Talent Management in Nursing
An Exploratory Case Study of a Large Acute NHS Trust

Susan Elizabeth Haines
RGN, BSc (Hons), MA

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Abstract

Introduction and Background

Talent management (TM) is described as an organisational process led by senior leaders that encompasses core components including; defining, attracting, developing and retaining talented employees to best meet strategic business objectives. In the pressing contemporary context of global financial and workforce challenges, including national nursing shortages and an aging population with increasingly complex health and social care needs, it is essential to ensure that nursing can compete with other industries to attract, develop and retain the full potential of the current and future nursing workforce. A review of the literature revealed TM as an emerging concept, a subject more commonly associated with business and Human Resource Management literatures rather than healthcare and nursing. Whilst there are numerous definitions of TM, two primary organisational approaches to TM were identified, inclusive and exclusive. This research addresses the lack of empirical studies relating to TM in nursing in the NHS.

Aims

The research primarily aimed to engage clinical nurses in an exploratory case study of one large acute NHS trust, to gain new insights and knowledge into how TM is emerging as a concept within nursing. I aimed to explore nurses' perceptions, lived experiences and possibilities of Talent Management. The secondary aim was to contribute to the development of TM in nursing within one acute NHS trust and to the emerging debates on TM in nursing in national and international contexts.

Objectives

- To identify how participants define talent in nursing
- To identify what participants see as the challenges of talent management and how talented nurses can be effectively attracted, developed and retained
- To identify areas for further research and contribute to the emerging debates on TM in nursing.

Methodology

A qualitative case study employed focus groups, one to one interviews, documentary sources and wider consultation involving 229 staff nurses. A thematic analysis of qualitative data was utilised and findings triangulated with other data sources, including a wider consultation.

Findings

Three common themes were identified; Nursing as talent, ward leadership and culture and career development. The findings were examined within the context of nursing as a gendered occupation. They identified a challenge for nurse participants in describing talent in nursing; nurses did not spontaneously describe what they did as talent. The image of nursing and public and media perceptions were identified as a concern when aiming to attract, develop and retain future and existing talented nurses. There was felt to be a lack of recognition and reward for nursing talent, a lack of clear career pathways and the impact of the local manager on talent development was influential. Talent in nursing could sometimes be viewed as negative, seen as a 'disruption' if individuals did not conform to existing expectations influenced by the leadership and local culture within a ward or department. In addition there was a need for greater recognition of BME nurse development. The need

for an inclusive approach to TM in nursing, creating an environment where all nurses felt engaged and valued with opportunities for education and development was identified.

Conclusions

This study contributes new knowledge identifying what participants regard as important in the development of TM as an emerging concept in nursing. Nurses were proud of their roles but felt undervalued and had no readily accessible point of reference for aspirational standards of excellence or talent in nursing. The majority aspired to clinical careers but career pathways in nursing were regarded as invisible. Nurses wanted to be recognised for their contribution, skills and talents and valued and engaged in the workplace. Recommendations include; a need for greater clarity in nursing career pathways, careers guidance for nurses, including the development of clinical career ladders for staff nurses, a need to improve managers' skills as talent developers and explore inclusive approaches to TM. There is a need for Directors of Nursing to make TM important at all levels within an organization. To meet the healthcare needs of the population developing talent in nursing also needs to be considered wider than the boundaries of individual wards and specialities. Further research is recommended including; evaluation of approaches to TM, strategies for nurse retention, nursing career pathways and exploration of means to identify and recognise excellence in nursing.

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TABLE OF CONTENTS

List of Tables

List of Figures

List of Abbreviations

American Nurses Credentialing Centre (ANCC)

Black and Minority Ethnic (BME)

Chief Executive (CEO)

Chartered Institute of Personnel and Development (CIPD)

Chartered Management Institute (CMI)

Department of Health (DH)

Deputy Sister (DS)

Director of Human Resources and Strategy (DHR)

Director of Nursing (DN)

Global Health Workforce Alliance (GHWA)

Health Education England (HEE)

Human Resource Management (HRM)

Individual Performance Review (IPR)

International Council Of Nurses (ICN)

Knowledge and Skills Framework (KSF)

Mid Staffordshire NHS Foundation Trust (MSFT)

Modern Matron (MM)

Newly Qualified (NQ)

Nurse Specialist (NS)

Nurse Consultant (NC)

Practice Development Matron (PDM)

Prime Minister (PM)

Registered Nurse (RN)

Royal College of Nursing (RCN)

Staff Nurse (SN)

Talent Management (TM)

The Nursing and Midwifery Council (NMC)

United Kingdom Central Council (UKCC)

United States of America (USA)

Ward Sister - Charge Nurse (WS)

World Health Organization (WHO)

Chapter 1: Introduction, Background and the Research Context

1.1 Background and Context

The effective recruitment, development and retention of workforce within the National Health Service (NHS) has never been more vital than in current times and is more recently referred to as Talent Management (TM). Talent Management is a concept perhaps more frequently associated with business settings than healthcare. The heart of TM has been described as, *'a matter of anticipating the need for human capital and then setting out a plan to meet it'* (Cappelli, 2008a,p.1). This is presented as a priority for all organisations. A study by Oxford Economics (2012) involving human resource professionals and executives from forty-six countries, identified the pressing nature of ensuring businesses can attract and retain the skilled employees they need. A contemporary context of global financial and workforce challenges was identified including; an increasing use of technology, increased competition, globalization, new emerging markets and changing population demographics. A reduced number of school leavers entering the employment market has resulted in an aging workforce with increasingly higher levels of retirement (Blass, 2007; NHS Employers, 2009; Institute of Leadership & Management, 2010). A 2014 annual global survey of businesses showed that 36% of employers reported the highest percentage of talent shortages in seven years (ManpowerGroup, 2014).

The issue of reducing availability of workforce talent is not restricted to the private sector. Specifically within healthcare, the Global Health Workforce Alliance (GHWA) Secretariat and the World Health Organization (WHO) (2014) identified shortages in the healthcare workforce, including nursing. It emphasised the centrality of human resources, workforce planning and political action in achieving

universal health coverage and reducing global health inequalities. Therefore, in a global context across a range of businesses and services, concerns are evident in securing the required workforce.

Whilst global workforce challenges are evident, within industry and healthcare there remain differences in the definition of the term Talent Management. In 2007 for the purpose of a national research survey involving Chartered Management Institute (CMI) members in the United Kingdom (UK), TM was defined as, '*the additional management processes and opportunities that are made available to people in the organisation who are considered to be talent*' (Blass, 2007,p.3). More recently within the NHS it was stated that;

> '*Talent Management should consider all individuals in an organisation. It should cover the development they require, the value they bring, and the position(s) that best suit their skills currently and into the future within an organisation and/or elsewhere in their career journey.'* (NHS Leadership Academy, 2013,p.6).

A variation in the interpretation of TM is evident. On one hand TM is viewed as additional input for those identified as 'talented employees', and another that TM should consider the development of all staff within an organisation.

This study is set in the NHS, in an acute hospital setting and the focus is on TM in nursing. Firstly I describe my interest in the subject of Talent Management. I aim to consciously present my own position as a researcher, my personal reflection and motivators for the study. I share this here, in order to enhance reflexivity in the research process, recognised as essential component of qualitative research (Denzin and Lincoln, 2011). In the introduction I outline the contemporary national policy context for health care and nursing in the NHS. This sets the scene for the exploratory study on

TM in nursing and concludes by outlining the objectives of the study.

1.2 Why am I interested in Talent Management?

As a registered nurse (RN) working within a nursing development department in an acute NHS Trust, my role involves leading and facilitating clinical education and practice development programmes. Through my work I regard reflection (Gibbs, 1988) as an integral component of professional development and personal growth. Personal reflection on a particular incident was the starting point for this study.

1.2.1 Personal Reflection

In 2008, a newly qualified (NQ) Staff Nurse (SN) approached me during one of the breaks at a development day we were running. She had been an active participant during the preceding group discussions. Her primary question was one that provoked significant personal reflection. She asked me if there were career opportunities in nursing as her Ward Sister (WS) had told her she was *'too clever to be a nurse and should consider medicine instead*.' This SN had even started to explore options for changing careers.[1]

This encounter with the NQ SN acted as a stimulus for personal critical reflection. Here was a motivated, professional SN who considered leaving nursing, directly influenced by advice from her Ward Sister. I questioned my own assumptions and considered the following in my reflection and analysis;

- The influence of the immediate line manager within a large organisation of 4500 nurses. Opportunities could remain

[1] (Ward Sister–Charge Nurse is the title in the organisation given to the lead nurse on a ward who line manages the nursing team. The WS is responsible for quality and standards within the ward. In some organisations and literature other terms are utilised for this role include ward manager, clinical lead, unit manager, head nurse and team leader. The WS as a title will be utilised throughout the thesis.)

invisible to the wider nursing team if the WS was not aware, or failed to communicate them to the team.

- Concern at the devaluing of the intelligence required to be a nurse and reinforcement of traditional stereotypes in nursing and medicine.
- How a NQ SN could learn about career pathways and whether I was clear myself.
- What could be learnt from other healthcare organisations and industries to develop and retain highly motivated employees such as this Staff Nurse.

I guided the SN towards accessing clinical supervision for her own professional guidance and support. My motivation to investigate was ignited and the research journey began. Having explored the contemporary practitioner literature, I identified TM as an organisational process for considering workforce recruitment and development of high potential employees. I identified an ambition to explore the potential for TM within nursing and consider transferable solutions.

In the following sections I now present the background and context for the study. Firstly a discussion of the background policy and professional context for nursing in the NHS acute care setting and consideration of workforce and career development challenges. This will primarily focus on the drivers for change in England since the launch of the NHS Plan (Department of Health (DH), 2000b), which set out an ambitious programme of investment and reform to modernise the NHS. I will also consider some of the policy drivers affecting post-registration nursing careers in the acute, adult nursing sector of the NHS. I will then outline the research questions and introduce and undertake a detailed review of literature relating to TM both within a business, healthcare and nursing context. I will conclude by summarising the aims of the study.

1.3 The National Health Care Policy and Professional Context

The NHS is the world's largest publically funded healthcare organisation. The NHS employs 1,387,692 staff with just under half of these being professionally qualified staff (Health and Social Care Information Centre, 2015). The largest proportion of this staff group (377,191), are registered nurses (NHS Confederation, 2015). I will briefly outline some of the significant changes to the NHS since it was first established in 1948. This serves to illustrate the continual process of change the NHS and nursing have faced under different government policies. I then focus on the current context of healthcare services in which nurses' work.

At the outset of the NHS, nurses trained in schools of nursing aligned to local hospitals and were employed as salaried members of the nursing workforce. Students and non-trained nurses made up the majority of the nursing workforce in hospitals (Dingwall et al., 1988). The General Nursing Councils for England and Wales and Ireland and Scotland, compiled and maintained registers of qualified nurses. Subsequent professional regulatory changes in nursing included the introduction of the United Kingdom Central Council (UKCC), a new overarching body and an education board for each of the four countries (Department of Health and Social Security Act, 1979). This provided a single professional register and an index of training, with country boards responsible for standards of nurse training and education.

Historically the NHS was reliant on the training and recruitment of educated young women into nursing to sustain workforce needs (Clay, 1987) and the WS was the key leader of ward nursing teams (Pembury, 1980). The WS set quality standards and had direct managerial authority over patients and nursing staff. Traditionally NHS nursing careers in hospitals were focused within a hierarchical framework of management and as a result were (and remain)

susceptible to change during NHS reorganisations. The Salmon report (Ministry of Health and Scottish Home and Health Department, 1966) implemented changes to the management structures in hospitals resulting in a new nursing officer hierarchy. There was a shift of nursing careers, with a greater division between clinical and managerial roles (Clay, 1987). In the 1980s, under increasing financial pressures and expanding demand for NHS services, Margaret Thatcher's government commissioned an inquiry into the effectiveness of the NHS management (Griffiths Report, 1983). Griffiths proposed radical changes to improve efficiency and introduced general management into the NHS. This was noted by the General Secretary of the Royal College of Nursing (RCN) as signalling the '*demise of professional power in the NHS*' (Clay, 1987,p.57). Clay identified that nurses were barely mentioned in the report. There were criticisms that the associated workforce cuts, reduced training budgets and removal of clerical staff from frontline areas, resulted in even further work pressures on clinical nurses (Salvage, 1985).

Workforce planning in nursing had been undertaken poorly and women were regarded as easily replaceable (Clay, 1987). Allen (2001) noted a change in national government policy in relation to nurse training and workforce planning during the 1980s, with changing population demographics predicting a reduced pool of school leavers to fill nurse-training places. There continued to be high attrition from nurse-training and an aging population to care for. There was a move from hospital-based schools of nursing to higher education institutions (UKCC, 1986). Nursing students were no longer included within the workforce numbers. They received a diploma level education and worked in a wider range of care settings other than hospitals. This evolving process of improved education with professional registration aimed to increase attraction

to nursing as an occupation, providing greater potential for different nursing career pathways (Allen, 2001). An independent review of the Nurses, Midwives and Health Visitors Act (1979) proposed a more strategic and streamlined professional body in the UK. This led to the abolition of the UKCC and national education boards and establishment of the Nursing Midwifery Council (NMC), which came into operation on 1 April 2002. Nationally nursing workforce data remained a challenge.

There were increasing moves in the NHS to introduce a more commercial approach to healthcare. The NHS and Community Care Act (DH, 1990) created an internal market and focused on cost-efficiency. In the new NHS management structure, nurses had lost the guarantee of any powerbase above WS level (Traynor, 2013). New Labour came to power and presented their vision for the NHS (DH, 1997). This was followed by Government commitment to financial investment, to reduce variation in quality standards and modernise the NHS (DH, 2000b). There was evidence predicting long-term resource challenges facing the NHS and growing public expectations (Wanless, 2002; Wanless, 2004). These reviews proposed a need to reduce demand on the NHS, through illness prevention and public health care. Within this changing context in a review of the nursing labour market in the UK, Buchan and Seccombe (2002) outlined a continued lack of accurate data, with workforce planning driven by assumptions, rather than being evidence-based. In 2011 Buchan and Seccombe again observed how nursing workforce data in the UK continued to be incomplete, out of date and vulnerable to government policy changes. This included reducing commissioned numbers of student nurse training places and proposed pension changes deterring nurses from staying within the workforce (Buchan and Seccombe, 2011).

1.4 Expanding Roles of Nurses

Enabling nurses to work to the full scope of their practice was, and continues to be, integral to NHS healthcare policy (DH, 2003; NHS England, 2014). This included expanding roles for nurse practitioners and challenging traditional professional boundaries. The '10 key roles' for nurses launched as part of the NHS Plan (DH,2000b) included; ordering diagnostic investigations, prescribing and discharging patients home, all traditionally viewed as medical roles. Clay (1987) had predicted that politicians would need to realise the full potential of nurses in solving the demands of the NHS.

The Scope of Professional Practice (UKCC, 1992) set out principles to enable nurses, midwives and health visitors to expand their practice to benefit patients, with appropriate training and competencies. Standards for post-registration education and practice (PREP) were established with a process of self-validation to remain professionally registered (UKCC, 1994). National healthcare policy, including the NHS Next Stage Review (DH, 2008b), continued to set further challenging NHS improvement targets, with increased patient choice and expectations. Within this context of changes new national NHS human resource frameworks were introduced. A single NHS pay spine (DH, 2004a) and a national Knowledge and Skills Framework (KSF) (DH, 2004c) aimed to present a flexible career structure for the NHS. Lifelong learning was seen as integral to NHS workforce policy and essential to achieving the required service changes (DH, 2000a; DH, 2008a).

In spite of this flexible framework for practice, local variation in nurses' roles persisted; Longley, et al., (2004) scoped specialist education and specialist nurse titles within acute care in the UK and found varying standards. There was potential confusion for the public, with wrong assumptions about job titles. In another report

for the NMC, a lack of clarity was identified in preparation for advanced practice and specialist roles (Longley, et al., 2007). The authors recognised that the KSF had attempted to provide an all-inclusive approach to career development as part of an annual individual performance appraisal. However, local interpretation of the KSF had resulted in inconsistencies in application in NHS organisations.

In a more recent study of a large acute trust, East et al, (2015) found similar complexity with role titles and pay bandings suggesting an ongoing national picture of variation. Career development for nurses within the NHS continues to vary, with a diverse range of optional national guidance (RCN, 2012; Skills for Health, 2015). Nurses seeking professional recognition, clearer career pathways and expanding roles within organisations, face local interpretation without the established education and career frameworks of an influential profession such as medicine. In ever-evolving healthcare context, nurses are expected to work in new ways, across care boundaries with an increased focus on community care and improving public health (NHS England, 2014). This poses new opportunities and challenges for nurses, traditionally seen as following hospital based careers within a medical model of care.

1.5 Reviewing Nursing Careers

In order to further explore the context of nursing careers within a contemporary NHS setting, the period of time from the launch of the national NHS Nursing Strategy 'Making a Difference' (DH, 1999a) is outlined. Subsequently a number of major national reviews have gone on to further consider nurses' roles and nursing careers. These included Modernising Nursing Careers (DH, 2006) the Prime Minister's (PM) Commission (DH, 2010c), The Willis Commission Report (2012) and the Shape of Caring Review (Health Education England (HEE), 2015).

Following the managerial changes of the 1980s and considering nursing career pathways, the NHS Plan (DH, 2000b) identified additional career opportunities for nurses. This included the Nurse Consultant (NC) role as the pinnacle of a clinical nursing career (DH, 1999b) and the introduction of the 'Modern Matron' (MM) (DH, 2001). The MM was presented as a figurehead to provide frontline leadership, responding to concerns about standards of care in hospitals. Both the MM and NC as career routes subsequently faced challenges. National research identified that the NC role was not well defined within the UK, with limited evaluation of the impact on patient outcomes (Kennedy, et al., 2012) and national guidance continued to be interpreted in different ways (Manley and Titchen, 2012). Manley and Titchen (2012) described the need for improved career structures, succession planning and organisational commitment to NC roles. Similarly research on the introduction of the MM role (Savage and Scott, 2004), found that its position within the NHS organisational hierarchy remained unclear, often with conflicting clinical and operational responsibilities.

Interestingly, while the MM role was subsequently implemented across the NHS, similar expectations of frontline clinical leadership to set standards of care have more recently focused on the Ward Sister (DH, 2010c). An inquiry led by Robert Francis QC into high numbers of patient deaths at one NHS Trust, reported organisational and systems failure at Board level resulting in serious care failings (DH, 2010e). This was followed by a Public Inquiry (The Mid Staffordshire NHS Foundation Trust (MSFT) Public Inquiry, 2013) also chaired by Francis, which focused attention on the Director of Nursing (DN) and the role of the WS as clinical leader at ward level. The inquiry reflected findings from previous studies of the importance of the WS role and the need for effective nurse leadership from the 'bedside to the boardroom' (Hoeger, et al.,

2009; RCN, 2009). The inquiry recommendations stated a need for culture change in the NHS, to value quality and compassion at the heart of healthcare, before finance. The associated negative media was seen to focus predominantly on nursing, which had already been debating the challenges of attracting new recruits and overcoming poor perceptions of the role of the nurse.

Modernising Nursing Careers (DH, 2006) had identified poor public perceptions of nursing as a career and a need to enhance understanding of nursing as a profession. This informed national consultation, which proposed a need for clearer nursing careers, structured around patient care pathways and working across traditional healthcare boundaries (DH, 2007). A survey of 90 NHS organisations identified agreement with proposals for new post registration careers based around care pathways (Ajayi, 2008), supported by Maben and Griffith's (2008) call for raising professional aspirations and expectations, to attract high calibre recruits, investing in continuing professional development and career planning for nurses. This national debate influenced the next NHS healthcare review led by Lord Darzi (DH, 2008b). There was a commitment to degree level education for pre-registration nursing, work towards standardising levels for advanced practice and investment in preceptorship (DH, 2010d). Once again opportunities were identified for nurses to lead and develop their roles. This was further reinforced by a national Commission on Nursing established by the then Labour PM Gordon Brown (DH, 2010c), to review how nurses and midwives could maximise the potential of their roles, developing and delivering healthcare services for the 21st Century.

Ten years after the NHS Plan (DH, 2000b) and Making a Difference (DH, 1999a), The PM Commission (DH, 2010c) recommendations reflected themes evident within previous reviews including; the regulation of advanced practice, increased research into nursing

effectiveness, development of flexible careers across care boundaries, strengthening the WS role and enabling fast-track leadership development opportunities. Non-medical clinical academic careers were proposed, with national funding investment (DH, 2012a). A position statement on advanced practice (DH, 2010a) was produced to act as a benchmark. The PM Commission found similar ignorance and myths about nursing roles and careers through public consultation, as had Salvage (1985) nearly 30 years earlier. Once again there was a negative public perception of nursing as a career option for school leavers; '*an extension of women's traditional work in the home*' rather than a professional career choice (DH, 2010c,p.90). Irrespective of the ambitions of the Commission, a change in Government led to one of the largest reorganisations of the NHS ever seen through the Health and Social Care Act (DH, 2012b). Once again there was a lack of progress in addressing continued concerns relating to the need to develop greater clarity in nursing careers and the gendered image of nursing. Within TM attracting and retaining high calibre candidates are central components (Capelli, 2008a) and as such the image and perceptions of a defined occupation warrant further consideration. The image of nursing will therefore now be considered further.

1.6 The Image of Nursing

There is evidence of an ongoing media discourse related to the image of nursing, that seeks to position nursing as a low intelligence occupation, indicative of a gendered profession (Speedy, 2002). The PM Commission called for an urgent marketing campaign to promote a positive image of the reality of nursing career opportunities; there were '..*a host of misperceptions based on out-dated stereotypes...*' (DH, 2010c,p.95). Davies (1995) argued that a gendered perspective is central to our thinking about the world and operates in organisations; '*masculine is hegemonic; the feminine is*

masked suppressed and repressed' (p.62). She described the propensity for nursing work to be deconstructed to tasks such as washing, caring, and feeding, often labelled as 'basic' and suggested that this reinforced a gendered nature of occupations. Nursing presented as work that, '*…can be accomplished (albeit under supervision) by people with little or no training…*'(Davies, 1995,p.94). The vocational dedication of the nurse as an 'angel' (Salvage, 1985) and further stereotypes of a handmaiden or nonentity, are media images of nursing reflected within the context of a gendered organisation (Holloway, 1992). Davies (1995) argued that within healthcare new managerialism represented a masculine bureaucratic vision which included targets, indicators and a performance culture which marginalised the business of caring. These concerns were also previously articulated by the General Secretary of the RCN who observed how stereotypical images of nurses as, '*the harridan, the angel, the nymphomaniac*' (Clay, 1987,p.114) were shared with women generally in society and effected the power and influence of nurses in healthcare.

The Francis Report (DH, 2010e) once again provoked media debate about nurses being too clever to undertake the basic caring skills required of nurses. There were allegations of nurses being 'too posh to wash', a concept first raised in response to the proposed move to a graduate curriculum (Scott, 2004). There was refocused media and government attention on nurse training and the role of nurses in the NHS. Therefore, whilst the Francis Report pointed to a need for more skilled and effective nursing leadership at all levels within healthcare organisations, conversely it led to greater media criticism of nurses' need for academic education. Nostalgic constructions of nurse education in the media reflected on an idealised 'caring' past, contrasted with nurses now '*perceived as too educated to care*' (Gillett, 2014,p.2495). However, an independent review of

preregistration nurse training commissioned by the RCN (The Willis Commission Report, 2012) identified that graduate nurse training was the right decision. This was then again reinforced through the Shape of Caring review of nurse education (HEE, 2015), which also illustrated a continued confusing picture for nursing careers, frequently reliant on local organisational interpretation and implementation. With the ambition of attracting high calibre candidates to nursing to meet modern healthcare needs; a poor, inaccurate public image and lack of clear career pathways represents a potential workforce challenge within the context of Talent Management.

1.7 Contemporary NHS Challenges

The global economic recession and unprecedented financial challenges facing the NHS, further focused the healthcare workforce and policy agenda (Roberts, et al., 2012). The need for radical innovation, effective leadership and a focus on productivity and quality were reinforced (DH, 2010b). The economic reality meant new roles had to show value for money in complex changing health care settings, both within the UK and wider global context (Buchan et al., 2013). In the USA, the need to maximise the potential of the nursing workforce has been recognised (Institute of Medicine, 2011), with a 19% predicted growth in demand for RNs between 2012 and 2022 (Rasouli and Dash, 2015). The Centre for Workforce Intelligence (2013) confirmed that countries, including Canada, Australia and Europe predicted nurse shortages and aimed to improve nurse workforce modelling in the UK.

Both national nursing workforce statistics in the UK (RCN, 2013; NHS Employers, 2014; RCN, 2015a) and global nursing workforce reviews (Buchan, et al., 2013) present a challenging picture of nursing shortages. This is set within a UK context of reported increases in nursing staff stress (Ford, 2014). The retention of the

existing nursing workforce, career development, maximising the potential of advanced practice roles, attracting new recruits and encouraging nurses to return to practice, remain important workforce policy drivers (HEE, 2014a; Buchan, et al., 2015; HEE, 2015).

In a UK labour market review Buchan and Seccombe (2012) identified reductions in student nurse commissions, due to the global financial crisis and reduced training funds. Nursing in the UK moved from net inflow of nurses to outflow due to global shortages. Conversely, within the MSFT Public Inquiry (2013) resulted in a recommendation for higher ratios of RNs than were provided within some acute hospitals (RCN, 2010b; NICE, 2014). In a national survey of NHS providers in England (NHS Employers, 2014) 83 per cent reported a supply shortage of qualified nurses. These global workforce challenges require not just increased recruitment, but also longer term solutions, including consideration of how health systems '*…make optimum use of the skills of those already in the workforce*.' (Buchan, et al., 2013,p.305). The importance of the RN role and an effective workplace environment on patient outcomes is supported by emerging international nursing research (Aiken et al., 2012; Aiken et al., 2013; Aiken et al., 2014) and research in to the culture of care in NHS Trusts (Rafferty et al., 2015a). The importance of attracting, recruiting, developing and retaining nurses with the right skills in a changing healthcare context is a contemporary workforce priority. I aim to consider whether for nursing within the context of acute healthcare in the NHS, there are opportunities for Talent Management.

1.8 Background Summary

When reflecting on the question asked by the NQ nurse that initiated this study, it became evident that the lack of clarity in career pathways was not an issue unique to one organisation. I

have outlined the NHS policy intention to reduce costs and transform healthcare delivery. As the largest workforce in the NHS this requires nurses (and other healthcare professionals) to work in new and different ways, changing cultures (NHS England, 2014). Within a competitive global employment market, TM is described as essential for anticipating and meeting human capital needs (Cappelli, 2008a). Faced with these nursing workforce challenges I propose that there are opportunities for nursing and the NHS to learn from wider industry and business settings.

As a nurse looking into a different body of research and professional practice, I aimed to seek greater insight in to models of TM utilised, evidence of impact and consider the potential and possibilities for TM within an acute care nursing context. In order to explore and gain new insights, the research questions comprised;

- How is talent defined within nursing?
- What characteristics are used to identify talent in nursing?
- How do clinical nurses describe the challenges of attracting, developing and retaining talented nurses in an NHS organisation?
- Is there a difference between senior leaders' perspectives and those of NQ/junior nurses in terms of definitions, career aspirations and expectations of TM in the NHS?

The following chapter presents a detailed literature review and concludes with a summary of the study aims. In chapter 3, I describe the case study research and methodology design utilised. In chapter 4 the findings and analysis are presented. The final two chapters discuss the findings and present the conclusions of the research and the recommendations for practice.

Chapter 2: LITERATURE REVIEW

2.1 Introduction

In this chapter, the history and emergence of TM within the business, human resource and healthcare literatures is examined. Firstly, this considers definitions of talent and Talent Management. I detail the models utilised, practical approaches, barriers and enablers to Talent Management. Secondly I outline TM more specifically within the NHS and nursing, noting the more limited focus on TM within healthcare and nursing relative to the other fields. It is this gap in the literature to which I aim to contribute.

2.1.1 Literature Sources

The literature reviewed for the study was accessed utilising library databases via the University of Nottingham. This included British Nursing Index, CINAHL, MEDLINE, EBSCO (2009–2015). Professional nursing, NHS, Government and international nursing web sites also provided a valuable source of reference (see Table 1). This range of sources was utilised to establish an overview of the subject of TM and identify established links to TM in healthcare and nursing.

Table 1: Sources Utilised

Professional & health related web sites
American Nurses Credentialing Centre (ANCC) http://www.nursecredentialing.org/default.aspx
Chartered Institute of Personnel and Development (CIPD) http://www.cipd.co.uk/
Department of Health (DH) www.doh.gov.uk
International Council Of Nurses (ICN) http://www.icn.ch/
NHS Employers http://www.nhsemployers.org/
NHS Leadership Academy http://www.leadershipacademy.nhs.uk/
The Advisory Board Company http://www.advisory.com/topics/nursing

Professional & health related web sites
The King's Fund http://www.kingsfund.org.uk/
The Nursing and Midwifery Council (NMC) http://www.nmc-uk.org/

A search on the term 'Talent Management' using library databases in August 2010 returned no hits containing that term from within nursing journals. An Internet search in Google using the same term yielded a vast wealth of resources. These included case examples from management consulting companies offering TM solutions to businesses. This literature was predominantly from the UK, United States of America (USA), Australia and Canada.

Within the literature there were diverse and numerous specialist references to TM, for example in sports science, education and hospitality industries. In order to manage the vast amount of potential data, four areas of focus for searching were employed. These included TM in business, organisational development and management consultancies, human resource management (HRM) and healthcare. Due to the proliferation and breadth of literature the search was subsequently narrowed to focus on healthcare and nursing as specialities. This section presents;

2.2 Definitions of Talent
2.3 What is Talent Management?
2.4 Models of Talent Management
2.5 Talent Management in the NHS
2.6 Talent Management in Nursing

Within the nursing literature key themes considered included; attracting and retaining nurses, succession planning and talent spotting. In order to enable a starting point for exploring the concept of TM, I firstly consider the concept of talent as presented within the TM literature.

