to allow nurses to feel more sense of self-autonomy within their work.

The LEO programme is a three day course designed to introduce the "empowerment imperative" to the NHS. As Smith (2001) suggests, empowerment within the NHS occurs then employees "feel valued for their contributions as decision-makers and affirmed for their risk-taking in pursuit of high-quality care" (Smith, 2001).

The LEO course involves developing a shared language, "equipping participants with tools and techniques and engaging in practical planning of personal, team and organizational future actions" (Smith, 2001). The educational background to the LEO programme is the idea of facilitation rather than merely teaching. Within facilitation participants are enabled to learn for themselves in an active way by the "facilitator", as opposed to the more passive receiving role that students have with the traditional teacher.

A recent analysis of the leading empowered organization (LEO) course that was completed by 30,000 nurses suggests that women and men have different approaches to leadership. As Harrison (2003) suggests, "in general female nurses see leadership as a 'nurturing' role, while men place greater emphasis on directing their staff". This follows the results of other studies on leadership from a range of disciplines.

An alarming number (54%) of nurses felt that they were merely cogs within a machine in their work for the NHS, and a similar number feel undervalued. Male nurses feel that leadership that stresses being in charge and vision is the solution, while female nurses stress nurturing. A more recent study of the Leo programme (Hancock, 2005) suggested that "there was evidence of a sustained impact of the LEO programme . . . in

relation to competence, action plans, delegation, communication strategies, problem solving, risk taking, leadership and management." However, much of what occurred within the LEO programme appeared to be ameliorative in nature, dealing with the sense of empowerment (and normally lack thereof) of the participants when they entered the programme, rather than building upon an already positive outlook.

Another analysis of the programme, by Cooper (2003) found that "role conflict, whether nurse or manager, was apparent in nurses' perceptions of their roles . . . respondents claimed many positive leadership attributes but lacked assertiveness and skills for handling conflict." (Cooper, 2003) While LEO was shown to have a statistically significant effect upon workplace leadership "it could be improved by considering the package holistically, including not only the course content, but entry level, pre-course preparation and post-course mentorship.' (Cooper, 2003) The programme should thus be outward as well as inward looking, both in its design and in evaluations of its effectiveness.

The RCN programme took place over a much longer period – 18 months, and was originally tested on just four senior nurses and 24 ward sisters in four acute hospitals. The RCN training programme was "set up in 1995 and sought to identify how clinical nurses in recognized leadership positions could improve the quality of patient care" (Cunningham, 2000) The results of the programme, as Cunningham (2000) suggests, were highly promising. There were significant improvements in the ward sisters and senior nurses performance. Five key components of leadership were developed within the programme:

- Managing self
- Managing the team
- Patient centered care
- Networking
- Becoming more politically aware

Apart from these developments, the programme was designed to test a series of hypotheses, all of which seem to have been at least preliminarily proven. The hypotheses sought to tester whether after participation in the programme -

> Senior nurses will significantly improve their leadership ability as measured by the multifactor leadership questionnaire. Ward sisters will significantly improve their leadership quality as measured by the multifactor leadership questionnaire
>
> Quality of patient care will significantly improve following ward leaders' participation in the programme as measured by the organization care tool and qualitative data from patient narratives and observation of care.
>
> (Cunningham, 2000)

As stated, it appears that all hypotheses were proven by the programme, suggesting that a much wider training programme involving many more health leaders would improve the quality of patient care throughout the NHS.

A recent study of the programme (Large, 2005) used a total of 16 case-study sites (two from each region) of the 80 English trusts taking part in the study. 143 key stakeholder interviews were undertaken from a whole cross-section of the employees and

co-workers who took part or who were associated with those who took part in the programme. Large et al. came to some very encouraging conclusions:

> The pre-eminent finding of this study is the positive change in leadership capability of clinical leaders . . . leadership change is confirmed in the triangulated data of the qualitative interviews of the key stakeholders from the 16 case-studies and from the findings of the more broadly applied baseline and post 360-degree Leadership Practices Inventory.
>
> (Large, 2005)

This analysis of various case-studies concluded that the RCN programme clearly offers one way of delivering the leadership development crucial to translating the national and trust-level policy agenda to provide more patient-centered care." (Large, 2005) This importance of this finding may be found within the manner in which the RCN turns *theory* into *practice*. It is this bridge that the NHS needs.

Large et al. made a number of recommendations that suggest that the RCN programme should be expanded to a much greater number of NHS employees. These recommendations included providing "more pre-programme information to local facilitators and clinical leaders about the experiential learning principles underpinning . . . " (Large, 2005). Note again the linking of experience with principles, ie, practice with theory, within this recommendation. They also recommend that a practical database of patient complaints, staff retention and recruitment be created as "outcome indicators for the impact of the CLP" (Large, 2005). This is a very important recommendation that should be followed by the NHS: the practical results of the programme are the most

important feature of it. Thus an analysis of case-studies that suggest that those how have taken part in the programme think that it has worked is one matter, showing that it has through patient outcomes is another.

Those who are working with nurses within the healthcare setting need, as Upton and Brooks (1995) suggest, to consider the changes that are needed from three distinct vantage-points.

First, very broad trends at a national and international level. Second, regional and localized change patters of service delivery and third, the fact that the manager herself is an instrument of change. The methodological issues surrounding these vantage-points are very important. If nurse retention is seen from the first, very broad level, a whole different set of factors and possible alleviations may be analysed as compared to those at the much more personal and smaller scale represented by the actual managers working within individual healthcare settings.

4) *What are the advantages and disadvantages of the case-study approach to an analysis such as this?*

Case studies have several different advantages and disadvantages associated with them. The case-study approach offers several advantages. These include (but are not limited to) the discovery of hidden forms of behavior, the exploration of causal mechanisms linking phenomena, the revelation of a critical case and the explanation of variations (Leedy & Omrod, 2005). The case-study approach also provides a way of studying human events and actions in their natural surroundings (Babbie, 2003). The nature of *leadership* is by nature complex and thus may actually be revealed in the “forms” of what people do,

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be considered within a deeply humanistic paradigm that recognizes the uniqueness of every situation.

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CHAPTER 5 – FINDINGS

The literature review, case-study analysis and methodology all lead to the conclusion that it is a lack of leadership that has led to the shortfall of nurses within the NHS. We thus start with an analysis of this lack of leadership and how it has occurred, as well as attempts to alleviate it.

In the last decade the NHS has seen many changes in an attempt to bring the service into the 21st Century. Following the election of The New Labour Party in 1997, a number of key policy documents were released as the NHS set out to reform services and relieve mounting pressure on emergency care (DOH 1997, Hewison and Griffiths 2004). White papers including the 'Calman Report' (DOH 1997) The' NHS Plan, A Plan for Investment, a Plan for Reform' (DOH 2000) and 'The New NHS, Modern, Dependable' (DOH 1997) all acknowledged the need to change the face of the NHS in order to retain the traditional, centrally focused public service. Alternative methods of healthcare were sought which led to the launch of NHS Direct as the 'flagship organization' aimed at helping to relieve pressure on emergency services and provide a vehicle through which a 24 hour health service could be delivered to the public. (DOH 1997) More recently, the Modernisation Agency advocates the creation of 'community matrons' and 'case managers' to support people with Long Term Conditions in the community. (NHS Modernisation Agency and Skills for Health 2005)

As the NHS became modernised, it became increasingly obvious that leadership development would be central to the modernisation agenda. (Hewison and Griffiths 2004) This was backed up by Lord Hunt, the health Minister at the time, who argued that good clinical leadership was required in order to deliver the NHS Plan (DOH 2000) It was

recognised that, if better leadership was required to drive the changes required to transform the NHS, then there was a need for National learning about leadership in the NHS (OECD 2001, Hewison and Griffiths 2004). Certainly, as the creation of new roles gains impetus, it would seem foolish to 'manage' without effective leadership to support new incentives and old.

This has resulted in the emergence of new local and regional development programmes for leaders (Edmonstone and Western 2002), as well as the provision of government funding to greatly increase the uptake of National development programmes such as the RCN Clinical Leadership programme and the Leading an Empowered Organisation programme. All of these are driven by political as well as managerial energies. The NHS is seen as a role-model for other sectors of the economy, and as such should model the kinds of leadership that are envisioned as the correct ones by government.