2.2 Definitions of talent - innate or learnt

The Oxford Dictionary describes talent as 'natural aptitude or skill' (Oxford University Press, 2010). This definition of talent emphasises the perspective of 'nature over nurture' in the development of talent. Tansley's (2011) review highlighted varied international definitions of talent, analysing this concept across a number of European languages. She identified similarities, describing how talent was viewed as, 'an innate giftedness that manifests itself in a particular field of endeavour and is linked to outstanding performance in some way '(Tansley, 2011,p.268). Whereas from a different cultural perspective, the Japanese definition of talent focused more on talent as an acquired accomplishment, '…seen as the product of often years of striving to attain perfection' (Tansley, 2011,p.268). This description more readily reflects the principles outlined within TM literature; namely that individuals may show some aptitude, but require focused development opportunities to fulfil their leadership or other skills potential within an organisation (Blass, 2007; CIPD, 2010b).

Meyers and van Woerkom (2014) considered the significant implications of the underlying philosophy of company leaders in defining talent and approaches to Talent Management. They described how when talent was seen as reflecting innate personal characteristics or cognitive ability, it was regarded as less likely to be characteristics that were sensitive to development in other individuals. This was more so the case than where leaders viewed talent as knowledge and skills, which could potentially be developed in others. As a result these perceptions influence decisions concerning the approach to TM utilised within an organisation (Meyers, et al., 2013).

In one UK study of businesses Tansley et al., (2007) identified characteristics most frequently associated with talented individuals

as; high levels of expertise, creativity, leadership behaviours and initiative. They also described how the culture and expectations of an organisation influenced the level of importance attached to a particular characteristic. Ericsson et al., (2007) applied their findings on deliberate practice of a skill to leadership, identifying that leadership was not necessarily an innate trait or talent. More recently Nijs et al., (2014) proposed a conceptual framework that encompassed both ability and affective components of talent, emphasising a need for further consideration of context and what motivates employees, as important influences in defining and developing talent.

From reviewing the different definitions, talent can be described either as an innate characteristic, or as skills and ability developed through focused practice, education and personal investment of energy by an individual. There is agreement in the literature that each organisation needs to consider what constitutes talent within their business context. This can range from an identified focus on management and leadership talent, to the technical or specialist talents required (Blass, 2007; Tansley et al., 2007; CIPD, 2010b). The perspective of talent adopted by an organisation may identify a relativist view, where talent is regarded as limited, or a perspective that all employees have potential talents (skills and strengths), suggesting a different philosophical approach to TM (Ross, 2013; Swailes et al., 2014). It is therefore recommended that senior managers ensure all line managers are aware of the agreed organisational philosophy of TM, as perceptions of employees are important in determining outcomes of TM (Meyers and van Woerkom, 2014).

The literature also presents an alternative view; rather than focusing on defining talent, Ross (2013) recommended greater emphasis on identifying the desired measures of success. She

suggested that enabling individuals to understand and develop their own strengths could lead to, '*personal and professional success*' (p.169). The notion of talent therefore can be seen to emerge as a socially constructed concept; not solely dependent on culture, but on the context and philosophical beliefs of those who define what talent is. As this also influences the concept of TM, the emergence of TM within the literature will now be considered in the following section. Firstly I review TM as presented within the business and HRM literatures, before moving on to consider TM within healthcare and nursing literature.

2.3 What is Talent Management?

2.3.1 The Emergence of Talent Management

The term Talent Management emerged as a more widely referenced concept within the HRM, business and management literatures, following a report published by the management consultancy company McKinsey's entitled 'The War for Talent' (Chambers et al, 1998). Towards the end of the 1990s the changing global economic and demographic context had motivated a wider exploration of human resource approaches to talent development in practice (Cappelli and Keller, 2014). Cappelli (2008a) described a shifting paradigm from an old world view of a career for life, working in one organisation throughout a lifetime as in the 1950s, to a more diverse workforce with flexible career patterns. Schoemaker and Jonker (2005) described how changing skills were required, moving from an industrial age, towards an information age. Businesses were increasingly dependent on the talent of their employees; they required research and development, marketing and computer technology skills.

'The War for Talent' (Chambers et al., 1998) involved private companies within the USA; the study findings identified a

competitive value in investing in high performance individuals regarded as talent, to influence the strategic and financial position of the company. A practitioner book of the same title included additional case studies and presented practical advice on TM to organisations, businesses and other professional audiences (Michaels et al., 2001). Blass (2007) defined TM as targeted development opportunities provided to an identified high performing segment or 'talent pool' within an organisation's workforce. This was also reflected by CIPD (2007) who differentiate development opportunities for people who were identified as talent.

Talent Management was described as a 'practitioner generated term' (Cappelli and Keller, 2014,p.306). This may be associated with the fact that it had emerged more widely following the study by McKinsey's (Chambers et al., 1998) involving management consultancies and HRM professionals, rather than generated from academic sources. The literature identified inconsistent interpretations of the concept of TM and varying scope, definitions and application in practice (CIPD, 2006; Blass, 2007; Tansley et al., 2007). It has been suggested however, that all organisations have a TM system by 'default or design', some being more transparent than others (Lubitsh and Smith, 2007,p.3). Lubitsh and Smith (2007) identified concerns that favouritism and preferential treatment for some employees occurred, even where no model for TM was evident within an organisation. The 'Talent Management Loop' (Tansley et al., 2007) presented TM as a dynamic, four-phased, cyclical organisational process containing core components including; attracting, developing, managing and evaluating talent. The literature also indicated the inclusion of an additional first stage within a TM process; clearly defining, understanding and communicating what constitutes 'talent' within an organisation (CIPD, 2006; Blass, 2007; Michaels et al., 2001).

The literature review identified an absence of an agreed theoretical framework, variable definitions of TM and limited evidence of empirical research. The core components of TM typically described included; defining talent, attracting, selecting, developing, managing and retaining talented employees. For the purpose of this study the definition of TM as outlined by CIPD (2010b) was utilised;

> '*Talent management is the systematic attraction, identification, development, engagement/retention and deployment of those individuals who are of particular value to an organisation, either in view of their high potential for the future or because they are fulfilling business/operation-critical roles'* (CIPD, 2010b,p.1)

This was selected from literature available at the time of developing the research proposal. It described TM as a process that encompassed both current and future potential within leadership and other business critical roles. This had particular relevance within a healthcare setting where technical talent, such as clinical skills in nursing, are equally as important as filling senior leadership positions. As outlined within the policy context in chapter 1, subsequently in the NHS it was stated that '*Talent Management should consider all individuals in an organisation.*' (NHS Leadership Academy, 2014a,p.2). When compared to more exclusive approaches to TM described within the business and HRM literatures, increasing variation in the definition of TM was evident.

In a review of the TM literature Lewis and Heckman (2006) described a '*disturbing lack of clarity regarding the definitions, scope and overall goals of talent management*' (p.139) and concluded TM was in its infancy. They identified confusion in the literature and in businesses, with terms such as 'human resource

planning' and 'succession planning', being used interchangeably with the term 'Talent Management'. They and others from within the field of HRM, including Collings and Mellahi (2009) and CIPD (2006), identified a lack of research in the field of TM and the need for some form of agreement on a working definition. A need for further academic study was identified, to enable theory generation and effective evaluation of the impact of different TM models (Cappelli, 2008a; Tarique and Schuler, 2010).

Reilly (2008) contended that HR professionals should engage line managers and integrate TM within human resource systems. Whereas the Hay Group (2010) (a global management consultancy), identified TM as the responsibility of business leaders supported by human resources. Thus also illustrating different perspectives on responsibilities for TM within the literature. The lack of agreement on definitions on TM within the literature makes empirical analysis and evaluation of any particular TM approach a challenge. Vaiman and Collings (2013) identified that whilst approaches varied, there was agreement within the literature for senior organisational leadership and commitment to the TM process, aligned with organisational strategy and key objectives. Collings et al., (2011) noted that whilst the practitioner community had embraced the concept of TM, the academic community were more critical on the lack of definitions, conceptual foundation and rigour (Collings and Mellahi, 2009; Scullion et al., 2010). They suggested that through emerging literature, whilst still remaining dominant in a US context, the study of TM had moved from infancy to adolescence, as examined in the following section.

2.3.2 Talent Management from Infancy to Adolescence

Tarique and Schuler (2010) asserted that organisations were getting better at collecting data relating to recruitment, retention and other human resource practices. They suggested opportunities for action

research as a means to bridge the gap between TM concepts and practice, focusing on issues of pressing relevance to leaders in business. However, Cappelli and Keller (2014) described that very few organisations made the wider links and analysed data for meaningful learning. Thereby failure to develop partnership research presented a potential barrier to the advancement and evaluation of TM in practice. Evaluation of TM interventions was least evident within the literature. This may reflect the challenges already outlined in agreeing on a definition of TM, the diversity of organisational context and also the complexity of following up individual employees who have undergone different components of a TM process. Ulrich and Smallwood (2012) went further, identifying that TM was not just about an individual employee's performance and potential, but engaging their commitment and contribution to the organisation; '*Contribution occurs when employees feel that their personal needs are being met through their active participation in their organization*' (Ulrich and Smallwood, 2012,p.6).

The Journal of World Business (Scullion et al., 2010; Ariss et al., 2014), the International Journal of Human Resource Management (Vaiman and Collings, 2013) and Human Resource Management Review (Dries,2013), all published special issues focusing on Talent Management. These were recognised as providing a welcomed focus of theoretical contributions to TM (Meyers and van Woerkom, 2014). Reflecting a variety of contributions from academics within the business and HRM fields; this included Thunnissen et al., (2013), who identified a significant increase in publications on TM since 2010 but concluded that the academic literature remained narrow and focused on conceptualising Talent Management. The authors proposed a new pluralist view of TM that moved away from an elitist, differentiated approach, to consider greater staff engagement and wider societal wellbeing, supported by Tansley et al., (2013).

Dries (2013) summarised that different approaches to TM '…*are all equally viable and can subsist in a myriad of configurations, each with its own merits and drawbacks*.' (p.283). More important was assuring best fit with organisational culture, strategic objectives and HRM processes.

A move was evident in the literature, to a perspective that TM was driven by context and that no single definition is possible or desirable (Boudreau, 2013). This hybrid approach to TM is a concept now more widely accepted within the practitioner focused literature (Turner and Kalman, 2014; The King's Fund, 2015b).

The literature review also identified that historically, 'succession planning' was more widely referenced in HRM literature, sometimes being utilised interchangeably with the term Talent Management. It related to the preparation of specific individuals for senior executive posts (Friedman, 1986). However as with TM, there was a lack of research evaluating the outcomes of different approaches used for succession planning (Carriere et al, 2009).

2.3.3 Succession Planning

Succession planning has been described as important in proactive planning for replacement of both management and technical talent within an organisation (Rothwell, 2005; Calo, 2008). Rothwell (2002) analysed a predicted shortage of graduates required by the US workforce and proposed strategic succession planning as a means of meeting the talent demands in an increasingly competitive environment. Furthermore, Rothwell (2005) criticised TM as narrow in scope, focused on developing a few elite performers. However 'succession planning' was also criticised as reflecting only a narrow aspect of a strategic TM process (Cappelli, 2008b). It is no longer regarded as appropriate to prepare individuals for specific roles in one organisation over a prolonged period of time; mainly due to the

faster paced, changing workforce context, where a specific role may not exist in the longer term business plan, or an individual may leave before the benefits are realised (Barlow, 2006; Cappelli, 2008b). Others support a view that succession planning is an integral component of TM (Garman and Glawe, 2004; CIPD, 2010b) and both terms have also been identified as potentially interchangeable (Tansley,et al., 2007). Research undertaken within the UK described that in some cases TM may now be seen as a more currently 'acceptable' term within an business context (Tansley, et al., 2007). Yet the same study took a more favourable view of TM over succession planning, viewing it as a dynamic process better suited to an uncertain and fast changing business environment.

2.3.4 Leadership and Technical Talent

The importance of nurturing and developing individuals with leadership potential has been widely acknowledged within the TM literature (Rothwell, 2005; Blass, 2007; Carriere et al., 2009; CIPD, 2010b). Focusing on leadership talent alone has been challenged, with Rothwell and Poduch (2004) suggesting that organisations should also develop people with specialised and tacit knowledge, enhancing knowledge transfer, which they identified as key to business success. Calo (2008) also considered the importance of knowledge transfer, capturing specialist knowledge where companies were downsizing or due to the retirement of older workers. A picture emerges of TM as more than a process focused on high performance employees with leadership talent. In addition to current performance, CIPD (2010b) identified an important consideration for TM was future employee performance. This included considering individuals with potential for both leadership roles and other roles considered business critical within an organisation. These roles have been described as 'pivotal positions'

(McDonnell, 2011,p.170) and as 'strategic roles' (Cappelli and Keller, 2014,p.309).

Within the public sector Tansley et al., (2007) identified that individuals were often promoted to leadership roles based on their technical competence, rather than management and leadership abilities. It has been suggested that evidence of technical and professional competence does not necessarily result in producing individuals with the required effective leadership and management skills (Branham, 2005). In addition McDonnell (2011) identified the criticality of business strategy driving TM strategy and defining pivotal roles, which may not necessarily just be leadership positions. These pivotal positions may include other strategically important roles, such as technical or knowledge based roles. Once identified these roles then receive a greater level of investment within an organisation's TM strategy, as they are recognised as making '*the greatest strategic contribution*' (McDonnell, 2011,p.170). Collings and Mellahi (2009) advocated a similar approach for TM, involving a level of segmentation in investment, recommending that organisations identified, '…*key positions which differentially contribute to the organization's sustainable competitive advantage*…" (p.304). Therefore when considering both technical and leadership talent, different knowledge, skills and abilities will be required within various business and employment sectors.

So far the emerging concept of TM has been described. It has been suggested as a continuous organisational process, composed of a range of different components aligned to best achieve strategic business objectives. Philosophical perspectives and definitions of both talent and TM have been outlined as varied between organisations and contextual in nature. Within the debate on TM, analysis of the literature identified the main differences in approach

related to the use of inclusive versus exclusive models (CIPD, 2006).

2.4 Models of Talent Management - Inclusive and Exclusive

Approaches to TM can be viewed on a continuum, at one end an exclusive approach, at the other, an inclusive approach. The exclusive can be described as relativist, '..*only those persons possessing high levels of some ability can meaningfully be seen as talented*.' (Swailes et al., 2014,p.2). Talent is viewed as a limited resource, those employees who contribute proportionally more towards strategic business success and this was reinforced within a 'War for Talent' (Chambers et al., 1998). With an exclusive approach there is greater investment in those employees identified as having talent. This involves segmentation of the workforce, identification and development of elite performers for maximum organisational performance (Collings and Mellahi, 2009). An inclusive approach, regards all employees as having potential talent. Along the continuum there are also different hybrid combinations of exclusive and inclusive components. For example, an organisation identifies that all employees have talent and provides access to development opportunities, but targets development and investment for some critical roles (Turner and Kalman, 2014; NHS Leadership Academy, 2014a; The King's Fund, 2015b). Traditionally TM has focused more on exclusive models however, there is a shift towards broader definitions of talent and more hybrid talent-management systems (Meyers and van Woerkom, 2014). Wider organisational investment in TM may enable more effective responses to rapidly changing business needs. In research undertaken by CIPD (2012) inclusive TM approaches were evident in two fifths of companies surveyed. Some of the advantages and disadvantages of these two broad philosophical approaches are summarised within Tables 2 and 3.

Table 2: Exclusive Approaches to Talent Management

Exclusive Approaches To Talent Management	
Advantages	**Disadvantages**
Develops high potential individuals Build leadership skills and relationships within a larger company (Lubitsh and Smith,2007*)*	Not reflective of culture of equity and fair access historically evident within the public sector (Tansley et al.,2007)
Offers incentive, aims to attract and retain higher fliers, who wish to be selected within a 'talent pool' (McDonnell et al.,2010).	High fliers not part of an identified 'talent pool' may leave (Martin and Schmidt,2010).
Targets investment on a smaller pool of individual employees identified as having the talents to enable greater competitive advantage to an organisation (Blass,2007;McDonnell et al.,2010).	Risks alienating employees not included as high fliers in 'talent pool' (Swailes 2013;Tansley et al.,2007).
Develops organisation's own internal talent, reduces cost of external recruitment (Blass,2007; McDonnell,et al.,2010).	Departments reluctant to release high fliers to wider company. Risk talent mismatch for business need, wasting resources. (Blass,2007).
Exclusive development programmes may be seen as more valued by employees (CIPD,2010b)	Risk perpetuating bias. i.e. race, gender, age, cultural (Mäkelä, Björkman and Ehrnrooth,2010).

Exclusive Approaches To Talent Management	
Advantages	**Disadvantages**
	Reduced diversity and wider staff engagement (Downs and Swailes,2013).
Business advantage for companies investing in highest performers (Michaels et al.,2001)	Little evidence result in business advantage (KPMG,2014)

Table 3: Inclusive Approaches To Talent Management

Inclusive Approaches to Talent Management	
Advantages	**Disadvantages**
Aims to maximise workforce talent development, avoid alienation of individuals. Incorporates existing human resource processes (Boudreau and Ramstad,2005).	Re labelling existing employee development processes, as by default '…a workforce cannot all be talented. ' (Mcdonnell et al.,2010,p.151)
Includes strategies for enhancing staff engagement. More open access to development opportunities for all employees. Reflect values of organisations within the UK public sector (Tansley, et al.,2007; Powell et al.,2012)	Requires greater resources, than exclusive approaches to TM (McDonnell et al.,2010).

Inclusive Approaches to Talent Management	
Advantages	**Disadvantages**
Enhances diversity. Reduces risk of perpetuating bias (Swailes,2013)	

2.4.1 Exclusive Approaches

Exclusive approaches to TM include a process described by Michaels et al., (2001) as involving 'A' players (exceptional) 'B' players (solid performers) and 'C' players (bottom 10% performers). In an exclusive model 'A' players are engaged in additional development processes and fast tracked career progression. This aims to motivate and develop talented individuals to enable their maximum contribution to business performance. Blass (2007,p.7) refers to advantages of 'talent segmentation' in order '*to target investment in those offering future potential to meet the organisations strategic objectives'.* The literature illustrates that attracting talented individuals and succession planning (Hoeger et al., 2009) are central to an exclusive approach to Talent Management (CIPD, 2009a; CIPD, 2009b). This exclusive TM approach requires careful consideration of workforce planning to reduce the risk of oversupply, whilst still ensuring business needs were met.

Debate continues within professional journals, Briner (2015) criticised inconsistency in the application of TM and a focus on elite performers with little evidence base for practice. In response Collings (2015) argued that increasing evidence indicated the benefits of an organisational strategic approach to TM and identification of roles that offered the most potential for differentiating business performance. There are concerns regarding the ethics arising from exclusive approaches to TM, where investment in a small number of elite employees includes the risk of

reinforcing organisational values, culture, stereotypes and organisational structure (Swailes, 2013). The CIPD (2010a) surveyed the views of senior managers in a number of both private and public sector companies based in the UK who had TM programmes, including two NHS Strategic Health Authorities. There was less impact than anticipated on those who were not selected for the competitive, exclusive TM programme. Their analysis reflects that the senior level of sample included NHS participants who were all operating at a regional health authority level and were not based within NHS provider organisations. The impact on staff groups lower down in an organisational hierarchy may be very different and is not yet well researched in the public sector. Subsequent research with NHS managers has favoured a more inclusive approach to TM (Powell et al., 2012 Powell et al., 2013; Powell, 2014).

2.4.2 Inclusive Approaches

An inclusive approach to TM recognises all staff as having potential talent and has been defined as;

> *'…the recognition and acceptance that all employees have talent together with the ongoing evaluation and deployment of employees in positions that give the best fit and opportunity (via participation) for employees to use those talents.'* (Swailes et al., 2014,p.5)

Here a fully inclusive TM approach describes the need for 'best fit' to roles and access to opportunity. Swailes et al., (2014) identify the value of supporting an employee to find alternative employment, when their talents do not match those required by the organisation. Therefore inclusivity is not presented as less focused on maximising business performance than exclusive TM approaches; rather its philosophical underpinning is different in recognising all employees

as having talent and thereby aims to maximise workforce talent development (Boudreau and Ramstad, 2005). McDonnell et al., (2010) criticised this as purely renaming existing organisational employee development processes; by default a workforce cannot all be talented. Tansley (2011) and Powell (2014) continue to advocate an inclusive approach, contending that in only recognising narrow definitions of talent there is a risk that the full potential of a workforce is not realised.

An inclusive approach to TM includes increasing gender and Black and Minority Ethnic (BME) diversity and career development within organisations. A lack of women on the boards of businesses within the UK has been the focus of a national strategy to increase gender diversity (Department for Business, Innovation and Skills, 2015). Women's representation on the boards of the FTSE100 companies has increased from 12.5% in 2011 to 26% in 2015. In addition the Athena SWAN Charter and Race Equality Charter (Equality Challenge Unit, 2015) aim to address gender and race equality, develop talent and advance the careers of women and BME employees within higher education institutions in the UK. Research on social capital has highlighted the importance of inclusiveness and of regarding the workforce as a '*collection of talent segments*' creating and applying knowledge (Guthridge et al., 2008,p.56). They suggested this inclusiveness as beneficial to all, with high performing employees benefitting from operating in positive and diverse networks.

The importance of inclusivity is also reflected in emerging literature regarding the benefits of staff engagement on business advantage (Macleod and Clarke, 2009; Alfes et al., 2010; KPMG, 2011). It is suggested that psychological empowerment and effective employee engagement can enhance overall business performance and enable talent development of the wider workforce (Macleod and Clarke,

2009; Bux and Tay, 2010). More recently, research in healthcare has also identified the importance of staff engagement and collective leadership in creating positive healthcare organisational cultures (The King's Fund 2014; West et al., 2014; The King's Fund, 2015a).

In a review of the TM literature, Beechler and Woodward (2009) challenged the notion of a 'War For Talent' and the scarcity mentality. They advocated a move to a more global mind-set and the capacity to '*leverage diversity*' in all employees' talents (Beechler and Woodward, 2009,p.282). It has been suggested that in modern service based industries, there are fundamental changes in the nature of the relationship between organisations and the individuals they employ, one of mutual interdependence. The individual ultimately makes an active choice to utilise their talents, being liberated from an organisational hierarchy they are able to influence the organisation (Gratton and Ghoshal, 2003; Schoemaker and Jonker, 2005). Traditional bureaucratic hierarchies were criticised as limiting individualism, with the employee viewed as a commodity constrained by organisational strategy and finances (Rothwell, 2005). The emergence of an interdependence between the individual and the organisation aimed to establish a relationship based on reciprocity (Schoemaker and Jonker, 2005). Barlow (2006) proposed a self-management model for talent development in organisations, where individuals take charge of their own careers and require personalised development rather than '*sheep dip training*' (p.7).

Whilst management consultancy companies offer various TM solutions to business, Swailes (2013) identified that there remains minimal evidence of impact or evaluation of TM approaches. He suggested that an inclusive approach to TM offered an alternative perspective and that companies who wish to promote themselves as

having the skills to provide solutions perpetuated the perception of a shortage of talent. Furthermore, Swailes (2013) identified that consultancy companies had a vested interest in promoting more exclusive models of talent and leadership development. Cappelli and Keller (2014) also noted the interests of some consultancy companies as external providers of recruitment services. In such cases, research that revealed less effective practices may result in business losses for the identified consultancy company. When proposing evaluation of different TM approaches, in addition to the different philosophical perspectives, a further business and practice related complexity emerges. Whilst there is a limited empirical research relating to TM models, there is evidence that this field of study is evolving and reinforces the need for independent empirical evaluation. From a UK perspective Tansley et al., (2007), Powell et al., (2012) and Powell (2014) identified that the predominant focus of TM literature remained within private sector companies. They identified similar workforce challenges in the public sector and a need for more research within these alternative contexts. Having set the wider context I now review more specifically TM in the healthcare and nursing literature.

2.5 Talent Management in The NHS

Within the consultation paper 'A Health Service of all the talents ' (DH, 2000a), developing healthcare staff with skills and flexibility to deliver care where needed, was described as integral to national workforce planning. An inclusive ambition was described, to develop the full potential of all staff through modernising workforce planning in the NHS. The policy aimed to break down role barriers, review funding for education and training and create more flexible careers. A more systematic approach to TM was proposed to ensure senior executive talent was prepared, to lead the changes required in the NHS (DH, 2004b). The skills required for excellence in leadership

were described within a national leadership quality competency framework based on research undertaken with Chief Executive Officers (CEOs) (NHS Institute For Innovation and Improvement, 2006). NHS Employers (2009) published guidance for TM that included principles for inclusivity;

> *'..It can be defined as attracting and integrating highly skilled workers and developing and retaining existing workers...TM should not be the domain of HR alone.'* (NHS Employers, 2009,p.2)

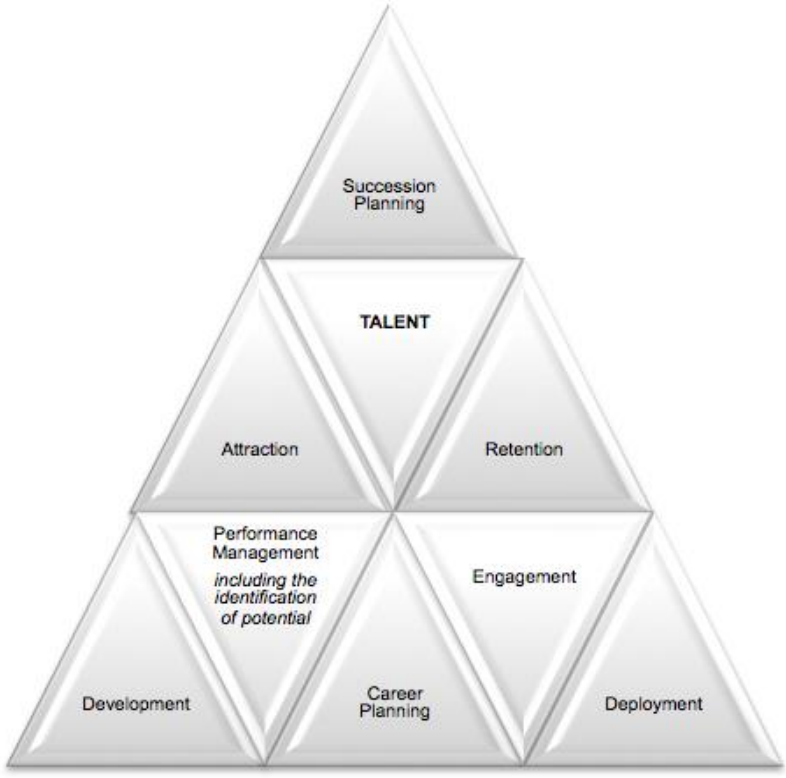
Whilst inclusivity was described, priorities were initially focused on aspiring CEOs, Directors and increasing BME and women representation at this level (NHS Employers, 2009). Powell et al (2012) identified that TM in the NHS had previously been seen as more exclusive and lacked a transparent process. Other studies involving the public service sector, recommended a TM model that valued inclusivity and reduced alienation and disengagement of the wider workforce (Tansley,et al., 2007;Devine and Powell, 2008).

Powell (2014) reviewed the history of TM within the NHS during the global financial challenges and political changes of 2010. In addition, as described in chapter 1, the Francis Inquiry (DH, 2010e) questioned the skills of leaders in the NHS and recommended an increased focus on values, compassion and inclusivity, indicative of an evolving TM philosophy within the NHS and healthcare. More recently The King's Fund (2015b) described TM as *'…a set of integrated organisational workforce processes designed to attract, develop, motivate and retain productive, engaged employees.'* (p.1). This aligned with the emerging literature on staff engagement and inclusive TM is also evident within HRM and business literature.

A new NHS Leadership Model and TM Strategy were launched (NHS Leadership Academy, 2014a,b). As part of the new model for TM,

multiple components were identified (see Figure 1). It is suggested that all these require consideration within an effective strategic TM process and include a range of different approaches. Interestingly, in spite of the lack of evidence base for different approaches to TM, evaluation is not included as a component of the NHS TM model. The limited research into TM available in the NHS has identified that evaluation is essential (Powell, 2014).

Figure 1: Components of Talent Management



(NHS Leadership Academy, 2014a,p.12)

Within the NHS there was evidence of a hybrid approach to TM, with targeted leadership programmes developed for differentiated staff groups, as well as an emphasis on staff engagement as an enabler for development. The importance of the manager's role in developing employees potential through effective appraisal was recognised (NHS Leadership Academy, 2014a). This represents an area for ongoing improvement within the NHS; for example the staff

survey (Picker Institute, 2014) identified variation in the quality of appraisal across the NHS, whilst 83% of staff indicated they had received an appraisal, only 38% said this was well structured. In addition, whilst the NHS Leadership Academy (2014a) advocates an inclusive approach to TM, there is also recognition of the ongoing need to increase diversity in senior NHS manager roles, including women, black and minority ethnic representation (Kline, 2014). Abbott and Meerabeau (1998), Speedy (2002) and Clay (1987) noted that even in female dominated professions such as nursing, men were more frequently in managerial roles, whilst women undertook more care focused roles with patients.

Although there is a national NHS TM strategy, Powell (2014) described evidence of varying levels of engagement with TM across different NHS organisations. It should be noted that as an advisory body, the NHS Leadership Academy has no direct operational influence over organisations. This poses potential challenges, as there is a risk of diverse approaches to the implementation of TM, dependent on local context and organisational cultures. Due to changing business models and a multiplicity of service providers, Powell (2014) recommended an urgent need for evaluation research, observing some unresolved challenges for TM in the NHS. Fundamentally there was a variation in whether staff regarded the NHS as one system, or as individual organisations with different and competing priorities. There is a lack of an evidence base to inform NHS organisations on the advantages and disadvantages of different approaches to Talent Management. This may lead to increasing variation in application, or organisations choosing not to implement TM due to a lack of an evidence base. There is an emerging discourse relating to TM in some areas of the NHS, yet potential barriers to implementation can still be identified. Further national

strategies for leadership development and TM have been recommended (Smith, 2015).