At times there is almost a mysticism or a mythology surrounding the healthcare industry, one that precludes the addition of other management theories. Perhaps the most fertile ground will be on the most recent kinds of leadership theory which tend to focus upon the relationship between the "leader" and the "led". Fielder (1996) argues that there is "a complex interaction between the designated leader and the social and organizational environment", and that this interaction is perhaps more important than the individual leadership qualities that the leader may or may not possess. For example, with the new "Matrons" that now have authority within NHS hospitals, success will be depend upon the types of wards she supervises, the quality of the outsourced services, the skills of the nurses and the general organization of the NHS trust that the hospital belongs to.

Often there is an idealistic tinge to these studies of leadership. Thus McCauley defines leadership development as "expanding the collective capacity of organizational members to engage effectively in leadership roles and processes" (McCauley 1998), while Keys (1988) describes leadership as enabling groups of people to work in meaningful ways. Often these theoretical approaches seem to be based upon what the authors feel *should* be the case rather than what actually is. Of course the concept of leadership training has room for a re-evaluation of the nature of leadership and how leaders should interact with their subordinates or team-members, but as the experience of the essentially "leaderless" NHS at the ward level before the reinstitution of Matrons illustrated, leaders must have clear lines of authority if they are to be effective. A team approach in which the leader is merely coordinating the team as a member of it is all very well, but a clear hierarchy is often needed as well.

A mixture of theoretical approaches to nurse leadership is the most effective. Thus Drath (2001) is perhaps most applicable. Drath argues that there are situations in which the *personal dominance* model of leadership is needed: in which a leader initiates action and controls other people; and there are others in which an *interpersonal leadership role* is more appropriate, in which collective action is required and the group needs to be convinced, motivated and then spurred to action in a particular way. For example, in her role as administrator of outsourced services such as food/laundry within the wards she is in control of, the Matron would be well-advised to adopt the *personal dominance* model. Outside vendors need to know what is required of them and need to meet those specific tasks. Their role is essentially limited within the hospital – and as such more inclusive interpersonal techniques are not needed. However, when leading her

nurses, the Matron needs to adopt the *interpersonal* role because she is a member of nursing team that need to interact with one another in a complex manner. They are essentially part of a team rather than a hierarchy.

Diversity in Leadership

Approaches to encouraging diversity within the NHS concentrate upon two main factors. First, that the NHS should be an example for all other employers as it is one of the largest employers in the UK. Second, that diversity in leadership is a desirable outcome for the good of the NHS itself. As one study puts it, "the NHS must be an exemplar of good practice in managing diversity and equal opportunity issues . . . this is more than a legal requirement – the effectiveness of the service we provide depends upon making the maximum use of the talent within our workforce" (Leadership 2004)

Thus diversity within leadership is a legal, ethical and pragmatic necessity. The NHS Leadership Centre provides mentoring programme that is designed "to develop the capabilities of all leaders at all levels within the service in order to achieve service improvement and to promote diversity of leadership in the NHS" (Leadership 2004). The diversity mentoring that takes place is in a sense completely contrasting to the traditional mentoring model, in which the subordinate is mentored by the more senior member of staff. Within the diversity mentoring programme at the NHS the following occurs:

- learning by the more senior person is a key part of the process
- differences in background and perception provide much of the basis for learning exchange.

(Leadership 2004)

The *outcomes* expected of the programme are explicitly stated:

- a raised awareness of racial and cultural diversity amongst senior NHS managers
- greater understanding by BME staff of management thinking – and a chance to influence it
- BME staff develop and implement career management plans that will result gradually in senior management being more representative of the wider racial and culture mix
- A swift and positive impact on how the NHS responds to the differing health needs of BME patients

(Leadership 2004)

For the purposes of this study it is perhaps most interesting to note that the programme seems to assume that all the senior NHS managers will be white men who are in need of better understanding of cultural diversity, something they will glean from contact with the more "diverse" staff at lower levels. By "diverse" we may assume the programme's developers mean women and non-white minorities.

There is little formal, empirical and independent investigation of how well this programme actually succeeds. Indeed, because of the essentially qualitative and even private nature of the kind of mentoring that is occurring, it may well be argued that it will

be impossible to perform such an analysis. The transformation of innate attitudes that a manager will bring from his/her outside life, and which will have been part of their upbringing as children, is very difficult to assess.