I will now go on to focus in more detail on the literature that relates more specifically to TM and nursing. As outlined in chapter 1, nurses represent the largest number of employees within the NHS and a number of workforce challenges were described. The focus on nursing literature aimed to ascertain any specific evidence relating to TM within this occupational field.

2.6 Talent Management in Nursing

In spite of the nursing workforce challenges identified in chapter 1, the literature review identified TM was not a widely referenced concept within nursing academic, or practitioner journals. A search of the nursing literature was subsequently broken down further in to components of the cyclical TM process as described by Tansley et al., (2007). This included recruitment and retention, succession planning, leadership development and workforce planning. This demonstrated a wealth of literature related to individual components that may be included within a TM process, but did not include consideration of the concept of TM, as defined for the purpose of this study. A detailed exploration of all the literature relating to potential components of TM as a poorly defined process went beyond the scope of this thesis. However, three areas of a TM process were identified to be of particular relevance to TM in nursing. These will now be outlined and included; attraction and retention of nurses, talent spotting and succession planning for pivotal talent positions. Within the context outlined in chapter 1, pivotal talent positions are those that differentially contributed to the competitive advantage of a company (Collings and Mellahi, 2009).

2.6.1 Attracting and Retaining Nurses

Attracting and retaining staff is an integral component of a TM process. As outlined within chapter 1, global healthcare workforce concerns include a shortage of nurses. Within the UK there are contemporary and unresolved nursing workforce shortages, with increased international nurse recruitment to support NHS organisations (RCN, 2015a). There have been special issues of the International Journal of Nursing Studies (Rafferty and Clarke, 2009; Van den Heede and Aiken, 2013) focused on global nursing workforce priorities. These presented similar challenges facing different countries and identified the importance of recruitment, retention and also considering the health and well-being of the existing nursing workforce, referred to as the 'talent pool' (Rafferty and Clarke, 2009,p.875). Investing in these current nurses was seen as an additional importance to the need to invest in recruiting new nurses.

In an editorial for the Journal of Advanced Nursing, Buchan (2006) reflected on the cyclical nature of nursing shortages in a global context and identified the importance of focusing not just on recruitment, but on nursing retention. Organisational approaches to nurse retention were described as positively influenced where there was access to continuing professional development and decentralised decision making in clinical environments. In a study of 10 European countries, 9% of nurses intended to leave the profession; whilst burnout was one factor, a variation in other influencing factors indicated a need for further research within individual countries (Heinen et al., 2013). Previous research undertaken in the USA during nursing shortages in the 1980s, studied hospitals that effectively retained nurses (McClure et al., 1983) and identified themes subsequently described as forces of magnetism, which attracted and retained the nursing workforce.

The research led to the development of the Magnet Recognition Programme® run by the American Nurses Credentialing Centre (ANCC, 2015). This credentialing process recognises hospitals that achieve and sustain standards of nursing excellence. Studies have identified a reduced turnover of nursing staff (McClure and Hinshaw, 2002; Ulrich et al., 2007) and lower patient mortality in Magnet hospitals when compared to non-Magnet organisations (McHugh et al., 2013). The importance of retention of the existing nursing workforce is therefore recognised internationally, and further supported by empirical work demonstrating the positive impact of RN staffing and a good work environment on patient safety and outcomes and improved patient satisfaction (Aiken et al., 2012; Aiken et al., 2013).

In a review of literature between 2006-2012, Hayes et al (2012) identified that turnover of nurses continued to present significant challenges to healthcare including; economic impact, poorer patient and nursing care outcomes and yet there was a lack of longitudinal research to effectively evaluate the impact on costs, patient care and nurse satisfaction. In one longitudinal survey Robinson et al., (2008) considered patterns of employment movement and retention of NQ diploma nurses in England. There was variation in migration between regions related to age and profile of nurses. Older nurses were more likely to remain in the same area, however regular career discussions and guidance were advised for all nurses new in their careers to assist with retention, as the first job did not necessarily determine future direction.

As outlined within chapter 1, in the UK there are concerns that negative media coverage presents nursing as an unattractive career option and therefore risks influencing recruitment and retention of the current and future nursing workforce. Rafferty and Clarke (2009) summarised a lack of existing evidence base in the field of

nursing workforce, skill mix, work environment and management practices and an urgent need for innovative research. Evaluation of nurse retention strategies remains an identified nursing workforce priority (HEE, 2014a). Advancement in these fields of research is also integral to gaining greater understanding of the opportunities for TM in nursing.

As outlined earlier in this chapter, within TM identifying pivotal roles including specialist and technical talents that contribute to a greater extent on strategic priorities, includes a process of succession planning for these positions. This includes talent spotting and recruiting individuals with the skills, or potential to develop the required skills, and is described as integral within more exclusive or hybrid approaches to Talent Management.

2.6.2 Succession Planning For Pivotal Positions in Nursing

The term succession planning is more widely referenced than TM within healthcare and nursing management literature (Garman and Glawe, 2004). This is driven primarily by concerns relating to a future shortage of nurses to take up senior leadership roles (Titzer and Shirey, 2013). In a qualitative study of leadership development as a component of TM within 15 US healthcare organisations, Groves (2006) identified that best practice organizations engaged managers in development activities such as mentorship, tracked high potential employees and used project based learning experiences as part of succession planning. A focus on workforce challenges in one issue of the Journal of Nursing Management (Sherman et al., 2013) emphasised the importance of addressing a predicted shortage of future senior nurse leaders, also identified as a global nursing workforce priority. This required a more systematic approach to careers guidance for aspiring executive nurses (Trepanier and Crenshaw, 2013), including individual development

plans, identifying competency gaps and developmental assignments.

Nursing management is one of the more traditional and transparent nursing career pathways in the nursing career framework (DH, 2011). In spite of the recognition of the influence of the leadership ability and skills of the WS role, preparation and development for those taking up the position is often limited. (McCallin and Frankson, 2010;Paterson et al., 2010). Literature and case studies over many years have identified the importance of clinical leadership and the impact of the WS on performance and patient safety at ward level in the NHS (Audit Commission, 1992; Burdett Trust, 2006; Hay Group, 2006; DH, 2010e). Within the UK and global context, there is ongoing discourse relating to the influence of nursing clinical leadership on patient care and outcomes (Wong and Cummings, 2007; RCN, 2009; Germain and Cummings, 2010; The MSFT Public Inquiry, 2013). A national study by the Royal College of Nursing (2009) identified that the WS role was not viewed as an attractive career option for more junior nurses, due to the work pressures. Staff Nurse internships and mentorship were utilised in one Canadian study to expose SNs to managerial roles, helping them to develop greater understanding, skills and reduce levels of anxiety about senior roles (Wendler et al., 2009).

Available evidence suggests that nursing is not planning effectively for the specialist roles required in the NHS (HEE, 2015; Rafferty et al., 2015b). As within the business literature, succession planning in nursing was also identified as important for 'technical' talent; roles such as NCs and Specialists, often noted to have poor preparation for roles (Hoeger et al., 2009*).* These roles require a combination of nursing, leadership and technical or specialist skills, yet there is limited literature on approaches to address these workforce needs.

2.6.3 Talent Spotting In Nursing

Talent spotting and recruiting and developing high calibre candidates for senior leadership roles has been presented as an important component of TM within the business and HRM literatures. The PM Commission (DH, 2010c) and national nursing strategy (NHS England, 2012), identified the need for talent spotting in nursing to develop future nurse leaders. They suggested the potential for fast track leadership development programmes. The importance of investing in NQ nurses with leadership potential to retain and develop these individuals is supported within the literature (Maben et al., 2006; Hancock, 2014; Edwards et al., 2015). There is limited evidence of methods utilised for talent spotting in nursing as part of a TM process, or evaluation research. Moreover, with clinical academic careers (an emerging career pathway in nursing) there is also a need to identify nurses early on in their careers, with the skills to engage in research training and higher-level degrees (DH, 2012a).

As previously described, within exclusive approaches to TM, organisational or role stereotypes can be reinforced and diversity limited. This may then be a barrier limiting talent spotting and development. In one study undertaken in an Australian hospital setting, a peer selection process was utilised to talent spot potential nurse leaders. The study concluded that SNs valued professional knowledge, this was a leadership skill that had not been identified by the senior nurses (Picker-Rotem et al., 2008). As within any approach to talent spotting, there could be a risk of reinforcing bias and team cultures that may not be the most effective. Conversely there are other examples in nursing where devolved management cultures such as models of shared governance (Swihart and Hess, 2014), aim to increase staff led decision-making and demonstrate evidence of increased leadership development, within a context of

inclusivity and increased staff satisfaction. Evidence of the business benefits of increased staff engagement and maximising the diversity of healthcare workforce talents have been presented (The King's Fund, 2014; West et al., 2014). Further research in nursing is required.

2.6.4 Summary of Talent Management in Nursing

There is an absence of discourse on the possibilities for TM within nursing, the literature remains limited to considering components within TM, rather than TM as an organisational process. From a USA perspective Douglas (2013) suggested the emergence of TM offers new opportunities for nursing, presenting a common language for nurses to use in the business world of health. Utilising the empirical work within business and HRM literatures, Douglas presents the potential of TM to articulate the value of investing in nursing staff, staff development and wellbeing. I suggest that achieving the ambitions of the NHS involves greater consideration of the possibilities of TM in nursing. This requires nursing leadership and an organisational process of; defining talents required, effective workforce planning, recruitment, retention, increased staff engagement, leadership development, succession planning for specialist roles and evaluation of impact.

The TM literature suggests that an organisation may naturally perpetuate bias and stereotypes within a chosen TM system. Existing gender and race inequalities within organisations were outlined earlier in this chapter. Davies (1995) presented gender as being at the heart of understanding how organisations work and furthermore described nursing work as gendered, inherently associated with female characteristics. As a result of this Davies described a lack of value for the role of nurses and a poor public image, with nurses also being disadvantaged in career progression. This resonates clearly with the policy and professional context

findings outlined within chapter 1. In the following section consideration of Davies's (1995) theory provides a useful framework within which to situate the study and consider TM as a concept in nursing.

2.7 The Gendered Predicament of Nursing

As a female dominated workforce, nursing inevitably faces value judgements about female attributes and is associated with an extension of domestic work (Salvage, 1985). The predominance of a female nursing workforce continues, certainly within acute adult nursing settings, recent research in England identified that the majority of the nursing workforce in hospitals (92%) remain female (Ball et al., 2012). Ten Hoeve et al., (2014) reinforced that a gendered perspective of nursing was evident globally. Nursing work often remains invisible and there is a lack of public awareness of nursing roles, research, scholarship and contemporary nursing practice (Price and McGillis Hall, 2013; Girvin, 2015).

The medical model of healthcare reinforces a sexual division of labour and positions the physician (male) as the technical, skilful, professional role within healthcare and nurses (female) as carers undertaking the basic tasks left over by physicians (Gamarnikow, 1978; Allen and Hughes, 2002). Nursing being so closely aligned with caring, is complex to define and easy to devalue as innate female skills and domestic characteristics (Davies, 1995), it is therefore devalued in a professional context (Mackay, 1989; Smith, 1992; Allen and Hughes, 2002). Thirty years ago LeRoy (1986) observed the challenges facing nursing in the USA as a female dominated occupation within hospital bureaucracies and a recurring theme of nursing shortages. The '*stratification*' of the nursing workforce (increasing nurse support roles) was described as a risk to the professional recognition of nursing, providing hospitals with a cheaper alternative workforce (LeRoy, 1986,p.30). This reflects

challenges in contemporary professional debate for nursing in the NHS with the removal of funded bursaries for student nurses and the proposed introduction of a new regulated nursing associate role to widen access to nursing roles (RCN, 2015b).

Davies (1995) acknowledged the complexity of theories studied within different sociological perspectives, including the influence of social class and power, to explain the interface between individual human actions and organisational structure. The notion of power bases within hierarchies in organisations has been identified as fundamental to opportunities and career advancement of individuals, irrespective of their personal talents and abilities (Moss Kanter, 1993). Davies (1995) drew on the work of feminist writers including Gilligan (1993), who described how the different voices of women and men are developed throughout childhood. Davies (1995) considered this as, '*cultural codes of gender*' (p.27) operating at different levels; individual and social. This is an important consideration when critically analysing TM within an organisation, where context had been identified as central to the TM philosophy and approach adopted and how talent may be defined. Where nursing is viewed as a gendered occupation, this could inherently influence how nurses are valued and developed. Those who have the power and authority to define talent and lead TM processes within an organisation will influence Talent Management.

The notion of image associated with nursing as a gendered occupation warrants consideration within the context of Talent Management. As introduced in chapter 1, nursing image has long been debated within the literature, ranging from frustration at media depiction of female stereotypes including angels and dragons (Bridges, 1990; Hallam, 2000; Summers and Summers, 2009). This is particularly emotive where nurses as women are involved within care failings. Traynor (2014) described how '*…nursing cruelty strikes*

at the heart of nursing's public presentation and its professional discourse as orientated around caring' (p.554). He cautions against promoting nursing in its historical moral context, as identifies that this encourages explanation of failures in care at an individual level rather than system wide level. From a USA perspective Summers and Summers (2009), also cautioned promoting solely the personal qualities of nurses to the public, as it risked devaluing the need for education and professional recognition. There have been successful campaigns to promote a positive image of nursing such as in the USA (Donelan et al., 2005) with nurses securing public confidence, being repeatedly voted the most honest and ethical profession in the USA (Gallup, 2014). In the UK concern remains relating to the image of nursing and the need to attract and retain high calibre candidates for a degree level workforce. A commission of senior nurse academics has been established by The Lancet (2014), to review evidence relating to the image of nursing within the UK. The Commission aims to propose solutions to counteract the negative perspectives of a degree level education for nurses. Therefore continued evidence at a national level within the UK indicates a need to challenge the traditional and gendered stereotyping of nursing. As such this poses important considerations for TM within nursing.

2.7.1 Devaluing Nurses' Work

As described earlier in this chapter, where talent is associated with an innate ability or personal characteristic such as caring, there is potential that it will not necessarily be viewed as a skill that can be developed in others. Where gendered stereotypes of caring are reinforced, this may adversely affect public perceptions that others, particularly men, are able to develop the skills required to be a nurse. Within a hospital context Davies (1995) described how doctors are reliant on other support staff, such as nurses and

clerical staff, who are cheaper to employ and predominantly female, to provide the majority of care and organise services. This was identified by Pembury (1980), who described issues of gender between nursing and medicine, where medicine as a male-dominated profession, presented cure and nursing was seen to support this in a caring role. It is only comparatively recently that caring has become more central to nursing professional identity, which was historically based on '*hygiene and order*' (James, 1992,p.97). James challenged the notion of nursing having a monopoly on caring describing the larger numbers of paid care workers, unpaid volunteers and family members caring for people in society.

Davies (1995) referred to medicine as the traditional male gendered model of a profession, associated with an elite body of specialist knowledge, requiring entrance qualifications, extended training and self-regulation. Nurses have historically striven for professional recognition and autonomy, through the acquisition of knowledge and debated the advantages of regulation modelling the medical profession (MacDonald, 1995). Thirty years ago LeRoy (1986) identified that whilst nurses were encouraged to view themselves as professionals, 97% were salaried employees subject to hospital policies with little control over their working conditions. This resonates as true in a contemporary context. Dingwall et al., (1988) outlined an ongoing debate in nursing evident since the late 19th Century and continued similarities, between a more managerial view of nursing workforce, which favoured a dilution of nursing skill mix resulting in different care support roles, wider access to nursing and a less expensive workforce. This was compared with those who drove for professionalization, aiming to increase the attractiveness of nursing as a career by improving training, education and working conditions.

Salvage (1985) and Davies (1995) critiqued the narrow pursuit of careers in nursing within a medical model of a profession. Previously nurses who did not want to go up a management career ladder, had created their own pathways of professional development by undertaking different post-registration courses to develop clinical skills (Davies, 1995). From a gendered perspective of career progression, this approach to expanding knowledge was devalued. Nurses were seen as a transient workforce collecting courses '*certificate gatherer*' (Davies, 1995,p.98). A new '*caring practitioner model*' was presented (Davies, 1995,p.149) that went beyond gendered thinking. Nursing should strive to a new alternative definition of profession (Speedy, 2002; Abbott and Meerabeau, 1998) actively seeking diversity in gender and class as a new approach within the profession. Within this new model the professional seeks to engage with patients, values an interdependent relationship and actively reflects on experience and expertise. This reflects principles now advocated within contemporary healthcare policy (NHS England, 2014), where partnership with patients is the ambition and actively sought, rather than relying on the expertise of elite professionals. However, the majority of registered nurses employed in the NHS continue to work at SN level within acute care hospitals. Accordingly, their role as direct caregivers in a gendered organisation (Davies, 1995) will now be considered.

2.7.2 The polo mint problem in nursing

In considering nursing as a gendered occupation and nurses' career aspirations within the organisational structure of a hospital, Davies (1995) described '*the polo mint problem*' (p.89). She illustrated how RNs found themselves required to supervise other less qualified, transient and temporary staff. This removed them from direct nursing care and caused conflict between the provision of

individualised care taught in training and their experience once qualified. In practice, there was a need to follow rules and routines in order to meet the workload pressures, devaluing nursing work and professional decision-making. Davies's theory is critiqued as failing to acknowledge work other than clinical work undertaken by nurses in organisations, including organisation of care, which has been described as invisible (Allen, 2001; Allen, 2014). Antrobus and Kitson (1999) also described how senior and experienced nurses' expertise was lost to the clinical arena due to movement into management and other roles. The lack of clinical career pathways has long been debated within nursing (Clay, 1987) and the role of the unregulated care support workforce. More recently the Shape of Caring Review (HEE, 2015) recommended a need for clearer post-registration career pathways and consultation on a new care role below degree level, to act '*as a bridge between the unregulated care assistant workforce and the registered nursing workforce*' (HEE, 2015,p.39). This illustrates continued debate over what talents and training are required in the nursing workforce.

2.8 Conclusion

In this chapter I have considered the HRM, business and healthcare literatures. Talent Management has been summarised as contextual in nature and described as organisational process led by senior leaders that includes core components; defining, attracting, developing and retaining talented employees to best meet strategic business objectives. I have presented the process of TM as socially constructed and have shown how philosophical approaches to talent vary across organisational contexts. Talent can be viewed as natural attributes, innate within individuals, or as potential skills and abilities that can be developed through training and practice. There is evidence of a lack of empirical research into TM, in particular evaluating the impact of one TM approach over another. However,

TM is a rapidly emerging body of research and is described as a priority for all organisations (Gallardo-Gallardo and Thunnissen, 2016).

There are important considerations for TM through the lens of a gendered occupation such as nursing. Davies (1995) theory of a gendered occupation offers an appropriate framework with which to situate the study. The literature identified that more exclusive approaches to TM segment and differentiate investment in the workforce, reinforcing organisational stereotypes and reduce potential diversity of talents within a workforce (Swailes, 2013). Within the NHS, there is a shifting sense of the importance of inclusivity and staff engagement to maximise the potential talents of the workforce (NHS Leadership Academy, 2014a;The King's Fund, 2014;The King's Fund, 2015a). From the perspective of a gendered occupation, if the aim is to challenge organisational culture and stereotypes, there is a need for nurses to understand TM and to influence potential developments. As with Clay (1987) nearly thirty years ago, Douglas (2013) emphasised an increasing urgency for nursing leadership to be heard in policy decisions effecting nursing workforce, safer staffing and also Talent Management. In spite of the contemporary nursing workforce and education challenges, review of the literature illustrated a lack of discourse and empirical research relating to TM in nursing. There are opportunities to consider the implications and possibilities for TM in nursing and for exploratory research to consider the wider perspective of nurses and to learn from research in other industries.

A primary aim of a DHSci is to show direct relevance of the study on professional practice. Parahoo (2014) identified the importance of nursing research contributing towards a body of professional knowledge and the development of nursing as a profession. I believe that the study will be of direct and contemporary relevance

to practice. The main objective of the study is to gain new insights into how TM is emerging as a concept within nursing. It aims to explore TM within one acute NHS trust, to engage and involve frontline nurses, enabling voice for clinical nurses. Through considering the gendered predicament of nursing, I will also reflect on my own experience as a woman, and a nurse working within an acute care NHS organisation. Undertaking the study as an insider researcher is presented as an advantage. Taking ownership and seeking to investigate and engage participants who may be harder to access in a traditionally hierarchical organisation (Davies, 1995). I explore clinical nurses' perspectives and lived experiences of TM within an organisational context, investigating how they define talent in nursing and what they see as the challenges of Talent Management. I also examine how talented nurses can be effectively attracted, developed and retained. In acknowledging the influence of context within TM, I also consider if there are differences between senior leaders perspectives and junior staff expectations for TM in nursing within a case study organisation. In the next chapter the methodological approach adopted for this study is outlined and the research design and process undertaken described.

CHAPTER 3: Methodology and Research Design

This chapter presents the methodology and research design of the study. It starts with the ontological and epistemological position and then details the research aims, questions and chosen case study approach. I also outline my role as an insider researcher, considering organisational context, issues of trustworthiness and the importance of reflexivity within the study.

3.1 Introduction, ontology and epistemology

Different research approaches enable the generation of different knowledge of a phenomenon under investigation (Denzin and Lincoln, 2011). Within any study it is important to have a clear understanding of the ontological assumptions of the researcher (Benton and Craib, 2001) and epistemological underpinning (Travers, 2001). Methodological approaches can be viewed on a continuum of paradigms, from an 'interpretivist' perspective, where knowledge is viewed as socially constructed and reality is subjective (Denzin and Lincoln, 2011). At the other end of the continuum is 'positivism' where reality is perceived as fixed and that rigorous quantitative methodology can produce objective knowledge and establish causality (Saks and Allsop, 2007). Adopting an over-simplistic view has been criticised (Hammersley, 1992), as quantitative research does more than test hypothesis and qualitative studies are not exclusively inductive in their approach. Silverman (2004) stressed the primary importance of establishing the research questions before agreeing the methodological approach. Educational research (Biesta and Burbules, 2003) and health researchers are increasingly drawing on a number of research paradigms to generate knowledge (Teddlie and Tashakkori, 2003; Saks and Allsop, 2007; Creswell, 2009).

I take a pragmatic approach, placing value on quantitative, qualitative and combined research to inform practice in a real world

context. Whilst there are varying perspectives of pragmatism, a philosophical movement of the early 20th century, Charles Pierce (1839-1914), William James (1842-1910) and John Dewey (1859-1952) are recognised as the founders of this American school of thought (Thayer, 1982). Pragmatism is concerned with the connection between knowledge and action. Dewey presented social inquiry as concerned with '*…actual social situations which are themselves conflicting and confused*' (Dewey, 1938, p293). His specific interest was in the theory and practice of education, regarding knowledge as a construction of the dynamic transaction a living organism establishes with its environment in an ever-evolving universe. This is particularly relevant for those who approach questions primarily from a practical perspective (Biesta and Burbules, 2003). This study aimed to provide new information to inform practice within the organisation and more widely. It was concerned with knowledge constructed within a social context rather than aiming for a generalisation of findings. Utilising a more pragmatic epistemology aimed to enable greater understanding of '*complex multifaceted institutions or realities*' (Teddlie and Tashakkori, 2003,p.16) within a real world context, this led to a case study approach (Stake, 2005; Yin, 2009). Viewed from a pragmatic research paradigm enables a focus on the research problem and the anticipated consequences of the research project, with a pluralistic approach to ascertaining knowledge (Creswell, 2009). There is openness to a diversity of information as data is interpreted from a '*multidimensional perspective*' (Feilzer, 2010,p.12).

This study started from an exploratory perspective. It examined TM in nursing within one NHS acute care organisation. The enquiry was driven by an encounter with a NQ nurse, which provoked my interest in Talent Management. I had initially viewed this from a

broadly phenomenological perspective, wanting to gain insight in to the everyday experiences of clinical nurses. Valuing this uniqueness of human experience implied an interpretivist approach to methodology, seeing knowledge as socially constructed, and reality as subjective (Denzin and Lincoln, 2011). However, the literature review identified the contextual nature of TM; Talent Management assumes a level of organisational influence on the development of employees, it was described as an ongoing organisational process, aligning the development of human capital with business objectives (Tansley et al., 2007). Nairn (2009) argued that social structures within nursing are complex, under-researched, and yet affect the agency of nurses. The importance of cultural context in making sense of data has also been emphasised (Hansen, 2006). Considering organisational influences and the structural dimensions that act as organisational barriers to TM and influence individual's career development was required.

An important component of case study methodology is that it advocates multiple sources of evidence and triangulation of data to enhance credibility and trustworthiness (Stake, 1995; Denzin and Lincoln, 2011). This case study utilised qualitative methods supported by data gathered from participatory consultation, documentary sources (including organisational policy) and staff survey feedback, providing an organisational context for the study. Talent Management has therefore been explored as a phenomenon considering both organisational context and participant experiences. I used an exploratory case study design, which aimed to capture rich descriptions and gain insight in to the day-to-day realities of participants' experiences of TM, within an acute care NHS context.

3.2 Research Aim, Objectives and Questions

The study aimed to contribute new knowledge to the body of evidence on TM and how this is emerging as a concept within

nursing, and to explore clinical nurses' perceptions and lived experiences of Talent Management. These aims have been met; in addition the study has informed future planning and practice for implementing an improved approach to TM in nursing within the case study organisation. I have also identified areas for further research.

3.2.1 Objectives

The primary objective of the study was to gain new insight and knowledge in to how TM was emerging as a concept within nursing. To identify how participants defined talent in nursing, what participants saw as the challenges of TM and how talented nurses can be effectively attracted, developed and retained. The secondary objective was to contribute to the development of TM in nursing within one acute NHS trust and to the emerging debates on TM in nursing in national and international contexts.

As shown in chapter 2, TM is a concept that lacks an agreed theoretical framework. In addition there is limited discourse and empirical evidence on TM within the nursing and academic literatures. This was an important consideration in developing the research design. While there was a potential lack of familiarity with TM as a concept within a nursing context, Tansley et al., (2007) identified that irrespective of philosophical approach to TM, there are core components to a cyclical TM process. These include attracting, developing, managing and evaluating talent, and were utilised to inform the development of the research questions.

3.2.2 Research Questions

1) How is talent defined within nursing (by case study participants)?
2) What characteristics are used to identify talent in nursing?

3) How do clinical nurses (pay bands 5-7) describe the challenges of attracting, developing and retaining talented nurses in an NHS organisation?
4) Is there a difference between senior leaders' perspectives (Trust Board level) and NQ or junior nurses' perspectives in terms of definitions, career aspirations and expectations of TM in the NHS?

3.3 Research Methodology and Methods

3.3.1 Rationale for choice of Case Study

Case study methodology is recommended when aiming to examine contemporary events in a real life context, through the different perspectives of participants (Stake, 2005; Yin, 2009). When utilising qualitative case study, researchers '*..choose that case from which we feel we can learn the most*' (Stake, 2005,p.451). In taking a broadly pragmatic philosophical perspective, this case study focused on the usefulness and purpose of the study, guided by the research questions (Feilzer, 2010). As an exploratory case, the study aimed to identify issues in an under-researched area and develop ideas for further study, rather than conclude the investigation. Stake (2005) describes an '*instrumental case study*' as one that aims '*to provide insight into an issue or to redraw generalization.*' (p.445). In this case study a qualitative approach is utilised to explore TM in nursing within a setting of professional relevance, aiming to facilitate and advance understanding in practice within one organisation.

A good case study should be significant, unusual or of general public interest with the underlying issues being of national importance in terms of policy, theory or practice (Yin, 2009). It should add to '*existing experience and humanistic understanding*' (Stake, 2000,p.24). This study is novel, in that the subject has not previously been studied within nursing in a large acute NHS

organisation, or more generally within nursing. The topic is of interest to practice and policy, particularly in light of the contemporary national concern regarding effective leadership, nursing workforce shortages and education within the NHS (NHS Leadership Academy, 2014a,b; HEE, 2015). As presented within the introduction and background chapters, the workforce challenges facing nursing have a level of commonality spanning healthcare boundaries. Thus, this study offers potential for wider national interest and shared learning external to the case study.

3.3.2 Introduction to the Case

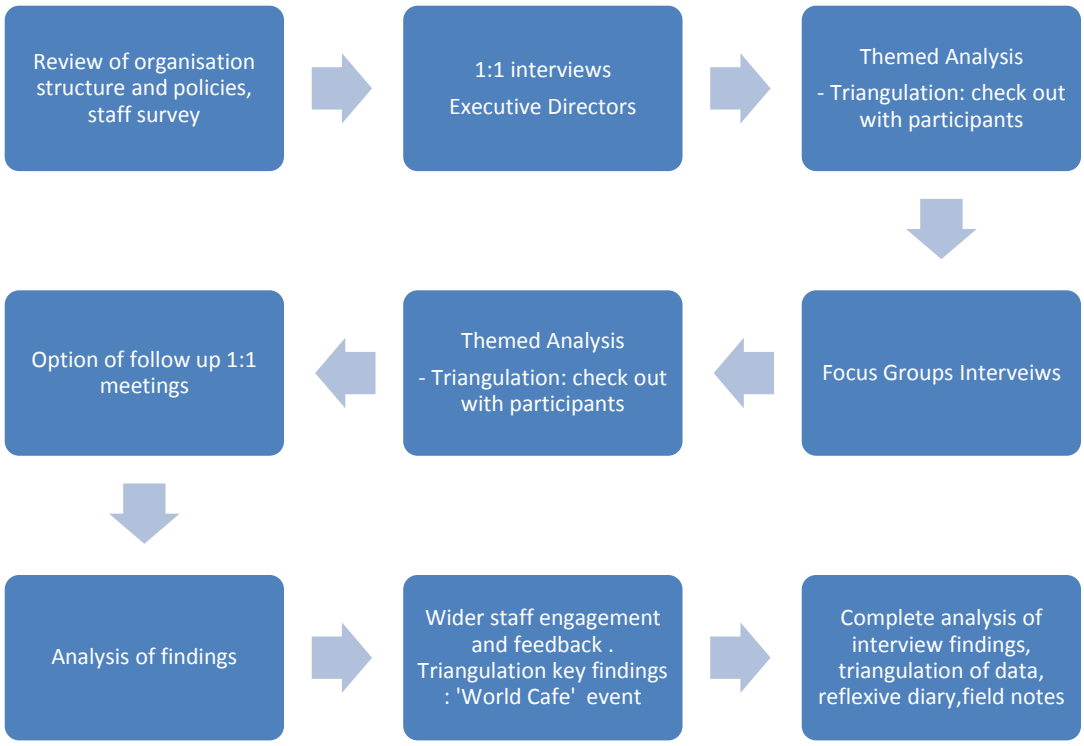
The organisation studied was a large NHS acute university teaching trust in the UK. It consisted of two acute hospitals on separate geographical sites. These hospitals provided a range of services including; emergency and acute care, long-term conditions, rehabilitation care and regional specialities. The organisation employed 13,000 members of staff, of whom 4,500 comprised RNs and midwives. The nursing hierarchy ranged from non-registered nurses (NHS Pay Bands 2-3), clinical RNs (Bands 5-7) and nurse managers (Band 8) (NHS Employers, 2015). At the time of the study it had 80 clinical ward areas and each ward team was led and managed by a Ward Sister (Band 7). The organisation had publically available policies as required to comply with national healthcare statutory regulations. These included human resource policies relating to staff appraisal, performance management and recruitment processes. Nursing turnover was comparable to similar organisations. To maintain anonymity due to the limited number of comparable organisations within the UK, further detailed description is not provided as would enable easy identification of the organisation.

There was no organisational TM strategy or policy, however the annual appraisal process included a performance rating system. This

had been implemented during the year prior to the data collection and required all staff to be rated by their manager. There were three rating options; an employee could be assessed as 'exceptional', 'meets requirements' or 'failing to meet requirements'. This rating system reflected processes described within the literature adopted within more exclusive organisational approaches to TM (Michaels et al., 2001). Other than implementing a rating system, there was no evidence identified from within the case study organisation that actions were taken (such as additional targeted investment) as a result an individual's rating within the appraisal process.

A case study must be complete and understanding the complexity of behaviours and data within the boundaries of the case study is important, as is being able to demonstrate that all critically relevant evidence has been collected (Yin, 2009,p.186). Within this study a clear research design provided the framework for data collection and set the boundaries of the case. This study included a wider participatory consultation process (see section 3.11, Table 7), to actively seek evidence from alternative perspectives. Robson (2011) advocates the use of a diagrammatic conceptual structure to enhance trustworthiness (see Figure 2). This enabled transparency to others, outlining the study regime, data to be collected and the important features of the study. As with high quality qualitative research, explicit attention is required to demonstrate and these issues are addressed later in this chapter.

Figure 2: The Study Design



3.3.3 Insider–researcher

As researcher and a senior nurse in the organisation I acknowledged potential advantages and disadvantages as an insider-researcher within case study research. The use of own knowledge as an insider-researcher within a case enables greater awareness of current context and understanding of the subject matter (Yin, 2009.) Within qualitative case study the researcher's inquiry is viewed as subjective, this uniqueness is described as 'an essential element of understanding.' (Stake, 1995, p45). However, this is criticised from a positivist paradigm due to the risk of subjectivity and insider bias (Punch, 2005). In taking a qualitative approach, I was conscious of the need for an open, consistent and transparent process. Actions were identified to address this, including the use of a clear research study design and regular meetings with research supervisors to challenge assumptions. I viewed positive benefits of

being an insider in a case study; I had a greater understanding of the organisation, established relationships with staff and therefore less obtrusive within flow of data collection (Bonner and Tolhurst, 2002).

3.3.4 Embedded Case Study Design

Stake (2005) describes how multiple cases can lead to better understanding of the phenomena under investigation. An embedded case study design was identified using defined units of analysis within the overall case (Yin, 2009). This enabled analysis across the different data sources looking for patterns, differences and similarities from within the case study. Considering the perspective of a gendered occupation as outlined within chapter 2, I wished to ascertain the views of the clinical nurses (Bands 5-7) who constituted the majority of the organisational workforce. Nursing roles have been discussed as often less visible and devalued within an organisational context. Gathering their views was fundamental to answering the research questions. Focus group and one-to-one interviews were utilised as a primary source of data within the case study. Data collection included fifty-seven participants within eight focus groups. This included the job roles of Staff Nurse (SN), Deputy Sister (DS), Ward Sister (WS), Practice Development Matron (PDM) and Nurse Specialist (NS). There were also three one-to-one interviews with Executive Directors (Executives) and a wider consultation process with SNs (N=229) from across the organisation. Integration of larger scale consultation on themes from focus groups within the research design enabled a more participatory approach and wider SN engagement.

3.3.5 Documentary Data Sources

A search of the organisation's intranet and Internet websites identified no evidence of documentation or policy relating to Talent Management. This was confirmed by the organisation's lead for staff

development. The organisation had a policy for staff appraisal and recruitment and selection. The documentary sources analysed for the purpose of the study are outlined in Table 4. Each source was carefully reviewed and analysed for applicability within TM in nursing in the organisation.

Table 4: Case Study Documentary Data Sources

Source	Rationale For Inclusion
Individual performance review and recruitment and selection policies	The policy and procedures for staff appraisal and recruitment and selection. Details the performance rating system utilised within appraisal.
Picker NHS Staff Survey (2012)	An independent national NHS survey with organisation specific data on staff experience and satisfaction.
Unpublished dissertation from case study (Cargill, 2011)	A study on TM undertaken within the organisation, involving senior managers. Discovered during internal review of the organisation's documentary sources. Provided a different perspective on TM within the case study.
Senior Nurse Time Out Summary (2011)	A summary report from an internal workshop senior nurse managers on vision for TM in nursing in the organisation.

A senior nurse had undertaken a research study as part of an unpublished Masters dissertation within the organisation the year before and involved two human resource managers and three senior nurse managers (Cargill, 2011). The findings reflected those of other research undertaken in the NHS involving managers as discussed within chapter 2 (Powell et al., 2012; Powell, 2014). The participants viewed TM as a relatively new and inconsistent concept, there was variation in application and experiences and a need to consider both leadership and technical talent in healthcare. These findings were also reflected in a summary report from a senior nurse workshop within the organisation (see Table 4). There was a perception that informal, non-transparent processes of TM existed in the organisation and a preference for a more inclusive approach to TM in the NHS.

The findings of the documentary analysis gave valuable contextual information and served to illustrate minimal discourse relating to TM in the case study organisation. The data was limited and not the primary source of data for the study. Yin (2009, p.105) suggests documentary evidence needs to be assessed against the *'centrality to your inquiry'* and must not be over relied on within a case study. For the purpose of gathering clinical nurses' perspectives, utilising an inclusive approach, the qualitative interview data and wider consultation remained the primary sources of evidence. The choice of focus groups as a method will firstly be considered in more detail.

3.4 Focus Group As Method

The use of focus groups aimed to involve the views from nurses at all levels of the clinical nursing hierarchy in the organisation. Focus groups emphasise the collective rather than an individual view (Robson, 2011) and have been identified as valuable when wanting to gain greater understanding of how people think or feel about a subject, their attitudes and experiences, or understanding of

workplace culture (Kitzinger, 2006; Krueger and Casey, 2009). Morgan (1997) and Fontana and Frey (2003) outlined the more recent recognition of focus groups as qualitative methodology, utilised within social research, sometimes linked with other research methodologies but also increasingly in their own right.

3.4.1 Advantages of Focus Groups

The primary aim for choice of this method was to provide richer data through group discussion. Barbour and Kitzinger (1999) identified the benefits of focus groups in exploratory research where there is little is known about the topic under investigation. Kitzinger (1994) and Morgan (1996) assert how focus groups help participants to develop their ideas, as they question not only each other, but also interact and explain their own perspectives to others in the group. This group interaction can spark ideas, prompt discussion and produce data *"…less accessible without the interaction found in a group"* (Morgan, 1997,p.2). Plummer-D'Amato (2008,p.69) described how interaction between group participants could generate data that may not emerge within one-on-one interviews.

Focus Groups can encourage participation, where traditionally there may be feelings of social or organisational marginalisation (Madriz, 2003). Within the context of a gendered occupation where nursing is described as having less influence within a medically dominated hospital bureaucracy, the use of focus groups aimed to actively facilitate participation of clinical nurses. The most effective focus groups are characterised by homogeneity (Krueger and Casey, 2009), participants need to have something in common. Homogenous groups were utilised in this study to encourage discussion, without the potentially inhibiting influence of nursing hierarchy. None of the participants in the focus groups were used to working together on a regular basis. Their commonality was their

professional registration as nurses and their clinical banding and roles within the case study organisation. The interaction and evolvement of ideas was essential within this study and would have been harder to achieve in one-to-one interviews with clinical nurses. There may have been an increased risk that the interviewer could have led or influenced the individual participants with their own agenda. Within this study the use of focus groups aimed to seek a diversity of views on an unfamiliar topic, it did not aim to represent individual views. The uniqueness of focus groups was identified as an advantage, enabling observation of interaction and a collective group representation, however they are not without potential disadvantages (Morgan, 1997).

3.4.2 Disadvantages of Focus Groups

Parahoo (2014) critiqued focus groups identifying the potential influence of group pressure on individuals. Groups may magnify extreme feelings creating a potential for polarisation and conformity of views (Sim, 1998). An individual may be reluctant to share personal views or sensitive issues within a group discussion where anonymity can be compromised (Krueger and Casey, 2009). Whereas Kamberelis and Dimitriadis (2011) described how participants in focus groups may feel more comfortable discussing unfamiliar or sensitive topics in a group setting, as this can diminish '*personal vulnerability and risk*' (p.557). Within focus groups findings cannot be taken as confirmation of an individual participant's views and there are challenges in measuring strength of view in groups, a researcher should report rather on presence or absence of views between groups (Sim, 1998).

Within this case study the benefits of group discussion outweighed the use of one-to-one interviews, as the concept of TM was not a familiar term within the organisation, nor evident within wider nursing literature. The risks of breaches in confidentiality were

weighed up with the potential benefits of data that could be generated from within a group discussion. The topic was not necessarily personally sensitive and participation was voluntary. The selection of an experienced moderator to facilitate participation of all group members and an observer (one observer per group) to monitor group dynamics, interactions and behaviour was utilised. The observer provided more detailed feedback on participation, non-verbal communication and group interaction. The three observers utilised had experience in group facilitation and research and utilised the same research protocol, information and consent forms.

The role of moderator and use of a moderator guide ensured consistency in prompts utilised within all the focus groups (see Appendix 1) and reduced the risk of a group leading the discussion in a way that detracted from exploring the research questions. Questions were developed from the literature, which had identified a cyclical process in TM (Tansley et al., 2007), they aimed to prompt discussion on how 'talent' was defined in nursing, how nurses could be attracted, recruited, developed and retained in the organisation, and focus group experiences and expectations of Talent Management.

3.5 Role of The Moderator

Within focus group research the role of the moderator is influential, their skills and attributes influence the quality of data collected (Kitzinger, 2006). The moderator must establish rapport and trust rapidly within a group setting for the defined period of focus group discussion. As investigator I was also an insider-researcher within the organisation. Whilst not within the management hierarchy of the clinical directorates within which participants worked, there was potential that my role might influence participation, specifically of more junior staff. Recognising the impact of my own role as researcher within the qualitative research process is an essential

component of personal reflexivity (Denzin and Lincoln, 2003). There were no financial resources to employ an independent group moderator for the purpose of this study, practicalities that resulted in an experienced clinical educator being approached. This educator did not work within the nursing operational hierarchy and had significant experience of supporting and facilitating groups. The same moderator was utilised for seven out of eight focus groups. One group (Gp8), was undertaken by the study's Lead Investigator, as the primary moderator was known to the group of participants and did not want to influence or bias discussion. Krueger and Casey (2009) described a risk where the group moderator becomes part of the group, acting as an 'insider'. For this study the contact for the moderator with the group was limited, the use of the observer enabled additional feedback to monitor for any bias.

3.6 One-to-One Interviews

To gain insight into the perspectives of TM from the highest management level within the case study organisation, a purposive selection of three Board level leaders was identified; the CEO, Director of Human Resources and Strategy (DHR) and Director of Nursing. These roles were identified for inclusion as lead executives setting the direction of organisational leadership and strategy within the case study. A semi-structured interview guide was utilised (see Appendix 4).

3.6.1 One-to-One Interviews - Benefits and Limitations

As an insider-researcher I had the advantage of an established relationship with the participants and limited time was required to develop a rapport. All three participants spoke freely and with interest about Talent Management. The interviews gave rich insight in to the Executives' perspectives of TM within the organisation and nursing as talent. The limitations of utilising this method within the case study approach are also recognised. The participants were

aware they may be identifiable within the case study and therefore perhaps more likely to communicate professional opinion, rather than any diverse or personal views. In addition, being interviewed by myself as a nurse and someone more junior within the organisation may have influenced their responses and what they chose to share**.** The interview guide was utilised to ensure consistency in questions asked within one-to-one interviews and open questions also allowed for individual perspectives to be explored.

3.7 Ethical Considerations

This study did not require NHS research ethics committee approval as it did not involve patients. Local approval was sought from the organisation's Research and Development Department and University of Nottingham Faculty Research and Ethics Committee (see Appendix 2). The interviews commenced following approval of the protocol, consent forms and participant information sheets (see Appendix 3). It was not anticipated that the study would raise significant ethical concerns. However, as within any interview or group setting there was a potential that individuals may become upset or be effected by group dynamics or peer pressures (Morgan and Krueger, 1993). All focus group participants were offered the option of a one-to-one follow up meeting with the group moderator. If they did not wish to contribute further to the study but required one-to-one support, they were to be guided and directed to the organisation's clinical supervision procedures for support. This did not arise throughout the study. The Executives were also offered opportunity for further follow up and feedback on the themes identified following analysis of their one-to-one interview. The study was conducted in accordance with the Research Governance Framework for Health and Social Care (DH, 2005).

3.7.1 Consent

All focus group and one-to-one interview participants were provided with a study information sheet in advance. They were given time to decide whether they wished to participate or not. In the case of the focus groups, the group moderator answered questions relating to the study. As research interviewer for the one-to-one interviews, I undertook this role. All participants were offered the option of changing their mind prior to the commencement of the group or one-to-one interview, without any effect on themselves if they chose not to continue with participation. The interviewer/moderator and the participant signed and dated the consent form before proceeding to participate in the study. The participant received a copy of the consent form and the original was retained in the study records.

During the wider consultation phase, all participants were briefed on the study and the aims of consultation at the beginning of each workshop. As the workshops provided consultation on themes identified following analysis of the primary data, individual information sheets and consent forms were not utilised. Participants were informed that their feedback and comments were an opportunity to contribute to the study, but that this was optional. They could choose to opt out, or to participate but were not obliged to contribute verbally. All attendees agreed to participate (N=229). No personally identifiable data was collected and participants were SNs from across the case study organisation. They were part of a wider number of 2,500 SNs attending time out development days over a ten-month period, this facilitated anonymity within reported findings.

3.7.2 Confidentiality and Anonymity

All interviews were audio recorded for purposes of data analysis. Each participant was assigned a study identity number, used within

the electronic database. Digital audio recordings, transcripts and notes were treated as confidential, kept securely locked within the investigator's office. Computer data was held securely, password protected on a secure dedicated web server. Access to all data was restricted to research personnel approved by the Principal Investigator.

Prior to the start of each focus group, the moderator led introductions, clarified the purpose of the focus group, agreed confidentiality and boundaries, gave an explanation of audio recording equipment and obtained signed consent forms. In research design initial consideration was given to utilise visual recording of the focus group interviews to enable more detailed analysis of interactions and individual contribution. Visual recording would have been a new introduction for these staff groups in the organisation and could potentially be seen as more intrusive than audio recording. From the theoretical perspective of nursing as a gendered occupation within a hierarchical organisation, this may have caused apprehension or suspicion for participants and inhibited or influenced discussion. Experience during data collection, demonstrated evidence of group apprehension regarding even audio recording and illustrated that this was the right decision for the study.

An initial decision was made to maintain anonymity of the case study in order to encourage open discussion and provide a rich and full exploration of the issues. The organisation would be identified as a large NHS teaching hospital on two geographical sites. During the consent process this was discussed further with Executive Directors involved in the one-to-one interviews. Due to the limited nature of comparable organisations within the UK and the executive roles within the organisation, there was additional consideration of a potential lack of anonymity as leaders of the organisation if the case

study was identified. All three executives agreed to proceed with full participation in the study

3.8 Sampling and Access

3.8.1 One-to-One Sample

As described in section 3.6 the sample of three Board members was purposive. The Executives had portfolios responsible for setting the organisational leadership strategy, workforce strategy and nursing within the case study. They were approached individually via email with an invitation from myself as research investigator. All consented to be interviewed. Interviews were arranged according to their diary availability. All interviews were undertaken within the participant's own office. Consent was obtained as previously described (section 3.7.1).

3.8.2 Focus Group Sample

Sampling strategies within a focus group approach are not standardised (Morgan and Krueger, 1993). The approach to sampling was guided by the research questions. As within other qualitative interview strategies, the researcher is aiming for saturation of data, where there is evidence of no new themes emerging from interviews (Guest et al.,2006). A purposive method aimed to include registered nurses (bands 5-7) was employed within the main clinical nursing roles in the organisation. The decision to use homogenous groups aimed to facilitate open and honest discussion and to identify if there were different perspectives from different clinical roles. As an exploratory study no other limiting criteria were identified.

Parahoo (2014) identifies that within qualitative studies the sample size is not the primary focus, the researcher aims to gain insight into the range of experiences to understand a rich picture of the phenomenon under study. Morgan (1997) suggests 10 to 12

participants for focus groups, whereas Krueger and Casey (2009) recommend 5-8 participants as an ideal size for a focus group. The number of groups was to be reviewed aiming for a point of data saturation, where there were no new themes being identified through the emerging data.

3.8.3 Sample Recruitment

An invitation to focus group participants was advertised via the organisations internal nursing email lists, nursing forums and through existing training days run by the Nursing Development Department. The study did not have funding to enable a financial incentive to encourage participation. With the realities of the everyday world of work in the organisation, recruiting to sample to form focus groups of the right size proved a challenge. The study aimed to recruit between 6-8 participants to each group. For senior clinical roles there was greater flexibility in diary management, therefore these band 6 and 7 participants were more readily recruited. The majority of clinically based SNs, (the largest proportion of the nursing workforce), worked twelve-hour shifts. It was difficult to ensure they had received information about the study, or secure release from clinical rotas. This relied primarily on the line manager as a 'gatekeeper' forwarding on communication to their clinical teams. Within an organisational context of nursing vacancies, pressure on the ward rota was intense and clinical pressures required avoidance of winter months (November–February) for all clinical staff. Within this context an active decision was made to review sample recruitment strategy.

3.8.4 Review of Focus Group Sample Recruitment Strategy

Robson (2011) identified the challenges and logistics of access to people within real world settings and the benefits of case study enabling a flexible use of approach with data collection. Sample recruitment was actively promoted through existing in-house

training days. Registered nurses were out of clinical rotas and were introduced to the study information at the beginning of their training day. One hour at the end of the identified training session was ring-fenced for the focus group. Those interested in participating were invited to stay at the end of the session.

The use of self-selecting volunteers has limitations; participants may reflect individuals who are more motivated, or conforming (Parahoo, 2014). These factors can potentially influence the wider validity of the data. To address this, the moderator was not directly involved in the training days and was independent from any direct influence over the participants. When briefly introducing the study at the start of the day, the moderator emphasised that there was no obligation and participation was voluntary. The individuals did not have to volunteer or leave in front of the moderator. The introductory explanation about TM and the aims of the study generated interest and resulted in a positive response to participate. For some groups, particularly the two involving NQ nurses, the moderator leading the group did not wish to turn away interested participants. This then resulted in a larger group of 11 on two occasions (see Table 5). Data collection and consultation ran from September 2012 to end of July 2013. The duration of the focus groups ranged from 1 hour, to the shortest being 45 minutes.

Table 5: Focus Group Sample

Focus Group	Job Role	Number of Participants
Group 1	Band 5 NQ SN	11
Group 2	Band 6 DS	5
Group 3	Band 7 WS	9
Group 4	Band 5/6 SN/DS (student mentors)	6
Group 5	Band 7 NS	4

Focus Group	Job Role	Number of Participants
Group 6	Band 5 NQ SN	11
Group 7	Band 7 PDM	4
Group 8	Band 5 SN (< 1year qualified)	7
Total Number Participants		**57**

When using focus groups, location and creating the right environment for discussions is an important consideration (Krueger and Casey, 2009). All the groups were held away from clinical areas in training rooms to reduce the risk of interruptions and enable focus on the topic under discussion. Due to the context and pressures of the clinical work environment, a maximum duration of one hour was confirmed with participants prior to them committing. In all groups participants were either away from the ward and therefore needed to return promptly to cover colleagues, or the focus group was held at the end of a study day. The moderator needed to motivate and engage participants, but not extend discussion time.

3.8.5 Sample Demographics

The focus group participants represented nurses with a range of post qualification experience and time employed in the case study organisation (see Figures 3 and 4). They represented a range of specialities across the organisation including; acute medicine, emergency care, oncology, haematology, surgical specialities and family health services. Distribution across the geographical sites indicated that there were more participants from Campus B 33 (58%) than from Campus A 24 (42%). Participation had been open to nurses across both sites and there was no particular rationale for this variation identified. All but two participants were female, Groups 6 (NQ) and 8 (Band 5 SN) had one male participant. This reflected the predominantly female workforce within the case study.

The majority of the sample (*f*=39) was under 40 years old and were employed as Staff Nurses. 70% of SN participants in Groups 1,6 (NQ) and Group 8 (Band 5 SN) were under 25 years old. The most difficult group to reach for the focus group sample was the more experienced SN employed for over a year within the organisation. The average time of employment in the organisation for the Band 7 senior clinical nurses was 20.7 years (range 6-39 years). The NSs were all over 41years old, had been qualified for over 10 years and employed within the organisation between 10-20 years (*f*=2) and 20-30 years (*f*=2). This was the group with longest service within the organisation, however one WS had been employed for 30-40 years by the organisation. Within the WS group there were also three participants who were under 40 years old, therefore a younger age demographic than the NSs or PDMs. They had been qualified between 6 and 36 years, but three had been employed more recently by the organisation, within the previous 5 years. Demographic information did not include details of other roles that an individual had been employed in during their length of service within the organisation.

When considering career development and academic attainment, the focus group sample had a range of nursing registration qualifications. This was from certificate level 7% (*f*=4), to Masters qualifications 11% (*f*=6), diploma qualification 42% (*f*=24) and 40% (*f*=23) had a degree. The nurses who were certificate level were in the 41-50 age range and had all been qualified between 20-30 years. Three were employed as WSs and one as a Staff Nurse. Two SNs were pre-registration Masters graduates and four other participants had a Masters qualification, these were all Band 7 nurses, (WSs, NSs, PDMs) with between 16-39 years' experience each. This illustrated the variance in academic qualifications across roles and pay bands.

Figure 3: Years Qualified As Registered Nurse

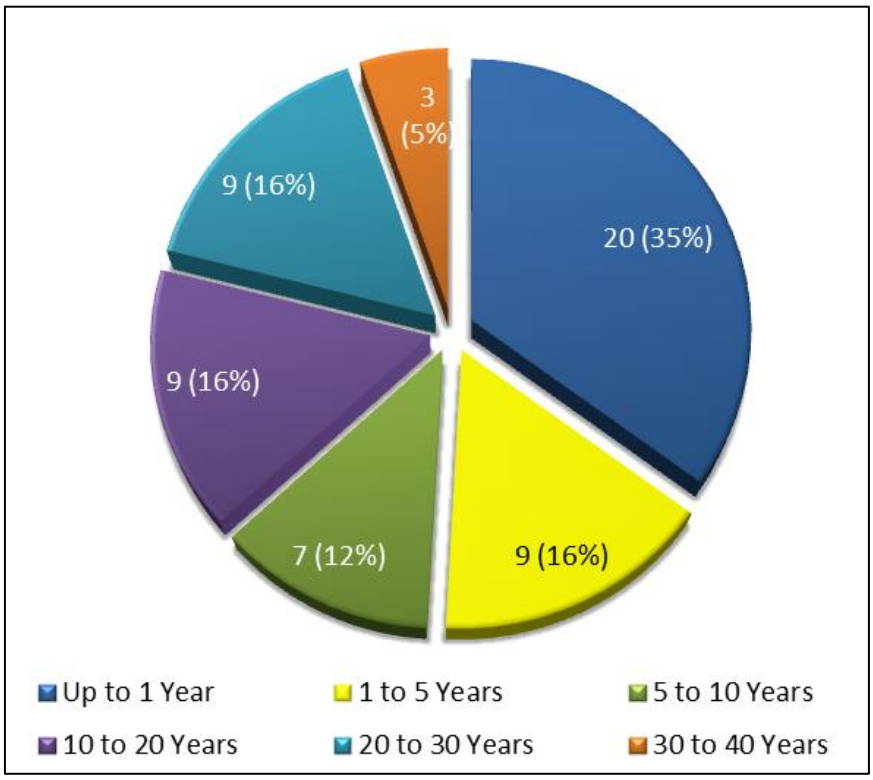
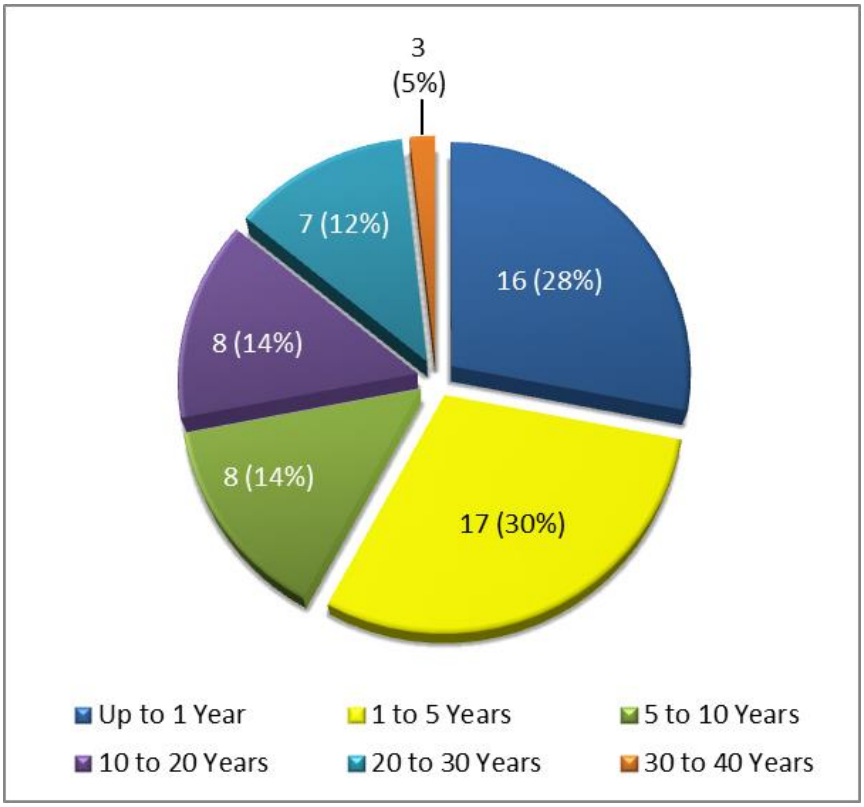


Figure 4: Time Employed By Case Study Organisation



3.8.6 Sample Limitations

Due to the size and complexity of the organisation, there were limited means of communication with the total registered nursing workforce and particular challenges recruiting Staff Nurses. Sandelowski (1986) described a risk of 'elite bias' in sampling, where participants self-nominate rather than being randomly selected. Where only the most articulate, available, or high status members of a group volunteer and are included; this could exclude others and influence the findings of the focus groups. In order to counteract this challenge, every effort was made to ensure wider awareness of the study and offer opportunity and accessibility to participate. The wider consultation phase was integrated to the study design. This phase aimed to engage and involve SN representation from across the organisation; testing out themes, capturing alternative experiences and seeking deviant cases within the case study, to further enhance validity and trustworthiness of the findings (Creswell, 2009).

On critical reflection, the wider consultation identified that BME demographic data would have provided an additional dimension of sample information within focus groups. The 229 participants at the wider consultation days reflected a greater diversity of SNs from across the organisation, including male and BME participants. There were observations raised by two participants during the workshops that BME groups were under represented in senior nursing roles within the organisation. A lack of BME representation in senior NHS roles is also reflected within national research (Kline, 2014).

3.9 Focus Group – Data Collection Process

All focus groups commenced with an exercise, participants were asked on individual 'sticky notes' to list three words they would utilise to describe nursing talent. This gave individuals opportunity to document their personal views, prior to sharing and potentially

being influenced by other group participants. The 'sticky notes' were then collected and collated by the moderator on to a flip chart. Participants then shared their ideas of talent and TM with the colleague adjacent to them. Definitions of TM from the literature were then shared by the moderator to further stimulate discussion. The moderator utilised the group exercise as an icebreaker to help generate discussion and subsequently followed the moderator guide (Appendix 1). Focus group participants were asked to consider what they saw as the challenges in relation to recruiting, developing and retaining talented nurses. In addition they were encouraged to share their own experiences, career aspirations and views on TM and the tools for development utilised in the organisation.