Further, the contrast between the "swift" impact that the training will have on the treatment of BME patients with the much more cautious, "gradual" change in the demographic makeup of leaders within the NHS suggests that the programme developers know they are on delicate ground when it comes to actually changing the types of leaders that occur in the NHS. The whole question of affirmative hiring of racial/gender minorities, which is characterized by some as merely another form of racism, only this time reverse racism, is raised by the idea of proactively seeking to change the "face" of NHS leaders.

The characteristics that the programme is intending to institute among senior leaders may in fact be seen as those that *all* leaders need to display if they are to be successful. Thus awareness of the following is needed:

- Different communication styles
- Different backgrounds and experiences
- Cultural differences
- Gender differences
- Stereotypes and biases

(Leadership 2004)

The programme ends with a definition of two vital terms:

> **Equal opportunities**: redressing discrimination and disadvantage arising from people's differences
>
> **Diversity**: changing the culture of the NHS through dialogue, so that people are valued for their differences
>
> (Leadership 2004)

A 2005 study addressed how successful (or otherwise), such diversity programmes have been. The University of Liverpool study (Bogg 2005) suggested that "the NHS suffers from an institutional gender bias that favours the progression of men over women" and that "old boy networks" are still in evidence within the NHS. As with other NHS attempts to diversify and improve its leadership, there seems to be a chasm between what it is trying to do and what is actually occurring:

> Of the 1,600 health professionals who took part in the study, 75% agreed that the NHS was working hard to promote equality and diversity but 64% believed that those from ethnic minorities were not well represented at senior levels in their organisation.
>
> The use of positive discrimination to redress this imbalance was perceived as an unfair recruitment strategy by the majority of participants who were mainly of White British origin.

> Disability and sexual orientation was also perceived as a barrier to career progression - 87% of disabled respondents felt their disability limited their chances of promotion.
>
> (Gender 2005)

A complex scenario thus emerges. NHS employees see that the NHS is trying to make its workforce more diverse, but also that the efforts are not currently succeeding, at least at the top levels of management. A majority of the workforce would also resist so-called "positive discrimination" in order to succeed in the NHS attempts at diversity. The theoretical need for diversity within the workplace is often countered by the natural propensity of most employees to consider their own success over that of others. If a majority of a workforce is white (as it is in the NHS) they are unlikely to support positive discrimination, however supposedly laudable the reasoning behind it.

CHAPTER 6 – CONCLUSIONS

This study has shown the perception of a current nursing shortfall within the NHS is based in large part upon fears of a future shortfall rather than an actual inability to fill current vacancies. Thus at King's Hospital there is currently a 1% vacancy rate for positions, and these seem to be filled fairly easily from a number of sources.

The shortfall of nurses should perhaps be more accurately described as a shortfall of nurses who are likely to stay within the NHS (or even the UK) and make a career within the organization. It is the fluid, transitory nature of many of the nurses that brings about fears of shortfalls in the future as the population ages and healthcare needs expand almost exponentially.

One of the major problems currently within the NHS is a lack of coherent leadership: nurses feel unempowered, overworked, underpaid and are generally dissatisfied with their situations. Many of these problems can be linked to a lack of leadership within the organization. The attempt to bring "industry" style management to the NHS in the early 1990's largely failed because of the lack of experience of these new senior managers within the unique circumstances of the healthcare system, and also the unapplicability of such a leadership style to healthcare. Thus both the personnel and the ideas were not suited to the NHS. Most of these leaders departed the NHS within a few years, and with the rise of New Labour to power, a renewed attempt to reinvigorate the NHS occurred.

In the last decade a number of programmes have been developed that seek to improve the leadership qualities of managers within the NHS and thus to improve the retention of that most vital of positions – the nurse – within the hospitals and other facilities. Overall, many of these programmes (led by the LEO and RCN projects) have been well-intentioned, but often based more upon theory than upon practice. The programmes are often couched within what is, to most ordinary people, incomprehensible language that sounds impressive but which often has little relevance to actual workplace conditions. Much of the theory behind these programmes seems to have stemmed from the quiet and rarefied atmospheres of university offices rather than the fast-paced, deeply pragmatic world of real healthcare.

To be succinct, many of the programmes to increase nurse retention seem based upon a vision of how the world should be, rather than a more down-to-earth, and less idealistic version of how it actually is. However, some bright spots have occurred.