3.9.1 Focus Group Observation

The specific observation of group interaction is requisite in focus group research and Morgan (1997) identified this as one of the advantages of focus groups as a qualitative tool. Observing the group process includes the use of non-verbal communication, body language, as well as verbal interaction and enables insight into the feelings and experiences of participants (Kitzinger, 2006; Morgan, 1997). Group observation was integral to the total analysis. Observation of the eight groups indicated active participation, engagement and discussion. It was interesting to note that the groups developed their views and ideas about TM as they progressed in their interactions. Those who spoke less were observed to consistently demonstrate active listening and non-verbal support for views expressed during discussions. This included, nodding, eye contact and supportive verbal murmurs of agreement.

Hansen (2006) identified the complementary benefits of utilising ethnographic and narrative methods in generating rich interpretation. Whilst ethnographic observation in clinical settings

was not utilised within the study, using focus groups allowed for observation of participants within an organisational context. In two groups participants had met previously, (DS Gp.2 and WS Gp.3), the group dynamics and discussion appeared more relaxed, with evidence of fluidity and equal participation in discussion. The moderator was required only intermittently to bring the groups back to focus on the topic. The same flow of discussion applied to the other groups of more experienced nurses, even where participants had not met previously. The NQ groups needed more encouragement and prompts from the moderator, they were larger (n=11) and participants had not previously met as a group. The moderator and observer both identified a greater participant awareness of the audio recorder and more apprehension about being recorded than had been anticipated. Dialogue was in shorter sentences, there were silences with more encouragement required from the moderator. Towards the second half of the discussion, sections of dialogue became longer and were increasingly led by the group.

3.10 Data Analysis

The role of the researcher in qualitative analysis is not passive and influences the analysis and themes chosen (Denzin and Lincoln, 2011). Braun and Clarke (2006) identified that whilst thematic analysis was frequently referred to in qualitative research, it was poorly acknowledged. The positive use of thematic coding analysis in exploratory studies has been identified (Robson, 2011). Braun and Clarke (2006) argued a need to make the theoretical position of thematic analysis clear and propose six steps; familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing a report. Understanding of the analysis process, how a theme is decided and

the perspectives of the researcher is integral to transparency within qualitative inquiry (Denzin and Lincoln, 2011).

This study does not seek to generate theory, but to explore if there are any key themes or common patterns in the data. The process for thematic analysis based on the approach of Braun and Clarke (2006) provided a suitable framework for both focus group and one-to-one interviews (see Table 6). There is particularly limited research on an agreed methodology for focus group research analysis as an interpretive approach (Polit and Hungler, 1995; Fontana and Frey, 2003). A significant amount of complex data can be generated (Kidd and Parshall, 2000). As lead researcher I undertook all data analysis, however the study involved a team undertaking the roles of moderator, observers and facilitators for wider consultation. The six-stage model illustrated by Braun and Clarke (2006) provided a transparent illustration of the process of data analysis. An inductive approach was taken as themes were strongly linked to the data. Due to the lack of empirical evidence there was no pre-existing framework. From the thematic analysis 'key concepts' as outlined by Krueger and Casey (2009,p.125) provided an analytical framework. This enabled greater understanding of how participants described factors that were of central importance for TM in nursing.

3.10.1 Data analysis one-to-one interview

The data analysis process for the one-to-one interviews followed the same six stage model as the focus group data analysis; this included transcription verbatim, immersion in data, coding, clustering and building up themes (coding as outlined within section 3.10.3). Initial analysis was sent back to the individual participants for their review and comments. All confirmed positively that the analysis reflected their recollection of the interview. The transcripts were also reviewed independently by the focus group moderator

and themes identified. This enabled further critical challenge between the moderator and myself as researcher on the themes identified through the one-to-one data analysis. The themes identified from the one-to-one analysis were then compared with those from the focus group data analysis.

Table 6: Data Analysis Process

(based on Braun and Clarke, 2006)

Data Analysis Process	**Focus Group Data Analysis** (R = researcher, M = moderator)
Stage 1 Familiarisation with data	Immediately post focus group - Debrief moderator and observer, notes made
	Within 24 hours - Debrief moderator (M) and Researcher (R)
	R- Listen to recording
	R- Listen and Make notes
	R- Transcribe verbatim
Stage 2 Generating Initial Codes	R- Read transcripts, immersion in data
	R- Analysis – initial descriptive codes using Nvivo
Stage 3 Searching for themes	R- Immersion in data searching for patterns, relationship core issues realised any repeats as emerging theme.
	R- Initial themes using Nvivo
	Concurrently - Moderator reads and themes first 3 transcripts as sample
	Comparison between Moderator themes and Researcher themes
	R- Mind map key themes for each focus group
	R- Feedback key themes to participants in separate focus groups
Stage 4 Reviewing themes	R- Re read transcripts
	R- Second level coding
	R- cross group emerging themes identified (Jan and again built on April 13)

Data Analysis Process	**Focus Group Data Analysis** (R = researcher, M = moderator)
	M- R meet to discuss focus group feedback and agree themes identified for wider consultation.
	Wider consultation phase – World Café approach. Themes presented with example quotations to illustrate. Participants discuss in small groups and indicate if agreed, disagreed or had any additional views or perspectives to include. Facilitators capture both group and individual feedback on flip charts.
	R, M and facilitators – debrief at end of each day, capture key findings, feedback.
	R- Review of all data from each individual time out day, identified areas of agreement and differences in perspectives.
Stage 5 Defining and naming themes	R- final themes reduced post consultation. R-M themes agreed
Stage 6 Producing the report	R

3.10.2 Focus Group Data Analysis Process

Following each focus group I started with an immediate debriefing with the moderator and review of the observer notes. This gave a clearer overview of group process for each individual group and consideration of group dynamics. This was followed by initial immersion in the data, listening carefully to each separate focus group audio recording. Questions I asked myself included; what strikes me as interesting about this group? What strikes me as interesting about the data? What are the key messages emerging? Interviews were then transcribed verbatim and transcripts read looking for initial descriptive codes emerging from each group. Then analysis progressed to the use of Nvivo, this was selected as a means to code and store large amounts of data more effectively.

3.10.3 Coding

Within qualitative enquiry coding is an interpretative approach to data analysis. Coding enables organisation and grouping of similar data into categories. The researcher uses '*classification reasoning plus your tacit and intuitive senses to streamline which data 'look alike' and 'feel a like*' (Saldaña, 2013,p.4). Within the data analysis it was evident that when undertaking initial coding, particularly within focus group data analysis, there was a risk of breaking down the focus group discussion in to component parts and losing the essential essence of the discussion and the richness of the description.

I coded each individual transcript for as many potential themes as possible using NVivo and coded inclusively keeping surrounding data where relevant to retain the context of data. Codes were utilised to reflect what was being said in the first instance, rather than interpreting in to a broad theme. Eighty-one codes were generated from the initial NVivo process. I then started to cluster them and analysed how the various clusters of codes interlinked and combined under wider headings, identifying patterns in the data and relationships. I theorised the significance of the patterns and broader meanings. For example, organisational culture became a theme. I felt immersed in data with a good feel for each of the groups.

For the focus groups it was important to remember not to lose sight of the group rather than the individuals within the analysis process. As discussion flowed, in some instances there was a need to reference a whole section of transcript as it could not be broken down. The richness of data provided through focus group interaction is able to answer some research questions without the necessity for statistical analysis, as risks losing the meaning or emphasis of a group discussion (Morgan, 1997; Pope and Mays, 2006). This was

particularly relevant and important where focus groups engaged in a free flowing discussion on a topic. Individual participant analysis is not the primary intention during focus group analysis and identification of individuals speaking within focus groups can be difficult within larger groups. This is acknowledged as one of the challenges when analysing focus group data (Parahoo, 2014). The aim of the analysis was to represent the diversity of views raised within groups, rather than the number of participants who supported a particular perspective, therefore individual representation was not as critical. For the two larger groups of NQ participants during transcribing, even with observer and moderator support, it was not possible to define exactly who was speaking for some verbal interjections on the digital audio recording. This was due to the larger numbers of participants and complex, fast paced verbal interactions. The use of an observer enabled contemporaneous notes of non-verbal communication and group dynamics. The observer noted all group members participated, although some members did so more than others. They also noted non-verbal agreement from those who did not speak so actively, when others were making points. There was no observed evidence of non-participation of individuals or conflict within a particular group setting.

Stage 3 of Braun and Clarke's model (2006) involved an additional process of challenge. The transcripts were reviewed independently by the moderator and themes identified. This was followed by critical challenge between the moderator and myself as researcher and agreement of themes.

A summary of themes from each analysis representing the individual focus group discussion were sent back to each participant, providing opportunity for individuals to confirm if they accurately represented their recollection of the discussion and offering

opportunity for further confidential one-to-one follow up. This was sent from a project administrator to reduce risk of any unintentional influence of the researcher. No participant requested further follow up or support.

The focus group themes were then compared across the groups to cross-reference an initial overview. Following six focus groups data analysis common themes emerged. Morgan (1996) and Krueger and Casey (2009) suggest further groups are needed until the point of data saturation is achieved, when little or no new information is emerging. A further two groups reinforced themes identified. The final group (Group 8) were SN participants who had been harder to access for purposes of the research. Within this group one participant spoke specifically about personal feelings of emotional stress delivering care in high-pressure clinical environments, which previous groups had not explored. Due to the complexity of accessing the SN sample for further focus groups and as the planned wider consultation was engaging larger numbers of SNs, further focus groups were not established. This theme of emotional stress was included for discussion within the wider consultation.

3.11 Wider Consultation Phase

Within larger organisations with traditional leadership hierarchies, opportunity for voice for those lower down within the hierarchy may be limited (Aiken and Hage, 1996; Buchanan and Huczynski, 1997). Consultation on focus group findings across a wider sample of SNs from the case study organisation was included within the study design. This allowed further opportunity for SN feedback, consultation and triangulation of findings. To develop a new nursing strategy for the organisation, 'Time Out Days' were running over 2012/13. Every WS was required to release all of their SNs to attend one of these days. During the research design stage, the DN gave support to exploring the themes from the focus group data

through the 'Time Out Days'. This enabled involvement of a more diverse sample of participants from across the organisation. For three days, consultation was undertaken involving a total of 229 participants (see Table 7). The process enabled unprecedented involvement of SNs from within one organisation. Participants shared their views on TM, the themes identified by focus groups and considered the enablers and challenges to attracting, recruiting and developing talented nurses through an interactive workshop. The consultation provided a wealth of additional data with support for focus group findings and built a richer picture of SNs' perspectives.

Table 7: Participants in Wider Consultation

Consultation events	**Number of participants**
Day 1	56
Day 2	86
Day 3	87
Total number of participants	**229**

3.11.1 World Café Dialogue

The process of consultation was based on a World Café approach (Brown and Isaacs, 2005), the seven principles for World Café dialogue provided a clear structure for facilitators and a consistent approach to consultation workshops (see Table 8). Brown and Isaacs (2005) argue that connecting through conversation and seeking diversity of views is essential to discovering collective wisdom and revealing possibilities for innovation. This approach was successfully utilised to create discussion and engaged participants in sharing their views on the themes identified through the data collection.

Table 8: Seven Core Design Principles For World Café Dialogue
(Brown and Isaacs, 2005)

Principle	Process
1	Set context
2	Create hospitable space
3	Explore questions that matter
4	Encourage everyone's contribution
5	Cross pollinate and connect diverse perspectives
6	Listen together for patterns and insights
7	Harvest and share collective discoveries

3.11.2 World Café Process

The workshops were held away from the organisation, within a hotel setting. This aimed to create a more relaxed atmosphere. The focus group moderator or myself introduced each of the 12 workshop sessions using a standardised guide to ensure a consistent approach. The session started with the exercise as undertaken by focus group participants. Individuals identified on 'sticky notes', their definitions of nursing talent. This further supported the findings of the focus groups. Participants found it challenging to define what talent was in nursing and indicated they had not previously considered this as a concept. Following the exercise, each group divided in to smaller groups of 4-5 participants, aimed at encouraging discussion and more opportunities for individuals to speak out.

Six flip charts with a theme from the focus group data listed at the top of each, were posted around the walls of the room. Quotes from data within each theme were listed below the title. A facilitator was available at each flip chart to enable equal opportunities for

participation and capture views of participants. The smaller groups had opportunity to discuss each flip chart. Participants recorded on the flip chart if they 'agreed', 'disagreed', 'did not know', or if they wanted to add something they felt was missing, or make any other comments. The group moved on to the next theme and progressed to review all flip charts ending up back with their original theme. They considered comments listed and identified any specific feedback they wanted to raise from the discussion. Facilitators then captured this on the flip charts. The exercise provided excellent opportunity for an inclusive and connected conversation. It built on the findings and identified support for research themes. The six theme headings were reduced to three overarching themes post consultation due to feedback on repetition and overlap (see Appendix 5). These three themes were; Nursing as Talent, Ward Leadership and Culture and Career Development.

3.11.3 Limitations and Benefits of Consultation

Utilising the World Café process enabled a structured and consistent approach to SN participation in a collective conversation on research themes. There remains the risk that some individuals may have felt inhibited to speak about their own individual views, or chose not to participate as within any group setting. Experienced facilitators were available at each workshop and for one-to-one follow up if required. Two individuals approached facilitators after or during the workshop, to share particular views, reinforcing their support for the importance of involving SN views and to ask a more specific query, or add a different perspective. With the permission of the participants these were recorded by the facilitator at the end of the workshop on the group flip charts. The consultation provided rich discussion and revealed a consistent support for the focus group findings.

3.12 Trustworthiness

Within qualitative research applying the same tests for validity and reliability as used with more positivist experimental research design is not appropriate (Denzin and Lincoln, 2011). Lincoln and Guba (1985) identify four evaluation criteria for establishing the trustworthiness of a qualitative study; credibility, transferability, dependability and confirmability. This includes the extent with which the findings have applicability within other contexts, are consistent and are reported with openness and transparency

The use of a case study protocol and standardised interview guides for moderators and observers aimed to ensure a systematic and consistent approach. As identified by Lincoln and Guba (1985) using a clear research design such as presented within this chapter, provides an open, transparent process, enables an audit trail of the research process and enhances the credibility of this qualitative study.

The primary sources of qualitative data were multiple focus groups involving clinical nurses and one-to-one interviews with three Executives. An embedded case study design enabled cross comparison of sources and active seeking of deviant cases, examining data for contradictory patterns or explanations (Creswell, 2009). A systematic approach was undertaken to data analysis and the focus group moderator was independently involved in developing and confirming themes. In addition peer debriefing between the moderator and observer, with notes recorded following each focus group was undertaken. For one-to-one interviews researcher reflection and debriefing was recorded immediately post interviews. Member checking (Stake, 2005) encouraged review and individual feedback by participants on data and themes identified from within focus group and one-to-one interviews. As previously described, all participants were offered opportunity to feedback.

Additional case study data also included documentary sources and a wider consultation phase within the research design.

Whilst the study was exploratory and not aiming to generalise findings, the emerging themes identified were reflected in contemporary national literature and data (The Willis Commission Report, 2012; NHS Leadership Academy, 2014a; HEE, 2015). This gave confidence that there was transferability and relevance for other contexts in nursing within the UK.

The wider SN consultation on focus group themes was integral to the research design to further increase construct validity, establishing rigour and trustworthiness. Testing out the themes with 229 SNs achieved a breadth of feedback using an inclusive and participatory approach. Triangulation of the different sources of data and use of reflexivity of researcher further enhanced validity and trustworthiness of the study.

3.12.1 Triangulation of data

Within qualitative case study research, due to the acknowledgement of subjectivity and multiple realities, Stake (2005, p.112) describes how triangulation of data is essential 'to increase credence in the interpretation…'. From a more positivist paradigm Yin (2009) also described triangulation of a range of data sources as a strength within case study research. Triangulation has been achieved in the study, through using different data sources (see Figure 2 page 62) and in seeking out a breadth of perspectives and rival explanations. In addition through investigator triangulation using observers, a moderator and member checking (Stake, 2005). The themes from the one-to-one interviews reflected those from the focus groups and these were also supported through the wider consultation and documentary data sources. As outlined, the following three themes were identified; Nursing as Talent, Ward Leadership and Culture and Career Development.

3.13 Reflexivity

Within qualitative research specific consideration is required of the researcher as key instrument within the process, collecting and interpreting data (Denzin and Lincoln, 2003; Creswell, 2009). Therefore researcher reflexivity is crucial, with awareness of personal values and socioeconomic and gender influences. This transparency enables the reader to situate the study within a more holistic context as the researcher presents their analysis building patterns and themes from the data.

3.13.1 Reflexivity within case study research

As a researcher I recognised the influence of the insider knowledge I had of the case study organisation. I had awareness of the organisational context, existing structures and established professional relationships with many employees at various hierarchical levels. This enabled me to more readily review and develop alternative sampling strategies when faced with challenges with sample recruitment. I actively chose a participatory approach, to openly share findings from the data analysis with participants and was able to facilitate the wider consultation design due to my insider role and knowledge. This was successful in engaging much larger numbers of participants in clarifying the accuracy of representation and seeking diverse views.

As the data collection occurred over an 11 month time period, during a period of changing NHS context and national publications, I reflected on the publication of The Willis Commission Report (2012) a national independent review of nurse education and the MSFT Public Inquiry (2013). Concurrently to this study, both these documents identified concerns relating to the image of nursing, recruitment, preparation of nurses for leadership positions and a lack of clarity regarding post registration nurse education and training. I felt motivated in that they reflected some of the

emerging findings of this study and gave indication that these were not isolated issues for the case study organisation.

In addition to research diary notes from data collection and data analysis activities, I captured my own learning using a personal reflective diary. I reflected on the challenges of undertaking a dual role of researcher and a leader in the case study organisation and of wanting to take action on the issues I was hearing. I needed to ensure I did not make assumptions in haste before robust analysis of the data was undertaken. In addition, I noted that in spite of having positive working relationships with all three executive participants, I felt nervous when interviewing them as a researcher. This enabled me to reflect on the potential impact of positional power and confirmed the decision to engage an alternative moderator for the focus groups.

3.14 Conclusion

In summary the ontological and epistemological approach to the study have been outlined. A pragmatic approach led to a case study research design, using qualitative methods supported by documentary sources of data. A case study enabled analysis of contextual influences within the case study organisation; the inclusion of multiple sources of data, a participatory consultation phase and triangulation of findings. The topic of TM was new to nurse participants, I was inspired as a researcher with the enthusiasm and interest of individuals, both nurse participants and Executives, that evolved throughout the data collection process and emergent conversations. Actively pursuing an inclusive and engaging research design enabled insight in to the experiences of participants. I was particularly motivated through the voices of those staff in more junior bands and BME participants, who fed back so positively about having had opportunity to participate.

The primary purpose of the study was to gain new insight and knowledge in to how TM was emerging as a concept within nursing and to explore clinical nurses lived experiences of Talent Management. Following the study design and data analysis process, characteristics of nursing talent have been proposed. Challenges and possibilities have been identified for TM in nursing within the case study organisation and three main themes emerged; Nursing as Talent, Ward Leadership and Culture and Career Development. These findings will now be presented.

Chapter 4: Findings of the Study

4.1 Introduction

This chapter explores the findings of the case study under the three themes of Nursing as Talent, Ward Leadership and Culture and Career Development. Each section contains relevant data from the case study including focus group, one-to-one interview and the wider consultation findings. The quotations are taken directly from transcripts of focus groups, one-to-one interviews and data collected at the three wider consultation workshops. They are utilised to illustrate each theme and to enhance trustworthiness within qualitative data (Lincoln and Guba, 1985) (see Table 9).

Table 9: Presentation of Quotations

Focus Group quotations	Focus group number, transcript page number and participant number; Group 2, page 2 participant 1 (Gp2p2p1) Within the two larger focus groups where a quotation could not be attributed to an individual participant during complex interaction, an x is utilised to distinguish within that section of discussion.
One-to-one interviews	Interview number 1-3, transcript page number and participant number Interviewee 2, page 1 will be referenced as (I2p1)
Wider Consultation	Quoted verbatim from flip chart recording and referenced to the relevant day time out day 1 (TO1), 2 (TO2) and 3 (TO3).
Where quotations exceed one sentence in length they are presented indented from the main body. Shorter quotations form part of the body of discussion to enable improved flow of narrative.	

Abbreviations utilised:

- Deputy Sister (DS)
- Executive Directors (Executive)
- Nurse Specialist (NS)
- Practice Development Matron (PDM)
- Staff Nurse (SN)
- Ward Sister (WS)

4.2 Nursing as Talent

4.2.1 Introduction

In this section the first theme from within the data Nursing as Talent is presented. The literature review identified defining talent as the starting point for organisations within a TM process. The case study analysis had failed to identify any existing organisational definitions or strategy for TM, therefore this provided a starting point within the focus groups. The participants were asked how they would describe nursing talent using individual words listed on 'sticky notes'. This initial focus group exercise acted as a stimulus for subsequent discussion in the groups. It successfully enabled insight into individual perspectives prior to commencing group discussions. Participants used the words to develop their thoughts on the concept of nursing as talent, building their ideas and descriptions through group discussion. The categories and sub-categories from within the data are illustrated within Table 10.

Table 10: Theme Nursing as Talent, category and sub-category expressed in the data

THEME	CATEGORY	SUB-CATEGORY
Nursing as Talent	Defining Nursing Talent	• Multiplicity of talents • Contextual nature of talent • Compassion and care as talent
	Image of Nursing	• Attracting and retaining nurses
	Recognising and Rewarding Talent	• Different ways of recognising talent

4.2.2 Defining Talent in Nursing

A consistent finding across all focus groups identified that participants were not used to describing what they did as 'talent';

this proved more challenging than anticipated. Talent was not a concept they had previously associated with nursing and they also felt nursing talent was not valued or recognised by others. Participants frequently required prompts to start considering the concept of talent in nursing. For example, the moderator suggesting they thought about a nurse who inspired them, this allowed participants to more readily identify and describe characteristics that they would define as nursing talents.

Figure 5 visually represents the diversity of words used to describe nursing talent. The larger the word is represented, the more frequently it was utilised by individuals within the exercise. The most commonly utilised words were knowledgeable, confident and communication. These characteristics could be applied to a wide range of occupations. Words reflecting personal values were also utilised including; caring, dedicated, determined, compassionate, integrity and honest. The analysis identified that some words utilised by participants could apply either as descriptors of skills, attributes or knowledge. For example integrity could be seen as a personal value, but also an attribute of leadership. The initial exercise did not aim to analyse the meaning behind the words utilised by participants, but acted as a stimulus for subsequent group discussion.

Figure 5: Representation of Words Utilised to Define Talent in Nursing

(All Focus Group Participants (N=57))

The exercise was effective in initiating and engaging individual participants in considering their own views, before progressing on to group discussions. All groups described how a talented nurse, anticipated patient needs, empowered patients and got to know them as individuals. The perception emerged that nursing talent reflected an ability to utilise a combination of talents. These included leadership qualities and professional knowledge and skills. For example using leadership skills to influence and take decisions, acting as a role model, advocating for patients, supporting the team and delivering excellence in care. Talent was therefore described more as a sum of the parts, rather than limited to individual attributes.

Whilst the Executives did not undertake the initial exercise, they were also asked to describe what they saw as nursing talent. This elicited descriptions that recognised opportunities for diverse talents in different nursing careers, but with a focus on leadership ability. One of the Executives summarised this as '*…an appetite for leading in an inspirational but clear and evocative manner that helps bring*

and enrol other staff, to achieve even better results.' **(I1p3)**. All focus groups went on to discuss leadership as nursing talent. Within the initial exercise participants' utilised words such as 'inspires', 'motivates', 'stands up for what they believe in' and 'proactive'. The NQ participants identified talent as the ability to inspire others and influence changes in practice, '*I think if you can see problems and instead of just complaining about it you actually implement solutions* **(Gp6p10-11px)**. This reinforced NSs' (Gp5) and more experienced SNs' (Gp8) perspectives that demonstrating clinical leadership in practice, interpreting and acting on clinical findings and advocating for patients were nursing talents.

Within one group of NQ (Gp6), a talented nurse was described as being a great role model, a nurse who had self-awareness, inspired others as a leader and had a continued willingness to learn; '*…you look up to them and you think that's the sort of nurse I want to be, I think that's what talent is.'* **(Gp4p3p1)**. This promoted agreement from within the group and a recognition of the importance of leadership role models to inspire students.

Nursing talents also included descriptions of clinical expertise and a professional attitude. One Executive described '*…there is a core sort of way that they approach things which is thoughtful, a thirst for knowledge, a wanting to do things differently*.' **(I3p3)**. The focus groups involving Band 7 nurses and the Executives, also reinforced that professional knowledge included other talents, such as research, education and business skills. These abilities were seen to enable progression into more influential roles such as management and academic careers.

Staff Nurses (Gp8) focused discussion on clinical skills and attributes, more so than other groups. This included the ability to

recognise sick patients, interpret clinical information, escalate care and manage complex workloads;

> *'…being able to spot when a patient is, you know, which way the patient is going to go. Whether they're going to end up being critically ill, or whether they're going to improve [aha] from your findings. I think you've got to have a certain talent rather than just looking at it and thinking, right, here you go doctor, or in some cases just leaving it.'* **(Gp8p2p5)**

Here the ability to interpret clinical findings, make complex decisions and proactively advocate for patients, were emphasised as nursing talents. Newly qualified nurses also identified the importance of clinical skills as talent, '*…if somebody's good at judging and making key decisions,..'* **(Gp6p10p11)**. The NS group further expanded on this, linking leadership talent to the impact on quality of care delivered. Irrespective of speciality or role across all groups a patient-centred approach was described as talent in nursing. Subsequently, data from the focus group and one-to-one interviews was analysed for further sub-categories within defining nursing talent. These are detailed in Table 11 and presented below.

4.2.2.1 A multiplicity of talents

The focus group interactions enabled the emergence of a multiplicity of nursing talents. Nursing was felt to require diverse talents and this was agreed across all groups from NQ to senior Band 6 and 7 nurses. Nursing talent included a '*multitude of different skills*' **(Gp1p3p11)**. Ward Sisters commented that talent was not a word utilised in nursing and was complex and difficult to measure. They identified that a talented nurse encompassed theoretical knowledge, caring, compassion and also practical organisational skills. In group 4 the diversity of skills required in nursing was also described as

complex and this was supported in a quote from group 1, `…*I don't think there is only one thing you can name to a nurse that can make her talented'* **(Gp1p3p11)**.

Nurse Specialists (Gp5), had a particularly animated debate, the section of transcript below illustrated a fluency of discussion. The participants questioned themselves and each other, focusing on the challenge of defining nursing talent. One participant questioned the concept of compassion and if caring was a talent. This provoked a strong response from others and general agreement that there was a diversity of skills that made up nursing talent.

> *3: But actually none of us are actually saying what we think talent actually is (no, no)……. It's people that have got really good communication skills and they've got that flexibility and they can lateral thinking (mmm, mmm) and compassionate and caring and good solid knowledge base, but that's not talent is it? (Loud verbal response, interruptions inaudible, group talking over each other)*
>
> *1: well I don't know, it's on a continuum isn't it*
>
> *3: Is it? Is it? Is it? (questioning tone)*
>
> *2: It's an all rounder*
>
> *4:- Can we have a definition? (Laughs)*
>
> *1: Absolutely what is talent?*
>
> *3: what is talent?* **(Gp5p3-4)**

Here the NSs' discussion evoked a strongly energised exchange of ideas and raised further questions within the group. Whereas the DSs group specifically described a talented nurse;

> *'…everybody wants to work with them, if I was ill I would want to be nursed by them (quiet murmurs of agreement from group). They get their work done efficiently, they're very organised but they still have a fantastic rapport with the patients (yeah) and you look at them and you think, 'how on earth have you got time to build up that relationship, and get all your work done, not be stressed and look after your colleagues as well'? (yeah) and that to me I think is an amazing talent.'* **(Gp2p2p5)**

Participants indicated mutual respect and understanding within the group of the qualities of this talented nurse described by the participant. This further reinforced evidence from the data that talented nurses did more than high performance of isolated skills. They encompassed multiple talents that included a range of leadership, professional knowledge and organisational skills and abilities.

In addition within this sub-category, WSs emphasised the importance of recognising excellent Staff Nurses. The DSs agreed, *'…it's important that we don't think talent management is always about getting people right to the top'* **(Gp3p3p5)**. This was also reinforced through the consultation workshops and emphasised a need for greater recognition and valuing of their roles, *'the talents of day-to-day nursing need to be recognised not just academic/corporate achievements'* **(TO3)**. The Executives supported the view that talented nurses were not necessarily seeking senior roles, but ambitious to develop within their own area of practice. Across all qualitative case study data including wider consultation, a more inclusive approach to TM was preferred, recognising the wider talents and expertise of nurses.

Another consideration within this sub-category was illustrated by NSs, who suggested some nurses lacked insight into their own abilities and talents, a view supported by DSs, PDMs and Executives. Nurse Specialists suggested a possible link with gender, the more self-effacing approach adopted by many nurses being described as '*…a female trait..'* **(Gp5p4p3).** All agreed managers should talent-spot and encourage nurses at every level within the organisation. Nurse Specialists and the WSs discussed how nursing was often viewed more as a vocation than a professional career, '*…it's just nursing as usual, we're just wall flowers aren't we...'* **(Gp3p4p5)**.

Whilst all focus groups acknowledged they were unfamiliar with considering talent as a concept in nursing, its importance was recognised. *'… I love it because I think we are all talented and it's brilliant to be recognised…'* **(Gp2p13p5)**. One WS described how the discussion had started to influence her perspectives on the importance of recognising and developing nursing talents. Experienced nurses in another group also reinforced how the process of discussion had been beneficial in developing thoughts on nursing as talent. In addition, the discussions identified the influence of context when defining nursing talent, which will now be considered.

4.2.2.2 The Contextual Nature of Talent

Both DS and WS focus groups acknowledged a changing context in healthcare. This included the need for new roles and talents, *'…it's going to be the people that can adjust that we need.…''* **(Gp2p13p1).** Both groups discussed with enthusiasm the importance of the right environment and role for characteristics of talent to be recognised and flourish; *'…we had a nurse who would cause chaos on the ward, because she would panic and stress, but put her in a research nurse role, she was amazing…'* **(Gp2,p2p3)**.

Participants described how an individual might be lost to the profession if their personal strengths were not recognised and developed. This was described as something that was not done well in nursing. The DSs talked fluently to build agreement that staff needed to be treated as individuals, in the same way as expected for patients.

> *2: '…sometimes we try and make people conform to how we think they should be operational and how we think they should function and sometimes we miss out on talent because it's misappropriated and it's not allowed for (yeah).'* **(Gp2p3)**

Here a sense that the context and work environment may influence what is recognised and nurtured as nursing talent. The Executives also identified the diversity of talents required within nursing; delivering high quality care and within the business context of the NHS, ensuring value for money. The PDMs supported this view;

> *'…you don't just need frontline nurses, you need people organising those nurses [lots of talking in background] you need people developing and educating them, you need people who are good with business and spend the government's money properly…'* **(Gp7p10p1)**

The PDM group went on to suggest that nurses often lacked self-confidence to take on new and diverse roles. They discussed the transferable nature of management skills, but how these were not necessarily valued within nursing where clinical specialism was more highly regarded. The WSs also agreed that finance and budget management skills were not traditionally seen as talents required in nursing. There was a risk that students and junior nurses with these talents may not get opportunity to be recognised and developed.

Therefore this would be lost, within an organisational system that did not provide careers guidance and more flexible career development opportunities from an early stage;

> *8: 'You are a nurse and you come on to the ward (mmm, mmm) and you nurse and so perhaps we don't pick up those hidden talents initially to develop the leaders of the future?'* **(Gp3p6)**

In spite of the evolving context of care, the WSs considered it important not to lose the essence of what it was to be a nurse, '*…you've still got that core need to want to care…'* **(Gp3p5p7)**. Therefore, whilst roles may develop and require different skills, care was discussed as an essential talent core to nursing practice. This will now be explored further.

4.2.2.3 Compassion and Caring as Talent

All groups discussed the delivery of care, '*…you get your satisfaction from the level of care you are able to give to people…*' **(Gp3p5p3)**. Experienced SNs (Gp8) also described their role caring for patients as potentially stressful, a problem not always recognised by managers or the public. One participant in the group described the psychological stress of working under constant clinical pressures; '*...I can't switch off and I often have sleepless nights [yes] and end up stressed [yes]…'***(G8p15p5)**. This participant expressed frustration at the lack of public awareness of the commitment and emotional pressures of the SN role. There was evidence of self-disclosure as he reflected on potential differences between expected female and male responses to these pressures. '*…even as a man, you know, a male nurse myself, I'm going home crying my eyes out…*' **(Gp8p9p5)**.

Whilst other members of the group did not share such specific personal experiences, they offered support to this participant

through non-verbal gestures and agreement that pressures of work influenced the inability to provide the best care. Participants in this group described how nursing talent was potentially lost through the emotional labour of caring in nursing and how they coped.

> *'…you don't have to care about everybody, because if you cared that much about everybody, you'd just become overwhelmed [I: it would eat you up], but it's giving the impression, making that patient feel cared for and showing the relatives that kind of professionalism.'* **(Gp8p3p2)**

Therefore ward SNs, explored the need for emotional self-protection and described compassion and caring from a different perspective. This included, acting professionally and being able to provide thoughtful, person-centred care, in a busy stressful clinical environment; rather than actually feeling genuine compassion for every individual. The group discussed the concept of caring through patient advocacy *'...there's different ways to care aren't there.'* **(Gp8p4p4).** This focus on the emotional labour of nursing was not raised in any of the other focus groups. The participants in group 8 were all at least one year post qualification, working in direct patient care roles in busy clinical wards. Participants within other groups were either NQ SNs, so had limited time in practice, or were in roles that did not consistently deliver direct care within ward environments. However, the stress of clinical work was supported through all the consultation workshops, which involved SNs from across the organisation.

Within the three focus groups involving Band 7 nurses (WS, PDMs, NSs) there was further debate as to whether caring and compassion were talents.

'…like being caring and compassionate and all the other skills that go to make a nurse and talent just doesn't seem to be like a lead word (9: - I suppose caring isn't a talent really is it) (yeah, yeah) its part of you (6: it's intrinsic to you).' **(Gp3p4p3)**

Whilst WSs had identified the centrality of care as a core nursing talent, participants supported the view that caring was an innate characteristic. As outlined earlier in this sub-category, NSs' had also questioned if caring was a talent, resulting in a heightened level of debate within the group. Conversely the PDMs identified a potentially limiting influence on the image of nursing where nurses were seen as focused on caring at the bedside. This reflected professional recognition in nursing. *'…I think only recently we've really started to say, right we are professional and this will be a degree-only profession and we are going to be equals with other people,…'.* **(Gp7p9p1)**.

Therefore whilst SNs reinforced a perspective of clinical skills, competence and patient advocacy as nursing talents, senior nurses identified how staying by the bedside was not necessarily valued as a professional skill by the public or media and there was a need to influence public awareness. Across groups there was agreement that nurses were not good a promoting their talents and achievements, but were just '…*quietly getting on with it*…' **(Gp8p8p4)**. How this affected perceptions of nursing within the media was described as important for TM in nursing and will now be considered.

4.2.3 The Image of Nursing

A challenge identified for TM in nursing across all focus groups and wider consultation, was the need to actively promote a more positive image of nursing in order to attract, develop and retain

talented nurses. There was agreement across all focus groups that the public had little insight in to what nurses actually did. One experienced SN described with frustration how even a family member had stereotypical perspectives; *'My own brother, all he ever says to me is, oh all you do is wipe bums all day'* **(Gp8p8p1)**. Staff Nurses in Group 8 considered the negative media experienced after publication of the MSFT Public Inquiry and how this had further damaged the public image of nursing. The potential impact on recruitment was a concern, as it did not project a positive image of nursing as a career, or a talented profession, '*…at the moment it is like nurses are awful, nurses don't care [mmm] [aha], nurses kill people… [1: there's like a stereotype {inaudible}]…'* **(Gp8p8p6)**. The NSs reinforced concerns raised by NQs (Gp1) that specialities such as healthcare of older people may have additional difficulties attracting talented nurses due to negative media and expectations. The concerns about negative media image of nurses, were not identified within Executive one-to-one interviews.

As within the focus groups, during wider consultation there was sadness expressed at the predominance of negative media stories, *'sometimes daren't say we are nurses'* **(TO3)** and a need for a proactive response. To counteract the high quantity and profile of negative media stories about nursing, SNs (Gp8) expressed a need for greater proactivity, '*…you don't see very many nurses out there in the media saying, well actually <u>this is what we do</u>…'* **(Gp8p8p3)**. This was supported in other groups. Here experienced nurses described *'….if we're not voicing our opinions then people aren't going to be made aware of our thoughts..'***(Gp4p10p6)**. The PDMs (Gp7) summarised the sense of importance in promoting a positive image; '*It's about reclaiming pride in our profession as well, saying this is what we do, this is what we can do*…' **(Gp7p13p3)**. The need for proactivity in promoting positive images was supported

across all the consultation workshops. Nurses needed to take the lead and influence this; *'…to feel proud'* and *'improve media image'* **(TO2)**.

4.2.3.1 Attracting and retaining talented nurses

Within this sub-category the public image of nursing was seen as influential in not just attracting new talented recruits, but also in retaining existing staff. Through the wider consultation the stereotypes of 'caring' were considered influential for TM within nursing; *'need to change image to attract more males'* **(TO1)**, *'nursing isn't just all about 'care' motherly role'* **(TO3)**. Some participants reported there was more diversity, including more male nurses and a view that nursing was seen as a more skilled profession. Conversely, initial discussions within the WS focus group reflected the very stereotypes of nursing identified within the media. There was a concern articulated from one participant regarding the national move to degree level preregistration education, occurring during 2012 in England. The participant associated degree level studies with academic ambition and suggested, '*…you may not necessarily get the type of nurses that you <u>want</u> to look after your patients.*' **(Gp3p5p3)**. Other members of the group questioned this view, participants reflected on previous changes to diploma education. Through a process of group discussion participant 3 moved to acknowledge concerns about previous changes were actually unfounded, '*…it doesn't make any difference they're still caring nurses at the end of the day.'* (**Gp3p6p3)**.

The WSs were the only group to initially discuss the move to degree training as negative. Within the other groups the degree profession was seen as important in attracting talented recruits in line with other occupations. In addition, nurses wanted to work in successful organisations; that applied to new recruits and also existing staff. All Executives identified the importance of a positive organisational

reputation in attracting the diversity of talented nurses required. They emphasised the important role of leaders recognising and rewarding talent in their teams and in offering a range of education and development opportunities.

4.2.4 Recognising and Rewarding Nursing Talent

Whilst initially finding it challenging to define nursing talent, focus groups and wider consultation agreed on the need to recognise and reward nursing talent and identified that this was not routinely done. The PDMs discussed the benefits of helping managers to recognise and develop talent within their teams. Recognition was also described by NQs as having a motivating influence '*…it boosts your own self esteem as well as the morale of the ward...'* **(Gp1p10p9)**.

4.2.4.1 Different Ways of Recognising Talent

This sub-category further considered how nursing talent should be recognised and rewarded. The organisation's Annual Employee Awards event was utilised by one group as a positive example of recognition, others felt that there was little recognition of day-to-day nursing talent, both within the organisation and nationally. The WS and NS groups and the DN all identified that rewarding high performance was not part of the expected NHS culture, '*…there are no incentives'* **(Gp5p5p2)**. It was acknowledged that in business, talented people were recognised and financially rewarded. There was evidence of different personal motivators, '*…I don't think nurses are always out for financial bonuses (6:No) I don't think they even think like that (6: no, no, no)…*' **(Gp4p6p2)**. The WSs agreed that reward in nursing was often seen as more intrinsic, through feedback from patients. Within all groups, participants described their appreciation of a thank you, positive recognition from a patient or their family. Staff Nurses identified, '*…you can go home and feel like you've done something [aha] good that day.'* **(Gp8p12p1)**.

There was frustration at the lack of differentiation and financial reward between highly motivated performers on a ward and those who were not. This was reinforced by more experienced SNs; *'You could have just come to work and done anything, nobody recognises when you've worked hard..'* (**Gp4p6-7p6)**. Positive feedback from managers was valued by all participants and supported at the consultation workshops. Whilst WSs debated the lack of wider recognition for nursing talent, the SNs described how they gained a level of satisfaction from positive feedback from their WS; *'It doesn't have to be complex though does it [aha] to recognise talent [no] and to recognise a job well done…'* **(Gp8p13p2)**.

Nurse Specialists saw providing educational opportunities and support as positive motivators. Both through focus groups and consultation, it was seen as demotivating that the NHS did not reward additional academic qualifications in nursing. This was seen as potentially hindering talent development. The onus for academic achievement was very much on the intrinsic motivation of individuals; *'I wanted to do it for me anyway to feel that achievement.'* **(Gp2p12p3)**. Consideration of individual motivators was seen as important in TM and influential in how nurses were recruited and retained. The WS, NS, PDM groups and Executives agreed on the importance of managers knowing their teams, individual's strengths and motivators. They recognised that these may vary across different generations, be they flexible rostering, academic or financial reward. This will be further considered under the next two sections of the findings chapter.

4.2.5 Summary - Nursing As Talent

The definition of talent in nursing was initially challenging and provoked wide discussion. Talent and TM were not concepts the clinical participants had previously associated with nursing. The data

revealed a multiplicity of skills and characteristics utilised to describe nursing talent and indicated a diversity of perspectives and contextual influences. This lack of clarity in defining nursing talent was felt to influence the public image of nursing and perceptions of the skills and knowledge required to be a nurse.

From the initial focus group exercise nursing talents were described as leadership qualities, patient-centred care and professional knowledge and skills. Through subsequent discussions the notion of nursing talent as a sum of the skills, rather than individual attributes emerged clearly. This reflected nursing talent as described by Executives; including effective leadership, being a role model and an advocate for patients. The importance of an inclusive approach to TM, recognising and valuing the skills of the clinical SN was emphasised by focus groups and reinforced through the wider consultation. However in the changing context of nursing careers, there was also recognition of a need for wider talents, including management, finance and research skills for those who aspired to different roles.

Within TM the importance of recognition and reward in nursing was identified and a more complex picture emerged. Findings identified a range of motivational factors including; the importance of feeling valued, positive feedback gained from patients, carers and managers, education and financial motivators and supporting family commitments. The next section will look at the second theme identified from the data 'Ward Leadership and Culture' and the influence this had on identifying, attracting, developing and retaining talented nurses.

4.3 Ward Leadership and Culture

4.3.1 Introduction

This section will outline in more detail the second theme of ward leadership and culture that began to emerge in the previous section. It will build upon the previous sections findings where the multiplicity of talents emerged and the contextual nature of how talents were recognised and rewarded. Importantly it was the style of the ward leadership and the culture of the ward that were seen as integral to participant experiences of Talent Management. To enable a common understanding of the term 'culture' during the analysis of the findings, the definition of culture within groups and organisations based on Schein (1992) was utilised within this study. Schein described, '*A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems'* (1992,p.12). In other words, summarised within a healthcare context as, '*the way we do things around here*' (West et al., 2014,p.5). This is presented as a definition that can be applied at a ward, department or organisational level and reflected how participants experienced different approaches to Talent Management.

The categories and sub-categories that emerged from the data can be seen in Table 11 and guide the discussion in this section.

Table 11: Theme Ward Leadership and Culture, category and sub-category expressed in the data

THEME	CATEGORY	SUB-CATEGORY
Ward Leadership and Culture	Manager Essential to Talent Development	
	Organisational Culture	• Culture of clinical pressures • Creating a learning environment • Talent as disruption • An inclusive approach to talent development

4.3.2 Manager Essential to Talent Development

The importance of the role of the WS and senior leadership team in talent spotting, staff development and influencing team behaviours was identified by all focus groups, in wider consultation and one-to-one interviews. A positive ward culture was one where staff felt valued and engaged in a supportive learning environment, with opportunities for development. The Executives further expanded on this; describing development of talent as dependent on an enabling organisational culture, with an effective appraisal process and varied development opportunities. There was acknowledgement by Executives that there were inconsistencies in experiences of TM across the organisation. They considered the skills of the manager to be integral to this, *'..I think making sure that individuals make wise, careful choices about careers is important and that includes not only the job, but who they work for, the organisation they work for…'* **(I1p6)**.

Clinical nurse participants did not discuss the manager as part of their consideration in career choices. This was in spite of reporting experiences of poor managers and unsatisfactory appraisals, which had resulted in some participants choosing to leave a job. The Executives agreed that managers needed support and skills development to recognise TM as a core part of their role. This was emphasised by the DN;

> *'…what strikes me is we don't give our senior leaders the skills with which to be able to spot talent, we don't make it something that's important. So we don't measure it, we don't performance manage it…'* **(I3p5)**.

The Executives identified that TM was not regarded as a priority in an NHS culture focused on clinical performance targets. They acknowledged that there was not a systematic approach to TM in the organisation. The CE described that the organisation relied on, '*tacit knowledge in the minds of individual managers...*' **(I1p2)**. The focus groups observed that there was limited opportunity for managers to talent-spot, as such this was regarded as a significant consideration for TM in nursing.

The WS was seen as essential to TM, and was discussed in all groups. The values of the WS influenced the culture of the ward. In one example, a NQ group shared an experience which indicated a culture where there was poor recognition and support of junior nurses from the WS*; "We don't even get a thank you from the ward manager or anything at the end of a shift, she just leaves without saying bye, [laughing in background]…"* **(Gp6p8px)**. Group participants here demonstrated empathy, active listening, eye contact and non-verbal support to the individual sharing their story. The laughter was that of disbelief at the manager's actions and in support of the participant. Both NQ groups described the importance

of the WS being an approachable leader, working alongside them in practice, creating the right culture to build trust, support staff and nurture talent. The experienced SNs (Gp8) had observed more evidence of visible WS leadership in practice with support and feedback to staff, but this was not viewed as consistent.

The WSs recognised the importance of their role in developing their teams, the potential to talent spot, coach and develop staff from the beginning of their employment**.** There were some positive examples of leadership and staff development shared by NQ, '…*the Sister said to us, what's your interest?'* **(G1p5p8)**. This importance of engaging staff through identifying their specific interests was seen as positive**.** The PDMs identified individuals may not always be aware of their own potential and managers had responsibility for assisting with this and focusing on developing an individual's strengths**.**

A complexity of perspectives is evident within the case study data. Whereas there was positive feedback from both Executives and within groups of managers encouraging others to develop their own strengths and talents, some focus group participants had felt 'blocked' by managers. Where a manager blocked development opportunities, the emotional impact was negative and had driven one participant within one group to leave a ward;

> *2 '…..I had that passion, but it wasn't nurtured [yes] so if I'd stayed there any longer [mmm] I can guarantee I would be quite an unhappy nurse [4: it was actually blocked wasn't it?], it was blocked, yeah [4: let alone enabled] it was blocked [4: it was actually blocked, yeah] you know...'* **(Gp8p7)**

There was a sense of disbelief and frustration expressed at the power of the WS to stop progression, without giving any

explanation. In another group one NQ nurse described feeling devalued and underdeveloped, losing self-confidence and was looking for other jobs in order to progress.

The importance of ward leadership in creating the right environment for education and development in practice was consistently reinforced through the wider consultation. A variation in experience was described and there was support of the themes identified within focus groups, *'Good leadership is required to support newly qualified and promote education at ward level'* **(TO2)**. There was a difference between participants' experiences and this will be further explored within the findings section 'Career Development'. Deputy Sisters discussed the importance of nurturing and developing talented individuals, but did not explore how they influenced this in their own role as leaders. They described seeking advice themselves and identified that further access to careers guidance would be helpful. The NQ nurses discussed the motivating influence of effective leadership, when staff felt valued and engaged, where there was good team working and rapport. One group described how this also influenced patient experience **'...***the patients say, oh it's lovely on here.'* **(Gp1p4p3)**.

4.3.3 Organisational Culture

The wider role of the organisation 'The Trust' in developing talent was discussed in all groups and one-to-one interviews. This section will consider how participants described the organisational barriers to TM in nursing including; the clinical context, the influence of workplace culture and the need for an inclusive approach with increased staff engagement, particularly at SN level. First the organisation as a barrier to change is discussed.

In three focus groups examples of personification were evident within the data and human qualities were attributed to the

organisation. Here NQ discussed the important role of 'the Trust' in recognising and rewarding nursing achievements; *'…the Trust recognising, because they've listen to what they've (patients) said and they've acknowledge you for it' (yeah).'* **(G1p10p11)**. The use of the word 'the Trust' here as someone or something that could give advice, *'…if the Trust gave us like a career advice every five years or something, and said well, where do you want to be in five years?'***(G2p4)***.* Therefore 'the Trust' was described as something higher than ward level, independent to line management, but evidence that this may mean different things to different participants.

In another group NSs described facing the 'wall', the organisation as an inert object and the barriers that needed navigating when trying to implement changes; *'Sometimes it feels like you're running against a brick wall (mmm – group; 4: absolutely) and you can only get knocked back so many times finding a way round* **(Gp5p10p1)***.* Here a sense of a lack of control and a perspective that the organisation created barriers to change. *'…'the wall' doesn't appear to have a patient focus (a- No, no) it feel like they've somehow lost that along the way, and sometimes I think we have to remind people that we're all here for the same reason* **(G5p10p3)***.*

Ward Sisters also described a sense of top-down control. Organisational rules controlled even what information posters could be put on the wall within the ward, *'…we are all puppets in some way in what we can do.'* **(Gp3p6p5)**. With the complexity and size of the case study organisation a sense of dissonance was evident. Participants at ward level described feeling some challenges in the shared sense of purpose, with the 'the Trust' potentially seen as blocking change. Conversely the importance of individuals feeling aligned to 'the Trust' was described by one of the Executives, as an influential factor in attracting and retaining talented nurses.

'….that they have a sense of creative ownership of what sometimes can I am sure feel like amorphous of (the Trust) two large hospitals, to actually feel some sort of alignment and purpose with that.' **(I1p4)**

Here the Executive described 'the Trust' as 'amorphous' suggesting a lack of definite form or shape. This was in direct contrast to the analogies used by participants within focus groups such as 'wall', which suggested a very resistant barrier. This posed different perspectives of the organisation as an entity and potential influences on the development of nursing talent. The wider SN consultation reinforced evidence that there was variation in perspectives of organisational structures that enabled or blocked change. For SNs this often appeared to depend on their employing department and their experience with their line manager, rather than the wider organisational system. The pressures of the ward environment were repeatedly identified in focus groups and wider consultation and these will now be considered.

4.3.3.1 A Culture of Clinical Pressures

All focus groups described experiencing relentless clinical pressures on the wards. They described the requirement to increase productivity and meet national clinical performance targets. These pressures were reported as influencing the time managers had available to focus on individual staff development and a resultant lack of time for study leave. The WSs discussed the impact that this had on staff retention, with a view that this caused levels of disillusionment for SNs; '*…they don't feel they as if they've got any real worth other than coming to work and delivering the care…'* **(G3p10p8).** The DSs, NSs and more experienced SN groups all discussed how managers risked looking out of touch with the pressures facing ward teams delivering hands-on care to patients; '*…sometimes it does feel that all people are interested in is the*

figures…' (**Gp4p7p6).** An NHS culture of quality auditing included specific nursing metrics, these were assessed monthly in each ward area. The emphasis in nursing, identified across all focus groups, was for managers to focus on negative scores, rather than recognising and celebrating achievements*. 'They come and say, you've only got 90% you need to score better and you just think, you know what, I've slogged my guts out all week…'* **(G4p8p6)**. Deputy Sisters (Gp2) felt that the audits enabled opportunity to provide more individualised feedback, recognising nurses who were '…*consistently doing fantastic work,'* **(Gp2p12p5)***.* This was supported and reinforced through the wider SN consultation. However, one NQ participant reflected on this; *"I think praise gets recognised, but I don't think talent gets recognised that much…'* **(Gp6p9p11)***.* Other participants within the group supported this view. Recognition from managers focused on praise for compliance with organisational systems and achieving expected standards of care within the ward, rather than considering the unique talents of the individual nurse. Creating a supportive learning environment on the ward was seen as integral to recruitment and retention of nursing talent.

4.3.3.2 Creating a Learning Environment

All Executives emphasised the importance of the organisation in creating a supportive culture;

> *'…the individual should be the process owner of their own development, but I think the organisation I think does have a responsibility for providing an environment in which their potential can, to the best extent possible, flourish*' **(I1p1)**

Here the importance of individual commitment and self-motivation was described, in addition to a supportive organisational

environment. The benefits of seeing the workplace as '*a learning laboratory*' **(I1p4)** was described. All Executives identified the need for skilled managers who understood peoples' ambitions, strengths and development needs. Within their own careers, the importance of working in partnership with a manager was described; '*…we have pushed ourselves forward, but actually we've also probably had the fortune to work with line managers that have supported and encouraged us…'* **(I2p1)**.

Participants in the consultation supported a view that career development was more than the responsibility of the manager or the ward environment, nurses needed self-motivation and commitment; *'you make your own choices and opportunities'* **(TO1)**. Secondments and rotational posts were suggested as providing a means of creating opportunities. In addition, dedicated clinical education support at ward level was described as essential to develop clinical skills and enable career development.

Access to clinical educator support was not consistent across the organisation. An example from Group 8 illustrated the feeling of being 'cheated' when a clinical education opportunity had been promised and not delivered. Participants 1 and 3 worked in the same ward; participant 1 identified how they had been promised clinical education when they had started. Participant 3 picked up the discourse and continued with strength of feeling and a sense of frustration and disappointment, '*…I was really excited and then it got to the {inaudible talking} year point and then we asked about it and it didn't actually exist…'* **(Gp8p5p3)**. A sense of not being valued enough to be told the truth, caused disbelief as this discussion progressed. Participants 1 and 3 went on to recount how a number of staff were leaving their ward, illustrating the negative impact on individual staff morale, when educational courses were promised but did not materialise. There were further discussions of

situations, where it was felt that an individual's skills were not being developed to their full potential. An example can be seen below, when NQ discussed their range of experiences for the first time within the group. As the discussion evolved there was an increasing sense of inequity in experiences and non-verbal support from the focus group as one participant described being supported to start a Masters Degree;

> *2:That's really good, it's really good, it makes us really envious because we just don't get anything at all, nothing [11: It makes a difference doesn't it, for somebody to kind of] [3: yes] mmm, [3: it's annoying in a way isn't it, in background]...'* **(Gp6p5)**

Through sharing personal stories within the focus group, there was realisation of the difference in experiences and an increasing sense of frustration emerged. Without focus group discussion individual participants may have remained unaware of the differences experienced within the organisation. This further reinforced inconsistencies within the organisation. Therefore an ongoing tension emerged, Band 6 and 7 focus groups articulated the importance of investing in staff and recognised their own role as developers of talent, but described the challenges of this in a real world context. Support to recognise and develop talent throughout all levels of the organisation was described as important by PDMs and Executives. This was felt to create a more supportive organisational culture of development, one where a diversity of talents was positively welcomed, which was not necessarily reflected in participant experiences. This will now be explored further.

4.3.3.3 Talent as a Disruption

Seven of the eight focus groups discussed how talent was not always seen as a positive in nursing as it could challenge the

traditional culture of conformity in wards. Group 1 were the only group who did not discuss a potentially negative perspective of talent. These participants had only been employed as registered nurses for a few weeks. In Group 6 one NQ participant used powerful language to describe how talent could be '*squashed*' and individuals who did not conform to ward expectations may be seen as '*…a discrepancy that needs to be got rid of...*' **(Gp6p9px)**. There was non-verbal agreement and verbal reinforcement of this view within the group. The group discussed how individuals may be rewarded for conforming to standards or ritualistic practice within the ward. Whereas talent, if different to ward expectations and culture, may be seen as something more radical to remove. The group agreed that experienced staff could dismiss new ideas suggested by junior staff.

More experienced nurses also agreed that established staff could react negatively to new ideas, '*…well 'we've tried it, we've done it', you know, it's that type of attitude by stopping them dampening down their spirits really'* **(G4p2p4)**. They described a traditional culture of conformity in nursing and the risk that talent can be seen as something more radical and not necessarily embraced. This was the very challenge identified by the NQ Nurses. The negative influence this had on new starters and the development of talent was agreed across groups and also reinforced through the consultation.

Where talent was associated with ambition in nursing, further complexities emerged. Participants in the WS and NS groups described a negative perspective of ambition, '*..people will drive forward to get what they want, but it doesn't matter what they leave behind…'* **(Gp5p3p2)**. Band 7 nurses in three different groups reflected on their experiences of ambitious individuals and a potential sense of threat was described;

> *'You don't want destructive ambition either do you, because that can destroy the team as well. So you want somebody that's ambitious, but not overtly so that it sort of detracts from what you're doing (yeah, yeah, voices). You don't want to push everybody else's noses out of joint.'* **(Gp3p3p3)**

Within the other groups, both positive and negative examples illustrated different perspectives on talent associated with ambition. The more negative interpretations of ambition were not articulated within the focus groups involving SN participants. What constituted as pushy, disruptive and ambitious in one ward area, maybe regarded as talent within another, reinforcing the contextual nature of talent. The DSs group discussed the importance of nurturing talent '*…instead of crushing it and saying no you're not the kind of nurse we're looking for, you know, you need to spot that and give opportunity and nourish that and let it blossom.'* **(Gp2p3p2)**.

The PDM group reinforced a need for managers not to feel threatened by talented junior staff who aspired to senior posts. This was also identified by the DN as a serious consideration for TM in nursing and referred to as 'tall poppy syndrome'. The term is utilised in western cultures to describe a social phenomenon where individuals, who exhibit talent or achievement, are actively resented and criticised by their peers or manager.

> *'…we rely <u>heavily</u> on the ward sisters not to have 'tall poppy syndrome', we <u>rely</u> on them not to chop off the legs of the ambitious go getting nurses.'* **(I3p1)**

Here the DN's perspective was more reflective of the SN participants, the term ambition was not construed as a negative characteristic, but associated with recognition of leadership potential

within an individual nurse. Therefore the terms ambition and talent were explored as different concepts through the data. This reinforced the potential influence of context and culture on how talent is defined and TM developed in nursing. Primarily, a preference for an inclusive approach to TM was agreed across all qualitative data.

4.3.3.4 An inclusive approach to talent development

This sub-category considers the importance identified in creating an inclusive approach to TM, where all staff felt there were opportunities available to meet their needs. This inclusive approach was agreed across all focus groups, as important in attracting and retaining nursing staff. Due to larger number of participants involved in the consultation, there was a more diverse and representative sample of Staff Nurses. In some teams they reported *'Cliques of staff... only help certain people within a group'* **(TO1)** and managers' needed to be *'Careful not to create jealousy'* **(TO3)**. Whilst displays of emotion within the focus groups were limited, during the consultation a small minority of individuals expressed stronger emotions, displaying anger and frustration at how they had been treated or denied opportunities by managers. They described with frustration, '*how do we change the 'culture' of a ward without it taking too long if there is an ineffective leader?*' **(TO3)**. The wider consultation reinforced the need for inclusive talent development, rather than purely focusing on individuals.

The WS, NS and PDM groups discussed the need for leaders to create an environment where developing talent was not seen as favouritism. This required greater engagement and involvement of all staff with recognition of equality and diversity, not just supporting high fliers or those who will *'push themselves forward'* **(Gp5p3p2)**.

Executives also described the importance of inclusivity and senior leaders' roles in supporting staff at ward level; *'…we as an organisation have got to do everything possible to allow those individuals, those nurses to feel supported and enabled, rather than the reverse, through the way in which we as an organisation organise ourselves'* **(I1p3)**. There was acknowledgement of the importance of recognising diverse talents and creating an enabling culture.