One specific type of programme within the NHS – that of the Matrons now in control of several wards in many hospitals across the country, at least seems to be laying the foundation for a more organized and thus successful health service at the ground level. If nurses feel that they are a part of a health service that actually provides a route towards career development then more of them are likely to stay.

Another factor that must be dealt with, but which is perhaps one of the most difficult to alleviate, is the pay-rates within the NHS. As about 75% of nurses currently feel they are underpaid for the work they do, it is not surprising that so many of them leave the healthcare industry entirely, seek better paying work within the purely private

sector or seek employment abroad in countries such as the USA where salaries can be double what they are in the UK, and where the cost of living is much lower.

While massive increases in nurse salaries are perhaps unlikely within the current economic environment, if nurses feel more happy within their working environment then they are likely to accept the pay disparity with more equanimity.

As with all the leadership programmes, this one has been in existence for too short a time to actually make firm comments on its efficacy. The first signs, however, are hopeful.

Much of the rest of the NHS leadership programmes seems to be based upon a lot of idealistic, and often obtuse, theory and philosophy, but there is often a large chasm between what is hoped for and what actually occurs. One reason for this is that fast-paced, practical nature of modern medicine seems to resist the theoretical niceties of "goals", "leadership outcomes", "managerial concepts" and the host of verbiage that currently resonates throughout the upper echelons of the NHS. One quango talks to another, but they have little effect upon what is actually occurring at the level of provider-patient where the health service is actually mean to work.

The NHS is attempting a very difficult but which, if successful, will be a very rewarding development within their management processes. If they succeed in their efforts to redefine leadership in terms of a twenty-first century healthcare system, using some ideas that originated in the Nineteenth Century (nurse matrons) and others that are cutting-edge, they may well provide a model for other organizations throughout Europe

and the world. However, a good deal of pragmatism needs to be mixed with the current idealistic approach. There also needs to be an avoidance of the use of language and concepts that sound more impressive on a superficial level than they actually are when in practice.

The tendency for verbiage rather than clarity is a practical matter, as NHS employees want clearly understandable and applicable policies to follow rather than theoretical models that would require a higher degree in the social sciences to begin to understand. This is not to say that simplicity is to be aimed for at all costs, but rather that clarity of design is not necessarily a weakness. If all levels of the NHS can understand the leadership programmes then they will be far more effective. If this needs a more transparent type of terminology that does not use the nuances of precision contained within some social science and psychological models, so be it.

CHAPTER 7 - RECOMMENDATIONS

To conclude, a number of vital actions should be undertaken in order to try to alleviate current and future nurse shortfalls. First, a continuation with practical programmes such as the Matrons who are now in charge of several different wards within many different hospitals. This programme has two distinct advantages to help the nursing shortfall: first, experienced nurses are supervising other nurses, second, it provides a clear promotional route for lower-ranking nurses and may help with retention.

Detailed case-studies of particular programmes within particular NHS trusts rather than ad hoc, system-wide programmes that provide only scanty and anecdotal evidence should be conducted.

Constant focus on *practical* programmes of leadership rather than ones based upon *theory* and/or *ideology*. Education regarding *diversity* that allows for opposing points of view.

Recognition that change in leadership styles and the demographics of leaders can only occur gradually. Coordinated and centrally organized empirical studies of the results of nurse retention and leadership develop programmes. These should be commissioned on a central basis, but be given to independent research units within universities to ensure as objective a view of the programmes as possible.

Short-term programmes over a wide range of NHS trusts together with long-term programmes that will be pilot in nature at a fewer number of Trusts. Mix together qualitative and quantitative studies of programmes, taking the advantages of each while

trying to avoid the weaknesses. Thus psychological studies of the effects of leadership programmes on individuals (qualitative) at particular NHS clinics could be contrasted with wider, empirical studies based upon questionnaires.

Simplicity of language and clarity of programme design should enable all employees, from entry level workers to NHS senior management, to be able to understand what the retention and leadership initiative entails. Impressive language that is incomprehensible is not a route to success.

Stress should constantly be given to the *pragmatic advantages* of a particular programme. Idealistic visions of leadership have their place, but should be subservient to practicality within such a vital service as the NHS.

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