Within this sub-category WSs recognised the influential role of the SN in the quality of care delivered to patients. There was a sense that this role was not enabled to its full potential, *'…. We don't foster that down at the very grass roots…'* **(G3p8p9)**. The need for involvement of SNs in decision making at ward level was discussed primarily within the focus group involving experienced SNs (Gp8). It subsequently received consistent support through the wider consultation. Many participants described how they wanted greater opportunity for involvement in decision making at ward level, *'..band 5s are not involved in decision making'* **(TO3)**. They questioned and gave examples of changes made by managers to issues from clinical practice; such as nursing documentation *'How do band 5s get involved with influencing practice?''* **(TO3)**. A pilot project underway in one ward area to improve SN engagement was discussed by SNs (Gp8). Five of the seven SN participants were involved in a project implementing shared governance, (as outlined within chapter 2, a model of devolved nursing management) engaging frontline staff in a 'Unit Practice Council', making decisions relating to improving practice on the ward. This was viewed as an enabling and positive development for TM in nursing.

Specific reference to minority groups and cultural differences was not made within the focus groups, however BME diversity was more evident within the larger consultation sample. Two BME participants

identified a lack of inclusion '*Minority groups are sometimes made to feel undervalued due to their cultural differences and scope for development is sometimes stifled*' **(TO3)**. As described in the methodology chapter, focus group participants had self-nominated and whilst gender had been captured as part of demographic data, ethnicity or other measures utilised for diversity monitoring had not. In order to gain further BME data within the case study organisation documentary sources were further explored. The NHS Staff Survey results (Picker Institute, 2012) were reviewed for the case study organisation, to ascertain if any issues relating to BME discrimination were identified. The data for the 2012 survey was gathered between September 2012 and December 2012 within the study time period. Analysis identified that the organisation employed staff representing 87 different nationalities. The survey asked staff if they believed the organisation provided equal opportunities for career progression or promotion; 93% white respondents indicated yes, whereas only 68% BME responded yes. In addition, one Executive identified that all nurse post holders at matron and senior manager level in the organisation were white. This did not reflect the diversity of BME employees and was described as one of the most significant challenges to implementing a more effective strategic approach to TM in the organisation; '*…to make sure that there is that equality of opportunity and there's that equality of confidence and there's that equality of encouragement for people?'* **(I2p4)**. Therefore, within the case study, evidence from data sources wider than the focus groups, enabled the identification of inclusivity and equality for BME staff as an important consideration for TM in nursing.

4.3.4 Summary – Ward Leadership and Culture

In summary this section sought to present the findings relating to ward leadership and the culture of the ward, seen as integral to

developing effective TM in nursing. The contemporary context of NHS targets and clinical pressures were seen as influential in the ability of leaders to free up time to focus on Talent Management. It was recognised that there was a need to develop an organisation, where all managers were recognised for developing talent in their teams and a diversity of talents was nurtured. It explored the importance of ward leadership in creating a supportive learning culture and developing talent on the ward. There were varying personal experiences described, which had influenced participant's access to education and development. The WS needed to be visible, out within the clinical area and know individual staff member's strengths and development needs. Creating a learning environment where clinical education and development opportunities were available at ward level, was considered important for TM in nursing. This included a need to further support BME staff in their development.

Talent and ambition as 'a disruption' in nursing were explored and the need for nurses to conform in order to prevent them being labelled as disruptive within a particular ward environment. This reflected the concerns of the DN who described 'tall poppy syndrome' where managers felt threatened by ambitious junior staff. Valuing and involving SNs in decision making at ward level was emphasised by group 8 and this was then expanded upon consistently through the wider consultation. A need for an inclusive approach to TM, where opportunities were open to all, not just a few 'high fliers', was regarded as essential in the recognition and development of nursing talent. The next section will explore career development as the third and final theme within the data.

4.4 Career Development

4.4.1 Introduction

This final section addresses issues that emerged from the data which included; a lack of clarity about career pathways available in nursing, a need for access to varied development opportunities, the need for careers advice and the importance of individual performance appraisal in talent spotting and career development

Within the literature, considering how staff are attracted, developed and retained within an organisation have been identified as core components of Talent Management. As already described, the organisation had a personal development appraisal policy, but no formal TM policy or strategy. All employees received an annual individual performance review (IPR) with their line manager, however participants reported experiences of this appraisal process as variable and the majority were not considered positively. The categories and sub-categories that emerged from the data can be seen in Table 12 and guide the discussion in this section. There was evidence of consistent support for the themes identified across focus groups, through the wider consultation phase of the study. Firstly a lack of career pathways in nursing will be considered.

Table 12: Theme Career Development, category and sub-category expressed in the data

THEME	CATEGORY	SUB-CATEGORY
Career Development	Lack of Career pathways	• Careers Guidance & Mentorship • Influences on career choice • Valuing the Staff Nurse role as career choice • Lack of attraction Ward Sister role
	Appraisals	

4.4.2 Lack of Career Pathways

All focus groups agreed there was a lack of clarity of career pathways in nursing. This finding was reinforced through the wider consultation and also supported by Executives. Only two NQ participants in one group articulated having a clear idea about their own careers in clinical specialist roles. One had already sought careers advice, *'…the only reason I did nursing because I wanted to be in trauma A&E…'* **(Gp6p4p11)**. This participant was the only participant to state this.

For participants there was a sense of inevitability that a ward-based career was the normal pathway in nursing. Only two groups, PDMs and DSs briefly referenced the potential for nurses to develop their skills within research, *'…you don't think about research nursing or any other sort of avenues…'* **(Gp2p4p3)**. One PDM (Gp7) had previously been a lecturer practitioner; these education roles were not discussed within other groups.

The NQ described a need for encouragement and careers guidance, *'….we're still trying to find our feet doing our normal job so we don't know what we could do in the future'* **(Gp1p7p3)**. For NQ the importance of preceptorship in nurturing talent was identified; having the opportunity to sit down with a more experienced nurse (a preceptor) and reflect on practice, to gain support and advice (DH,2010d). The findings indicated that this was inconsistent across the organisation, *'…I haven't met my preceptors yet and I've been here for seven weeks.'* **(Gp6p5p11)**. The importance of supporting NQ in their transition from student to qualified practitioner was also recognised by Ward Sisters. One participant described the personal benefit she had experienced receiving support when NQ; *'…I feel that that's the only reason after three years that I was ready to apply for a band 6…'* **(Gp3p14p7)**. These more senior nurses

recognised the need to invest in support and an individualised approach to career development.

The lack of clarity in career development was not exclusively an issue for NQ nurses. The WSs and PDMs were also unclear about career pathways available. They described how many staff lacked awareness of career opportunities, including new roles and those outside acute care and this inhibited career progression for some;

> *'You don't know what's out there, you don't know what you don't know. [Group voices - mmm] I just think it's not perhaps as transparent as it could be…'* **(Gp7p5p4)**

Two Executives identified the need for clearer pathways in to different nursing careers, including research and education. They acknowledged the lack of attraction to management roles including the WS. The third Executive emphasised a preference for a 'career climbing-frame' **(I1p6)** rather than hierarchical 'career ladders' to enable flexible staff development. Whilst the traditional nurse management career pathway was most widely understood, all focus groups felt this was limiting when considering the development of wider nursing talents.

> *'…not everybody will want to go on that particular road or not everybody is ,like sort, of that leadership or managerial talents...'* **(Gp7p4p2)**

Groups 3, 5 and 7 included band 7 nurses and offered a different perspective on career development. They described career choices becoming more limited once reaching their pay level. Similar to more junior nurses, the WSs recognised financial challenges for some nurses moving to roles that did not attract unsocial hours pay enhancements. They saw more flexibility and opportunity for career changes at Band 5 level. The NSs (Gp5) were positive about their

own roles, describing job satisfaction, a balance between patient care, leading and influencing a service. These core components of a NS role were also those citied by other groups as to why they wanted to be Nurse Specialists. The NS participants were not looking to move on to other roles;

> *'This is my dream job (laughs and group laughs with her). I was in management before and went back down to the patient and this is my dream job...'* **(Gp5p8p4)**.

This group was smaller (n=4) and, as with all the focus groups, participants had self-nominated, therefore had been motivated to attend to participate in the study. Their views may not be reflective of a wider sample of Nurse Specialists. An interesting difference was noted between WSs, who discussed the pressures of their roles and a desire, for some, to move on and NSs who described enjoying what they did '*I absolutely love it*' **(Gp5p9p3)**. They even expressed feeling rather guilty for that, *'…I feel a bit of a wimp for not moving on, but there's nothing that I want to do…'* **(Gp5p9p2)**.

Interestingly, whilst senior nurses discussed a lack of clarity as to career options open to them, NQ with ambitions for clinical careers, felt concerned about being blocked in their career progression, as senior roles were limited within specialities. Some interesting potential tensions emerged, posing a risk for staff retention, as there may be limited opportunities for specialist career development locally. Staff nurse participants questioned how nurses progressed in to clinical speciality careers*, '..,<u>how do you become a specialist nurse?'</u>* **(Gp8p10p3)**. They described frustration at how opportunities were often only open to those in clinical management roles, not SNs.

The association of career progression in nursing moving away from delivering clinical care at the patient bedside, was described as a

contrast to medical career progression, where the Consultant role retained a clinical focus at the most senior level. '*The higher up in nursing you become, the further and further and further away from your practice you are…'* **(Gp8p9p4)**. Participants did not refer to the Nurse Consultant (NC) role. Within the organisation there were only two CN posts and participants may not have had exposure to the role.

One PDM participant described frustration when trying to maintain clinical work within her role, which had not been sustainable due to other job pressures. This concern was reflected by DSs (Gp2) and deterred them from career progression, '…*you're going away from patient care and a lot of people I think don't want that (mmm, mmm).'* **(Gp2p4p1)**. One WS had just moved into a specialist role. They described that the reason for this was to continue to influence patient care and have a challenging role, but without the managerial responsibilities of being a Ward Sister. The lack of clarity in clinical career pathways and a need for more sign posting to clinically focused opportunities, was reinforced through the wider consultation.

4.4.2.1 Careers Guidance and Mentorship

The lack of awareness of nursing careers, coupled with a lack of career guidance in nursing once qualified, was identified across all groups and was felt to risk losing potential nursing talent. Interestingly, the Executives all identified the important role mentors had played within their own careers and concurred with the views of focus groups that not everyone recognised their own abilities. Four groups (WSs, DSs, PDMs and NSs) gave examples of the benefits of positive feedback on career development and motivation. Having a manager who spotted ambition and potential was regarded as important by Executives and described by two of the WSs as important in influencing their own personal careers. The

PDMs were the only focus group to refer to the term 'mentor' in the context of leadership development or careers guidance. One other group referred to 'mentors', but related that to the more common application of the term in nursing, for a qualified nurse who is trained to assess pre-registration student nurses in clinical practice. Both mentorship and an effective manager were seen to be beneficial in TM, guiding individuals and developing potential.

Some concerns were raised by SNs about discussing with their manager an ambition to leave. This was felt to cause inevitable tension for managers who were trying to staff busy clinical areas*; '… if a ward manager sees a really talented staff nurse and thinks they'd be great for this, that and the other [aha], they're taking them away again [yeah] …'* **(Gp8p14p4)**. Within one focus group of NQ, different experiences were shared and illustrated the impact of a manager's influence on career development. One participant was seeking independent career advice, one felt under-developed and one felt there was an expectation to do all their development in their own time. The variation in experience and the need for independent careers advice was strongly supported by the rest of the group, with both non-verbal and verbal communication.

Group 4, who were all qualified student mentors did not identify the potential of their own role within careers guidance. They reflected in silence on how they had lacked careers advice and often ended up in jobs by chance.

> *2: you kind of mumble around and hope that you get somewhere eventually, if that's what you want.*
>
> *(Silence)*
>
> *5: – (Quieter voice) yeah, that's right there is no one*
> **(Gp4p6)**

These participants were in potentially influential positions to support and develop other nurses and students and yet reflected very limited personal experience of career development. There were benefits identified across the data in having access to career planning guidance and, from the Executives' experience, this included mentorship. In addition, for a number of participants, the impact of family responsibilities and maintaining a work life balance was also identified as influencing career development and choices. These were discussed as potentially influencing the ability to pursue a career development opportunity and will now be presented.

4.4.2.2 Influences On Career Choices

Whilst a primary issue identified was the lack of knowledge of different nursing career pathways and how to access them, there was evidence of other influences on career development. For some participants these included family and caring responsibilities, concerns about job security and access to resources such as funding and time. All focus group participants were self-nominating and demographic analysis indicated the majority of participants were female. Family and childcare commitments were described as influencing job choices within the four focus groups involving more experienced nurses; *'It's difficult for women isn't it, you know with children'* **(Gp5p4p3)**. There were motivators, such as a preference for set hours to enable management of childcare arrangements. One DS who had two small children described working hours as important, *'I want to get away from the shifts….'* **(Gp2p6p5)**. Within one of the NQ groups, family and home pressures were seen as limiting time available to look up information about career opportunities. One PDM described how family commitments limited her ability to move geographically which reduced opportunities for career progression.

Two groups of more experienced nurses (Gps 4 and 2), expressed concerns about job security. They described a context of uncertainty with services changes in the organisation. There was reference to job cuts five years previously, when two hospitals had merged to make the current organisation. Progressing to band 7 posts (WS or NS) was subsequently seen as a potential risk; '*you feel safer on the ward as (–one of many) yes you're one of many…*' **(Gp4p5p6)**. Participants associated a financial risk with band 7 roles. The DSs described progressing to a band 7 post as a '*gamble…do I just stay safe, you know to ensure my work life balance is how I need it to be?'* **(Gp2p6p5)**. Whilst fears of job security influencing potential career decisions were articulated within these two groups of more experienced nurses, band 7 participants in WS and NSs (Gps3 and 5) did not express concerns about their own job security. However WSs did articulate some concern about the security of NS roles. There was a sense from the WSs of the potential vulnerability of NS jobs at times of financial pressures within the organisation. Conversely NSs (Gp5) did not express concerns around their own job security and this was not reflected in discussion within the other groups. Nurses more recently employed may not have had insight or exposure to previous service changes within the organisation.

An additional finding that emerged with greater emphasis through the wider consultation supported views discussed within focus group 8, that the SN role should be valued as a career choice in its own right. Therefore influences on career choice may also be due to participants enjoying their role as SNs and not wishing to progress further within a hierarchical career pathway. This is now explored further in the following section.

4.4.2.3 Valuing The Staff Nurse Role As Career Choice

Within the context of this sub-category, the focus is on valuing the SN role as a career choice. All groups discussed the importance of

developing and valuing the SN role as a career choice in its own right, stating development opportunities needed to be clinically focused, relevant to practice and broader than access to statutory mandatory training. The inevitability of ward work had more negative connotations in one group. One DS described, how due to the pressures of day to day work, getting stuck was as if on a treadmill, *'… you go on your first ward and then you're kind of stuck on this tread, say a conveyer belt so you move up the ladder or you stay where you are...'* **(Gp2p4p5)**. Staff Nurse participants did not all reflect this sense of a conveyor belt. The more experienced SNs (Gp8) articulated a need for a clinical career ladder for SNs, as required within the ANCC Magnet Recognition Programme®.

The consultation process allowed for much wider feedback from a further 229 Staff Nurses. At each workshop the majority of participants agreed with quotes utilised to illustrate themes from within the data. One quotation utilised opened up a rich discussion on the role of the SN within the workshops;

> 3: *'….being on the same ward for five years doing the same routine every single day that you're there isn't talent management. That's [no] kind of watching the same nurse do the same job [mmm] over and over again [mmm], that's not development [*1*: no, it's almost the opposite isn't it?...]'* **(Gp8p7)**

This quotation provoked a strong response during the consultation workshops. On day one SN participants consistently disagreed with this statement. They indicated that it would not necessarily be negative for a SN to stay on one ward for five years; *'…they can still excel at being a good nurse/ODP/midwife and still can pass on their expertise.'* **(TO1)**. For subsequent workshops further clarification was included on the context of this statement within focus group

discussions. It had related to a need for SNs to have access to development opportunities other than mandatory training. Feedback from participants articulated consistently enjoyment and a desire to stay as a SN within their speciality. There was seen to be a, *'Culture that you are frowned on if you stay as a band 5 for a long period'* **(TO3)**. The SN role was described as having most impact on direct patient experience in clinical practice, *'you gain experience over years, need staff who know the issues in the area and have the experience and knowledge to act on this'* **(TO3)**. A real enthusiasm for the role emerged through the wider consultation; specifically that individuals could excel at being a good SN, develop specialist knowledge and pass on their clinical expertise. This was described as needing greater recognition and value within a nursing career framework and considered within the concept of TM in nursing.

These views valuing the SN role as a career pathway contrasted to more traditional perceptions of other senior nurses. They described the ward nursing hierarchy as a 'ladder', a barrier to climb up and over before an individual could access alternative nursing career pathways. Therefore the ward career route was described as a gateway into alternative roles, rather than a pathway in its own right, *'… there is still that feeling that people have to do staff nurse, sister, you know ward, they have to sort of climb the ladder and then go into advanced nurse practitioner….'* **(Gp7p3p3)**.

4.4.2.4 Lack of attraction to the Ward Sister role

As a result of the clinical pressures, focus on organisational targets and the increasing demands of office-based work discussed earlier in this chapter, commonly participants did not want to pursue the WS role. This reflected the findings from the documentary sources of data, including the unpublished dissertation on TM that interviewed senior managers (Cargill, 2011). Focus groups and wider consultation described the WS as facing increasing

administrative pressures, '…*our ward sister does a walk round in the morning, says 'hello' to people and then only generally sees the patients when she's helping with meals and if they're complaining.*' **(Gp4p4p6)**. This was discussed within all groups as having a negative influence on career choices; *'…the things that I enjoy about nursing, is not being in the office, it's providing you know being a clinician, doing care.'* **(Gp2p9p1)**. This reflected findings from other previous national studies (RCN, 2009; DH, 2010c). As natural successors to the role, DSs described the office-based responsibility as essential to achieve the management requirements of the WS role. They enjoyed the balance of patient contact and managerial work their own role offered and unanimously agreed on the lack of attraction of the WS role;

> *2: '…I just see my ward manager looking as if she's going to tear her hair out every day. It's a thankless job as far as I can see it (laughter from multiple voices)….'* **(Gp2p8)**

The NQ viewed the WS role as distant from patient care***, '…****I think it takes you away from what you've started to come in to, which is patient care.'* **(Gp1p7p4)**. Only one of the NQ participants, whilst agreeing with these negative aspects of being a WS, also discussed the potential of the role for leadership and influencing change. This was then discussed and agreed within the group with non-verbal and verbal support, '*people will listen to you more'* **(Gp1p7p9)**. They identified a level of uncertainly about expectations of the WS role. There was a level of reflection on a role that was once seen as more clinically focused and a suggestion that there was an organisational will to see that return.

Ward Sisters agreed there were high pressures on their role, '...*I know I can't continue to do ward sister <u>indefinitely</u> because of the*

pressure of the job.' **(Gp3p10p5)**. However they all enjoyed the influence the post enabled*, '…I know I can make a difference now and until I became a ward manager I <u>wasn't able</u> to make a difference, not to the extent I can now.'* **(Gp3p9p4)**. The majority of band 7 participants described the matron role as even further removed from patient contact '*…I'd be soul destroyed! (yeah)'* **(Gp3p10p5)**. Only two of the WSs expressed interest in progressing along that management career route, considering the potential leadership influence of the matron. Therefore some similarities were comparable to the SNs who expressed interest in the leadership role of the WS role. For the majority of participants the WS reflected a more negative concept of a middle manager, '*…you're just a manager and you get pressures from above, pressure from below and you get less and less patient contact.'* **(Gp4p4p2)**. The DSs acknowledged that if the WS was able to focus on clinical standards, as a visible clinical leader, then it would be a more appealing career choice.

The importance of developing nurses with the talents to succeed in management posts has been identified previously within this chapter (section 4.1.1). Across all qualitative data sources the opportunity for careers guidance both for junior and more senior nurses was seen as important in TM, to develop leadership and other talents. The annual appraisal was also identified as providing opportunity for recognising talents and discussing career development. Therefore appraisals will now be considered in greater detail.

4.4.3 Appraisal

The Individual Performance Review (IPR) annual appraisal process was discussed in one-to-one interviews and all groups, apart from NQ (Gp1) who were in their first 6 weeks of employment within the organisation. These participants would not have been exposed to

the process as were still within their preceptorship period. The IPR included a rating system, an example of a TM process utilised in some businesses to segment levels of performance. Employees were rated by their manager on one of three levels; 'in need of development', 'consistently achieving' or 'exceptional' performance. This performance rating system was of concern within five groups involving nurses who line managed others. Debate within groups about how ratings were interpreted indicated a risk of variation in application across different areas in the organisation. Whilst there were a small number of positive IPR experiences identified, there was dissatisfaction across all groups with the documentation used within the organisation. It was described as '...*very woolly...'* **(Gp7p7p3)** and focused retrospectively on assessing employee compliance with the organisation's values and behaviours. Staff Nurses (Gp8) agreed that appraisers should be more proactive in talent spotting, *'…when I first started, I thought an appraisal was about checking up on me…'* **(Gp8p15p3)**.

The focus groups all identified how the quality of IPR experience related to the skills of the individual appraiser. However, the organisational target focused on the quantity, rather than the quality of IPRs completed. Executives also emphasised the importance of a quality appraisal as integral to Talent Management and recognised variability in the skills of managers as appraisers. The WSs (Gp3) with responsibility for the majority of IPRs, discussed concerns associated with completion of IPRs. *'…it is a paper exercise to say that they've been done…'* **(Gp3p8p8)**. The NSs also recognised *'enormous pressure'* **(Gp5p11p1)** to complete appraisals and a sense of a tick box approach, concurring with the view here by the DSs group;

> *1:'…the quality of appraisal is really poor. Like even if you do have an appraisal it's very much get it done,*

tick you know, quick, quick. (yeah - voices in agreement).' **(Gp2p10)**

Practice Development Matrons described that many managers undertaking appraisals had a lack of knowledge in how to access information about development opportunities, but had an important role in spotting talent and potential in others. Staff Nurses (Gp8) had a heated discussion that the current process was not satisfactory, *'…I know it's been re-jigged recently, but I don't think it's good enough, for purpose [mmm]…'* **(Gp8p15p4)**. These findings reinforced the view, that the knowledge and skills of the appraiser were important within the process when considering the development of nursing talent and workforce potential.

The lack of satisfaction with the quality of appraisal was supported across the wider consultation. There were further examples of positive experiences, but evidence of variation and the sense of pressure for managers to meet targets was reinforced. *'no opportunities or advice re further development, IPR is tick box exercise'* **(TO3)** and *'a paper exercise*' **(TO2)**. One SN described that different people had conducted her appraisal over the three previous years and that she did not know the person who had done her most recent appraisal. This was reported as an example where the organisation report achieving a target, but staff experience and satisfaction was inconsistent due to the quality of experience. The variability in the quality of appraisals undertaken in the organisation was also reflected in the independent NHS national staff survey (Picker Institute, 2012). This indicated that the different aspects of case study data triangulated to support the finding that whilst appraisals were occurring, the quality was inconsistent.

4.4.4 Summary – Career Development

This section has considered the theme of career development and discussed the range of challenges participants identified, that influence the attraction, development and retention of talented nurses. Through the data the need for career development as a component of TM in nursing has been viewed from different perspectives within an organisational hierarchy. The categories identified included; a lack of clarity of career pathways in nursing and the importance of effective appraisals including the influence of the manager's role. There was a preference for clinical specialist careers and a lack of attraction to the WS role. Yet the WS as a nursing leadership role, was recognised by Executives as essential for developing nursing talent and leading quality in patient care delivery.

It is evident that experiences of participants were variable and influenced by different factors. Newly qualified nurses described a need for effective preceptorship and clinical skills development opportunities, and the potential for a new SN clinical career ladder was proposed within one SN group. These findings were supported and reinforced through wider consultation. The consultation enabled further opportunity to hear participants emphasise the importance in valuing and recognising the SN role within a nursing career framework.

4.5 Conclusion of Findings

This chapter has enabled a rich insight into perspectives of nursing talent and clinical nurse's experiences and perspectives of Talent Management. This has been analysed within an organisational context, including documentary sources, multiple focus groups and the perspectives of three Executives. Three themes have been presented from within the data; Nursing as Talent, Ward Leadership and Culture and Career Development. Data has been compared across the different case study sources.

Under the first theme 'Nursing as Talent', TM was described as an unfamiliar concept to nurse participants. A multiplicity of nursing talents emerged which revealed the contextual nature of nursing talent. Nursing talents included; leadership skills, a patient-centred focus and professional knowledge and skills. Nursing talent was discussed as a sum of multiple skills rather than individual attributes. There was felt to be a lack of recognition of nursing talent and concerns about a negative media image. Participants described nursing as devalued in a professional context, which influenced public perceptions and recruitment and retention in to nursing. The findings reflected issues outlined within the literature review associated with a gendered perspective of nursing.

The second theme presented 'Ward Leadership and Culture'. The influence of the WS and the workplace culture they created on the ward were seen as integral to the success of Talent Management. Experiences were variable and the pressures of the clinical environment were described as impacting on the ability of WSs to release staff for development opportunities. There was evidence that some individuals were labelled as disruptive, particularly within a culture where their talents were not valued or recognised. There was a need to involve and engage frontline staff, creating an inclusive workplace culture where all staff felt valued, not just those

identified as high fliers. The needs of BME staff were identified as integral to developing an inclusive approach to Talent Management.

'Career Development' was the third and final theme. Existing narrow perspectives of nursing careers focused on the traditional ward management route and experiences of development varied across the organisation. There was a preference for clinical specialist careers and yet a consistent lack of awareness of how to access these, or other potential nursing careers. There was dissatisfaction with the quality of individual appraisals. The WS role was an unpopular career choice for more junior nurses, due to the observation of administrative pressures and yet the WS focus group enjoyed the influence their roles enabled. The need to value and recognise the SN role, as a career choice in its own right was identified by SN participants.

Therefore, an emerging and multidimensional relationship between the manager, the individual nurse and the organisation has been described as influencing experiences and possibilities for TM, within the case study data. The findings reflected the importance of context in TM and a complexity in defining talent in nursing. There was a responsibility identified for individual intrinsic motivation, for nurses to lead their own development. However, there was also two other important influences; firstly the skills of the manager as a talent developer and secondly the responsibility of the organisation in creating an inclusive environment where nursing talent was valued, recognised and nurtured. In the next chapter these findings will be discussed in the context of existing literature and considered from the theoretical perspective of nursing as a gendered occupation

CHAPTER 5: Discussion

5.1 Introduction

This study has explored Talent Management within one case study organisation. It aimed to provide new insight and knowledge into how TM is emerging as a concept within nursing, and explored clinical nurses' perceptions and lived experiences of Talent Management. The study has achieved these aims, identifying areas for further research and contributing to a new understanding of TM in nursing. One of the primary purposes of a DHSci is to show the direct relevance of the study to professional practice. In this case, the findings have contributed to wider regional and national discussions in nursing and provided new knowledge that informed planning for an approach to TM in nursing within the case study organisation. My findings provide valuable insight in to the views of clinical nurses on TM within an acute care NHS organisation and have wider relevance within the nursing leadership and workforce development literatures. Three themes emerged from the data; Nursing as Talent, Ward Leadership and Culture and Career Development. Triangulation of findings from the different sources within the case study data enabled enhanced validity and trustworthiness of the conclusions made.

The following sections of the discussion examine the findings of this study within three main strands relating to the research questions;

1) How is talent defined within nursing (by case study participants)?
2) What characteristics are used to identify talent in nursing?
3) How do clinical nurses (pay bands 5-7) describe the challenges of attracting, developing and retaining talented nurses in an NHS organisation?

4) Is there a difference between senior leaders' perspectives (Trust Board level) and NQ or junior nurses' perspectives in terms of definitions, career aspirations and expectations of TM in the NHS?

The first section examines how talent is defined within nursing and what characteristics are used to identify talent in nursing. I contend that nursing talent is a contested concept and influenced by a gendered view of the profession (Davies, 1995). The second section considers research question 3. It discusses the invisibility of nursing careers and the preference of participants for clinical careers. Finally, I consider the importance of nurses feeling valued and engaged within an organisation, and the enablers and blocks to the development of talent in nursing. This addresses research question 3. I present the important role of the manager as talent developer, a need to value inclusivity and diversity of talents and the risk of being labelled as a 'disrupter'. Where there were differences between senior leaders' perspectives and NQ or junior nurses (question 4), these are identified within each section.

This study presents a novel contribution to the nursing literature, where there is a lack of empirical research on TM in nursing; this requires further study and consideration more broadly than the case study organisation. The final chapter concludes with recommendations including implications for practice and further research, personal reflection and conclusions.

5.2 Nursing Talent: a Contested Concept

5.2.1 Defining talent

The first research question investigated how nursing talent was defined in the case study data. In chapter 2 reaching agreement on required talents was identified as an initial starting point when developing TM within an organisation. The complexity of participants' views reflected a number of longer-standing debates within the literature. In the first instance, whilst beyond the remit of the discussion, defining nursing remains as complex as that identified by the RCN (2014). Clarity around the concept of nursing is an ongoing debate and only serves to 'cloud the waters' for those involved in supporting career development and TM more generally. Within the case study, nursing talent, and how it was defined and recognised, were viewed through different organisational lenses. This reflected the influences of different clinical contexts, roles and workplace environments. The findings suggest challenges in defining talent and enabling a consistent approach to TM in nursing. As presented within chapter 2, this is an area of inquiry that has, until now, received insufficient attention within the literature. This study presents nursing talent as a contested concept, with evidence of a lack of local or nationally agreed standards or definitions of nursing excellence.

These study findings contribute further evidence of the diversity of nursing talents and specialisms. This suggests that diversity of talents in nursing may indeed enhance richness and variety in nursing careers. The multiplicity of nursing talents described by participants may be particularly important in recognition of the diversity of nursing roles required to achieve transformation of the NHS with new models of health and social care (NHS England,2014).

5.2.2 Multiplicity of nursing talents

Within the business and HRM literature, it is evident that talent is contextual in nature; this influences the definitions used. This is congruent within the findings of this study, where evidence of complexity in defining nursing talent was frequently reported, and importantly, many nurse participants did not initially identify the skills and knowledge that they possessed as 'talent'. Participants described a multiplicity of talents, with the focus groups acting as a stimulus to thinking about talent in nursing. They debated how these skills, attributes and knowledge were perceived by nurses and others outside of nursing, including the media and public image of nursing. In addition even within nursing, what may be highly regarded as talent within one work environment, may not be valued in another. This is explored further in this chapter (section 8.4.2), when considering 'organisational disruptors'.

Within the findings a diversity of talents were described including; leadership skills, personal values, professional knowledge and clinical skill. '*…it's a multitude of different skills that all blend together to make that whole person the talent that they are at nursing*.' **(Gp1p3p11).** Across the data participants included caring as a nursing talent. The Executives, familiar with TM terminology identified similar attributes to the nurse participants including caring, interpersonal skills and clinical skills. In addition they emphasised leadership and wider talents required for different nursing roles, such as those in education and research. This concurs with the findings of Tansley (2011), who in attempting to define talent, suggested that talent is more than individual attributes, skills or knowledge, questioning what distinguished those with and without specific talents? As previously discussed, Ulrich (2006) identified that the difference in talented individuals, was their ability to use their skills and knowledge to contribute directly and

proactively to the success of a company. Similarly the notion of talented nurses influencing and making a difference in practice was reflected in the findings of this study.

This study offers a new perspective of nursing talent, one which did not align to a job role, speciality, or level within a nursing hierarchy, and was more than individual skills and attributes. In this study talented nurses were described across all qualitative data sources as demonstrating leadership, knowledgeable, advocating for patients, influencing change, challenging poor practice and leading a team; '*…everybody wants to work with them, if I was ill I would want to be nursed by them…they're very organised but they still have a fantastic rapport with the patients (yeah)...'***(Gp2p2p5)***.* Talented nurses were admired and respected as positive role models; participants' described how they would want nurses with these talents to look after a member of their own family. Such characteristics of talent in nursing invoked a sense of professional pride and respect from peers. The importance of role models has been described in forming professional identity (Henderson, 2002; Maben et al., 2007), this is not limited to nursing as a female dominated occupation. Ibarra's (1999) study of junior consultants and bankers described the socialisation of new professionals and the importance of having positive role models at this time.

As with other occupations, in order to be accepted on to the professional register for nurses, a student must demonstrate evidence of achievement in the required areas of competence at point of qualification. The question remains, regarding when a competency to undertake a skill or professional role becomes a talent, and poses an interesting consideration for TM in nursing. Prior to this study, the notion of nursing talent within the concept of TM had not yet been robustly investigated. It is debateable that achieving professional registration would mean that all nurses are

therefore equally talented. Indeed, across the diverse specialities of nursing, this study identified that knowledge, skills and abilities varied considerably. From an inclusive philosophical perspective on TM (Swailes, 2013), it would be suggested that professional registration indicates a level of talent in nursing, when compared, for example, to a different occupational group. Therefore, once again the importance of context when defining talent is evident.

In chapter 2, the philosophical approach taken towards TM within an organisation was described as influential in defining 'what is talent?'. Chapter 4 identified concerns expressed by Executives on the limitations of exclusive TM models with restrictive, competency-based TM systems that may act as organisational barriers. There was agreement in this study that TM must allow for flexibility of talent development. The TM literature cautions against creating narrow definitions of talent that may restrict flexibility and innovation as organisational needs evolve (Tansley et al., 2007). Therefore it could be proposed that broad domains of nursing talent provide a more appropriate starting point for organisational analysis of TM, rather than more detailed competency frameworks that result in segmenting staff groups. In addition, there is growing support within the TM literature for identifying measures of success for TM (Ross, 2013) as a key enabler of business advantage, as opposed to focusing on defining talent. Indeed, involving staff and other stakeholders in defining required outcomes and talents is now positioned as integral to an inclusive approach to TM (Thunnissen et al., 2013). This study provides new evidence from within an NHS organisation of opportunities for recognition of a diversity of nursing talents within TM and consideration of desired outcomes.

As in other studies undertaken in the public sector (Tansley, 2011; Powell et al., 2012; Turner and Kalman, 2014), participants within this case study contested the value of exclusive approaches to

Talent Management. A more inclusive approach, such as that described by Swailes et al., (2014) was preferred by participants in this study, with all employees viewed as having potential talent and greater recognition of team achievements. This study provides new evidence on the notion of nursing talent and priorities for an organisational TM process within an acute care NHS Trust, specifically from the perspectives of nurses. It offers greater 'face validity' through engaging the voice of clinical nurses, a hard to reach group within a large hierarchical organisation and identifies a lack of empirical evidence considering nursing as talent and the relevant measures of success for TM in nursing. Utilising a case study approach has enabled a new depth of enquiry on TM in nursing, an emerging concept, within a real world social context (Yin, 2009). As presented in the findings (chapter 4, section 1) 'caring' was identified as a nursing talent across all qualitative data sources. Within this contested context I will go on to consider caring as talent and some of the different perspectives on caring. I will outline how, within this study the public image of nursing was felt to be influential for TM, as an emphasis on 'caring' influenced expectations of nursing as a career choice and nurses' self-image.

5.2.3 Caring as Talent

It is evident that whilst this study identified that nursing talents consist of a wide range of knowledge, skills and abilities, the notion of care or caring was central when considering nursing talent. How caring was then defined reflected the debate within the literature. Davies (1995) and Abbott and Meerabeau (1998) described the close association of nursing with caring perceived to be a "natural female" characteristic. The image of a poorly educated female workforce undertaking basic caring tasks, perpetuates the notion of caring as a gendered concept (Davies, 1995). Swanson (1993) utilised the term 'informed caring' to distinguish the difference

between the knowledge required to deliver professional nursing care learned through training, with the care provided by lay people such as family and carers. This study supports evidence of a lack of recognition of nursing talents, associated with a gendered notion of nursing. Clinical participants initially found it hard to consider what they did as talent; they described feeling unrecognised for their skills and abilities and commonly devalued what they did, associating nursing with innate attributes. This included WSs as senior clinical leaders; '*I suppose caring isn't a talent really is it… its part of you…I'm a caring person by nature I'm not talented*' **(Gp3p4p3)**. Nurse specialists also animatedly debated nursing talents describing 'life skills' and 'innate' traits, therefore potentially devaluing the knowledge required for a professional role. With this study only the experienced SNs (Gp8) defined and discussed caring more specifically from a professional perspective, recognised as distinct to the caring undertaken by lay people. '...*it's giving the impression, making that patient feel cared for and showing the relatives that kind of professionalism.'***(Gp8p3p2)**. Through the gendered predicament of nursing Davies (1995), suggested that the value of nursing work and knowledge has been diminished. She described how this had influenced the importance accorded to nursing work within an organisation and reduced nurses' self-concept. The data within the current study presents new evidence in relation to the potential influence of these concerns when applied to TM in nursing

As outlined in chapter 2, within TM the challenge with limiting talents to skills that are innate or personal traits is that it can restrict expectations of talent to a particular group or culture. This can perpetuate bias and reduce attraction to particular roles or careers, deterring more diverse applicants. McAllister et al., (2014) identified the centrality of caring to nursing and that where caring

was viewed as an innate ability, there was a continuing risk of it being associated with women, reinforcing stereotypical perceptions of nursing as a gendered occupation. This has led to challenges when nursing sought to be recognised as a profession in the traditional sense (MacDonald, 1995). These are important considerations for TM in nursing as potentially influential in recruitment and retention. Whilst the national nursing strategy (NHS England, 2012) emphasised the centrality of compassion in healthcare, there were criticisms of this for simplifying the complexity and context of nursing (Traynor, 2014). This study supports findings of existing research which identified tensions faced by nurses where there is an expectation of a 'caring' nurse delivering person-centred, compassionate care, whilst also required to work in a challenging, economic and performance focused healthcare environment (Doherty, 2009). Maben (2008b) also described how, within a culture of audit and performance measures, there was a risk that caring became invisible.

Following the Francis Inquiry (DH, 2010e) there has been a greater focus on values-based recruitment in nursing, aiming to recruit students with caring values, compassion and humanity (HEE, 2014c). Wood (2014) suggested a risk of setting up false expectations and increasing attrition at point of qualification and transition in to the workforce. The findings here provided support for these concerns, with evidence of SNs reporting frustration at the increasing pressures of the ward environment where they were unable to deliver the care they wanted to provide; '*…if there is another patient who is more of a priority [mmm] at that specific moment in time [yes] than another patient, but that's not our fault…'* **(Gp8p6p3)**. This reflects findings of previous research, which identified a disillusionment and dissonance, faced by NQ nurses when experiencing the realities of clinical wards (Maben et

al., 2006). This will be further explored later in the discussion (section 5.4.2).

This study offers a new contribution, engaging clinical nurses when considering how talent is defined within nursing and identifying a continued association with innate female attributes. When aligned to gendered occupations such as teaching, social work and nursing, caring remains stereotyped and associated with work predominantly undertaken by women employed within '*state bureaucracies*' (Abbott and Meerabeau, 1998,p.10). This study identifies a gendered perspective as potentially influential when considered within a TM process in nursing. In a competitive global employment market, where nursing aims to increase recruitment and widen diversity in recruits, I suggest that these different and contested perspectives of nursing talent influence media representation and both professional and public understanding of nursing. This study identified a limited understanding of the diversity of nursing roles from nurse participants, potentially influencing retention and future career choices. This poses challenges that require consideration within TM and are examined in the following section.

5.2.4 Gendered images of nursing and talent

As described in chapter 2, there are long-standing, socially constructed perspectives that present gendered and stereotypical images of nurses and nursing within the public domain. The primary starting point for this case study focused on the advice given to a highly motivated NQ nurse by an experienced WS, that they should consider medicine, as they were 'too clever' for nursing. These findings illustrate how nurses, and those external to nursing, continue to have varied views over the levels of academic ability required in nursing. This is in spite of increasing evidence that identifies an association between degree level education in nursing and improved patient outcomes (Aiken et al., 2011; Aiken et al.,

2014). From a gendered perspective of occupations, this notion of a low level of academic ability required in the nursing workforce is not seen as surprising. The subservience to medicine, resulted in devaluing of nursing as unintellectual '*women's work*' (Speedy, 2002,p.129). This study identifies this as an important consideration for TM in nursing and how talent is defined. The importance of leadership skills and professional knowledge were recognised as nursing talents. Staff Nurses (Gp8) reflected the importance of clinical knowledge and decision-making skills; that nursing talent was the ability to recognise and act on findings '*…rather than just looking at it and thinking right here you go doctor…*' **(Gp8p2p5)**. Newly qualified nurses described '*…if somebody's good at judging and making key decisions,..'* **(Gp6p10p11).** These findings identify wider and diverse talents than those associated with the image of a gendered occupation.

Participants frequently described the impact of media and public perceptions of nursing talent with a sense of frustration. In one focus group exasperation was expressed that even family members did not understand what nurses did, '*you wipe bums*' **(Gp8p1p8)**. Chapter 2 examined the challenges presented in the media over the need for nurses to be educated. The findings of this study add to this understanding, identifying that clinical nurse participants were concerned that negative images within contemporaneous media, particularly following The MSFT Public Inquiry (2013) could further influence recruitment to nursing. One group expressed feeling demonised by how nurses were portrayed in the media, '*nurses kill people*' **(Gp8p6p8)**. Wider consultation supported these concerns '*sometimes we daren't say we are nurses'***(TO3)**. Salvage (1985) described the most commonly held, stereotypical views of nurses within society as represented through the eyes of men, being; '*angels, battle axes and sex symbols*' (Salvage, 1985,p.20). From a

gendered perspective, where the focus is on nurses as 'angels' undertaking a vocation, when women then fail to live up to these societal expectations, they are viewed failing to fulfil their calling. Seen through the lens of a gendered occupation it becomes clearer why these stereotypical images of nursing perpetuate. They bear little representation of the reality of nursing or wider organisational or system failures (Traynor, 2014). It is suggested that with such a gendered history and a morally-based discussion of nursing work, nursing may expect polarised media treatment (Traynor, 2014). When considering research questions 3 and 4, including the challenges of attracting talented nurses and aspirations for TM in the NHS, this becomes an important consideration for TM in nursing. Within a competitive global employment market attracting, retaining and developing a workforce with the skills, knowledge and abilities to meet future population healthcare needs is an NHS priority.

This study revealed evidence of dissonance between the organisational perspective on nursing talent and the experiences described by clinical nurses at ward level. In the focus groups, and through wider consultation, SN participants spoke of the need to value and recognise the bedside SN role as a career choice in its own right; '*we don't think talent management is always about getting people right to the top*'**(Gp3p3p5)**, '*the talents of day to day nursing need to be recognised not just academic*'**(TO3)**. The Executives readily described the professionalism and value of nurses; their impact on patient experience and quality of care, the core clinical role and the potential wider career pathways open to nurses. However, nurse participants did not feel nursing talent was adequately recognised or rewarded. They reported inconsistent experiences of feedback, recognition and support at ward level. From the perspective of a gendered occupation, groups such as nursing (traditionally undervalued within a large hierarchical

bureaucracy such as a hospital), may be offered more recognition, value and career development within an inclusive culture of Talent Management. The advantages of maximising the potential of the full workforce are suggested as enabling an organisation to respond more rapidly to changing business contexts (Swailes, 2013). This study provides new evidence that an inclusive approach to TM offers possibilities for TM in nursing within the NHS. Broader awareness and visibility of the diversity of nursing roles, associated talents and development opportunities, both clinical and academic warrant consideration within TM in nursing. In addition, this study contributes new knowledge in recognising that the different, socially constructed, perspectives on talent, and varying approaches to TM (as outlined in chapter 2) have not yet been researched or evaluated within nursing.

5.2.5 The Influence of Image

As an exploratory study of TM in nursing, the findings provide new evidence in relation to the concerns of clinical nurses regarding attracting young people and the importance of the image of nursing within a TM process. 'I*t's about reclaiming pride in our profession*…' **(Gp7p13p3)**. As presented within the literature review (chapter 2), current global nursing shortages are resulting in a need to focus on the recruitment and retention of younger people (Fillman, 2015). Promoting diversity and attracting recruits with the right values skills and talents in to nursing is an important national workforce priority (HEE, 2014c). Health Education England (2014b) data identified the average age of a nursing student as 28 years old which will have implications for future careers and nursing roles if younger recruits are not attracted into nursing. The lack of attraction to nursing as a career for school age students has been suggested as emphasising an important need for work experience that presents the reality of different careers available (Neilson and

McNally, 2010; Fillman, 2015). This study provides further evidence of concerns about the representation of nursing as a low academic ability occupation and the potential impact this may have on new recruits. Ten Hoeve et al., (2014) advocated greater visibility to promote nursing as a more attractive career choice. The findings of this study supported the need for nurses to take a more proactive role in promoting their roles *'…you don't see very many nurses out there in the media saying, well actually this is what we do…'* **(Gp8p8p3)**. Whilst degree level training is now established across the UK and applications to training programmes are increasing, a shortage of registered nurses is continuing to provoke national debate on workforce solutions (RCN, 2015b).

Where nurses perceived there was a negative public image of nursing, Ten Hoeve et al., (2014) identified this could influence a low self-concept and professional identity. If the ambitions for the nursing workforce within NHS policy are to be realised, these are important considerations within the concept of TM in nursing. These findings revealed the importance of negative public images of nursing and how participants felt this impacted on the views held by patients, carers and politicians. Marlow and McAdam (2013) described how the development of self-identify is through both an individual's internalised dialogue and through socially situated context and culture. They discussed the potential influence of gender within different work contexts and whether an occupation was traditionally socially perceived as feminised or masculine. When analysed as a gendered profession Davies (1995) identified a low self-image and esteem as characteristic of an oppressed group such as nursing. This was evident within focus group data from this study where nurses described being unable to recognise female traits as talents, often being unassuming and not pushing themselves forward '…*we're just wall flowers aren't we…'* **(Gp3p4p5)**.

Andrew (2012) identified how media stereotypes of the image of nurses, political influences and polarised professional views had led to a more confused picture of professional identity in nursing. Indeed, online responses to an article within the nursing press outlining the new RCN CEO's commitment to an all-graduate profession (Ford, 2015), illustrated the heated level of debate that continues within nursing contesting the need for academic qualifications. The responses reflected in-fighting suggested as behaviours of a disempowered group such as a gendered occupation (Davies, 1995). It could be that arguments within nursing, played out on the public stage of social media, do not necessarily strengthen the public image of nursing as an attractive career aspiration. In addition to public perceptions of nursing, Emeghebo (2012) identified evidence of limited understanding between nurses of the work of nurse colleagues within other clinical areas. A cycle of low self-image was described, suggested as a key factor in influencing how the wider healthcare team perceived nursing (Emeghebo, 2012). Focus groups in this study did not refer specifically to their image within the local multi-professional team, but did identify challenges where nurses did not value talents required in different specialities and where there were public misconceptions. This is the first UK study to examine this concern of image within the context of TM in nursing. These findings reinforce evidence that the image of nursing and the talents, skills and abilities required of nurses remain situated in a contested context.

The importance of public image and understanding of nurses' roles is further illustrated when communicating with patients, in enabling informed choices about their care. These findings identified concern that the public did not understand nurses' roles. They provide evidence to support the challenge outlined in chapter 1 of a confusing arena of job titles for specialists, practitioners and

advanced clinical roles. Ten Hoeve, Jansen and Roodbol (2014,p.295) identified a '*diverse and incongruous*' public image and an invisibility of nursing in the public domain. Where there is a lack of clarity in patient expectations of nurses, they identified this could result in confusion for patients. In an increasing culture of measurement and evaluation in the NHS, it is important that nurses can demonstrate the positive benefits of their roles on patient experience, quality of care and financially within an organisation (Manley and Titchen, 2012;Buchan et al., 2013).

These case study findings suggest the continued influence of the image of nursing viewed as a gendered occupation. They demonstrate a contested nature of nursing talent both within the public and professional domains and support existing wider national evidence of a need for further action to promote a positive image of nursing and improve public understanding of nurses' roles. They recognise the notion of caring as central to nursing and the influence this then has on public and media perceptions of nurses. This study identifies that clinical nurses expectations of TM include, the need for nurses utilising diverse talents to be more visible within the workforce and wider public domain, demonstrating their contribution to patient care. In addition, across focus group findings there was an identified desire to work in a successful organisation with a positive image and reputation, in order to attract and retain talented nurses. Within TM, the importance influence of the organisation's reputation for nursing was also identified by one of the Executives, as a means of attracting other nurses to work within the organisation.

These findings provide new evidence of opportunities and challenges for TM in nursing. I suggest possibilities for TM relating to recruitment and retention of the workforce and the influence of image as an important consideration in presenting an accurate

representation of nursing in contemporary healthcare. However, the findings identified a lack of wider awareness both within nursing as an occupation and the public arena as to the talents and career pathways available. This lack of visibility of nursing careers will now be explored in more depth.

5.3 The Invisibility of Nursing Careers

When exploring research question three (identifying the challenges of attracting, developing and retaining talented nurses in an NHS organisation) a confusing picture of nursing careers emerged from the case study data. The findings identified a lack of awareness of the diversity of nursing careers available and concern that this potentially influenced the recruitment and retention of nurses. Nurses had little awareness of new role developments in different healthcare settings with the implications of NHS national policy, '..*we don't know what we could do in the future*.'**(Gp1p7p3).** Davies (1995) outlined a lack of value and investment in education and career pathways as characteristic of a gendered occupation.

The participants in this study described an inconsistency in experiences and a lack of understanding of how to access different development opportunities; Allen (2001,p.178) identified previously that, '*nursing has yet to find an adequate language with which to articulate its function and thus elements of it remain invisible to those outside of the occupation…*'. This was further supported by a study involving Irish nurses (Butler et al., 2006) which identified the invisibility of nursing work and a need for nurses to be able to articulate their contribution to patient care. The new roles and skills that nurses are undertaking to improve patient care and experience continue to be described as invisible within the public domain (Allen, 2014; ten Hoeve et al., 2014). Moreover, within the case study findings, with the exception of progressing to a WS role, there was also an invisibility of nursing careers from the perspective of the

nurse participants, '*you don't know what's out there, you don't know what you don't know.*'**(Gp7p5p4)**. This lack of awareness of opportunities risked influencing participants' career aspirations and failing to maximise the full potential of nursing talent, a concern also reflected within national reviews of nursing (DH, 2006; DH, 2010c; The Willis Commission, 2012; HEE, 2015). Unlike medical post-graduate education, where there are national specialist career pathways and education frameworks (General Medical Council, 2010); in nursing post-registration education and career pathways are frequently left to local commissioners for investment and implementation, resulting in an inconsistent and confusing picture (Rafferty et al., 2015b). This study presents new evidence of important considerations for TM in nursing identified by participants, including; a need to increase the visibility of nursing careers both within the public and professional arenas, develop clearer career pathways and the importance of continuing professional development opportunities.

The need for expert knowledge, specialist skills and autonomy in practice are primary characteristics of a profession in the traditional sense (MacDonald, 1995). Davies (1995) identified how this more traditional view of a profession valued an elite body of knowledge and social exclusivity. The majority of participants in this study did express a preference for clinical specialist careers, over managerial skills. The findings identified very limited awareness of alternative career opportunities other than the WS and Matron management route. The lack of clarity in career pathways is not a new challenge in nursing. Clay (1987) described a clinical nursing career pathway as a 'chimera', something sought after but never achieved. It is therefore interesting that in spite of national policy developments and different advances in clinical nursing roles over the past 30 years, for nurse participants within the case study, there remained

an invisibility and lack of clarity in how to pursue a clinical nursing career. In the UK, advanced and specialist nursing roles are emerging more rapidly and yet there remains an inconsistency in definitions and expectations of roles (East et al., 2015). Indeed within this study, both nurse participants and Executives expressed concern that routes into nursing careers other than management were unclear. Moreover participants suggested a need for access to individual careers advice locally, within the organisation.

The findings identified differences in how nursing careers and medical careers were perceived by participants. Maintaining clinical skills as a senior nurse was described as difficult to sustain in roles other than as specialist nurses; '*The higher up in nursing you become, the further and further and further away from your practice you are and in the end you can't actually practice, even though you are Head of Nursing*'**(Gp8p9p4)**. In addition this study identified that unlike senior medical roles, nurses aspiring to senior nursing careers (Band 7 and above), reported a level of concern about job security and saw nursing roles as vulnerable to organisational restructuring. Within a recent national review of nurse education in England, Lord Willis linked feeling valued with the investment and attention given to nurses career models; '*registered nurses….should understand that, like other professions such as medicine, there is a commitment to them as a valuable member of the team*' (HEE, 2015,p.4).

The findings of this study provided evidence of challenges for the predominantly female participants who were balancing career development and home/life responsibilities. Family responsibilities were discussed as influential in career decisions and working hours. This reflects Davies' (1995) description of career development and career structures within male dominated organisational hierarchies, where women with flexible needs and a lack of geographical

mobility are not naturally accommodated. Nursing has a '*patchwork labour force*' (Davies, 1990,p.10) with many part-time workers and episodic periods of employment within hierarchical organisations. These employment characteristics remain relevant within nursing in a contemporary context and this study provides new evidence of the potential influence of this when attracting, developing and retaining talented nurses within the emerging field of TM in nursing. The TM literature has identified the risk of silo thinking limiting the potential for talent development in and across organisations.

The Shape of Caring review (HEE, 2015), suggested an increasing diversity of professional development needs with greater movement of nurses across healthcare and social care boundaries. In addition Powell (2014) identified a lack of empirical study into TM within the NHS and challenges due to the fact that, whilst theoretically one system, the NHS is made up of a diversity of providers with varying organisational cultures. There is potential for NHS commissioning processes to result in further diversification of providers and increased competition for nursing workforce. This changing NHS context is an important consideration for TM in nursing as influences workforce planning, recruitment and training needs, both within an organisational and wider healthcare community context. The importance of organisational leaders and human resource colleagues working together to develop TM processes to meet future business priorities is identified. Participants across all groups and wider consultation in this study discussed a need for increased opportunities for job swaps, secondments and rotational posts, to enable insight in to different roles, career development and a more flexible workforce with transferable skills. In addition Band 6 and 7 participants identified the potential for experienced nurses and those not able to relocate geographically, to learn from national and international networking, '*…for those who don't want to kind of*

*move up the ladder…'***(Gp5p5p2)***.* They reflected on the importance of an inclusive approach to TM, recognising and retaining a wider diversity of talents in the nursing workforce.

As described within chapter 1 continuing professional development (CPD) is an integral requirement of professional registration and revalidation for nurses within the UK (NMC, 2015). The invisibility of career pathways also influenced variability in access to speciality training both in-house and formal university courses. Chapter 1 outlined how the KSF was launched with optimism as a single NHS development framework, to enable flexible career progression (DH, 2004c). Analysis of the case study organisational policy confirmed that a KSF job profile was required for each role and it was referenced within the organisation's appraisal document. However, it was not referred to at all within any of the qualitative data sources. It is evident that the KSF is not included within subsequent national policy reviews of nursing, or within the more recent Shape of Caring review (HEE, 2015), where a new model of nursing postgraduate career pathway is proposed. This study reinforces that nursing post-registration careers remain variable, inconsistent and invisible. Within a healthcare context where nurses are increasingly delivering NHS services in a plurality of health and social care settings through diverse providers, the NHS KSF may not meet the changing needs of contemporary careers.

In this study the most visible nursing career pathway was the route to Ward Sister. This was viewed as inevitable for those who wished to progress on the '*conveyor belt*' **(Gp2p4p5)** of ward nursing. The WS was not seen as an attractive role to more junior staff who described the role as '*just a manager*' **(Gp4p2p4)** and '*a thankless job*' **(Gp2p2p8)**. This negative perspective of a management career in nursing reinforced the views of Davies (1995), that nurse managers were seen as administrators within an NHS bureaucracy,

taken away from being visible both to junior staff and patients. In her research on the division of labour in hospitals, Allen (2001) found one reason for junior nurses' discontent was the time senior nurses spent doing paperwork, which they did not see as '*real work*' (p.64). Junior nurses wanted more control over their clinical work, but also wanted the WS to be visible for leadership support. This study presents further evidence to support the literature, with the tension between managerial visibility and time taken for paperwork clearly described. The participants in this study also outlined the contemporary pressures of meeting organisational performance and productivity targets within the NHS, *'They come and say, you've only got 90% you need to score better…'* **(G4p8p6)**. This continual pressure coupled with administration responsibilities, resulted in a lack of attraction to a managerial career pathway and supports similar findings of previous national reviews (DH, 2010c;RCN, 2009). Whereas the pivotal role of the WS as clinical leader was emphasised by Executives and the influence of the WS on the wider ward team was described across the findings. This illustrated the importance of further research into talent spotting for those aspiring to WS roles and leadership development for WSs within TM in nursing.

The need for ensuring effective nurse leadership in the NHS was identified within chapter 2 and succession planning as one component of a cyclical TM process. Interestingly these findings presented new evidence that the WS focus group reported enjoying their jobs, '*I know that I can make a difference now…*'**(Gp3p9p4)**. They also acknowledged they were high-pressure roles and required support from senior managers. However, this enjoyment was not visible to the majority of others, including Deputy Sisters. This supports the findings of Wong et al., (2013) who identified that a large managerial workload put more junior nurses off leadership

roles in nursing. Stivers (1991) described a conflict between managerial roles and the professional identify that nurses have with caring, suggesting that a culture of managerialism created a tension for nurses who are balancing both roles of clinician and manager. Following the MSFT Public Inquiry (2013) and the national focus on the WS as a visible clinical leader, it is evident that national recommendations on the implementation of supervisory status for the WS aimed to address some of these challenges (RCN, 2010a). The findings of this study provide further support for reducing the administrative burden on the WS role, '…*give her a PA to do all the paperwork…'***(Gp2p8p2)**. One NQ nurse saw the potential for influence as a WS, '…*people will listen to you more'* **(Gp1p7p9)**. This study presents new findings when considering possibilities for TM in nursing, recognising potential to lead within an inclusive culture and creating a more attractive career path for talented nurses aspiring to this important clinical leadership position. Within an acute care setting the invisibility of nursing career pathways has been described from different organisational perspectives. As outlined earlier in this section, the study findings identified the participants' preference for clinical nursing careers and within the context of a gendered occupation this will now be analysed further.

5.3.1 The Polo Mint Problem Revisited

As introduced in chapter 2, Davies (1995) described the loss of clinical nursing at the heart of practice as the polo mint problem. She suggested that the organisation of work in a traditional hospital institution devalued the knowledge of RNs and took them away from practice to supervise other non-qualified staff to deliver care. A lack of ability to give direct patient care has been identified as important professional concern in retaining RNs in practice (Nelson et al., 2002). In this study the findings provided evidence of an ongoing tension in nursing explored within all focus groups. Managerial

pressures such as administration and audits were viewed as taking RNs away from delivering direct patient care, increasing office-based work and limiting professional decision-making. One WS noted *'…we are all puppets in some way in what we can do.'* **(Gp3p6p5)**. Antrobus and Kitson (1999) expanded on the view that RNs were being taken away from delivering direct patient care. They suggested that nurses who demonstrated leadership potential migrated '*...to the mint which in this case would be academic, political and management domains*' (Antrobus and Kitson, 1999,p.751). The findings of this study identified similar participants' perspectives and suggested this as a challenge for TM in nursing. How to develop and retain talented nurses who enjoyed clinical roles, when career progression removed them away from practice into more bureaucratic management roles?

Allen (2014) challenged Davies' (1995) model which appeared to recognise practice above other nursing roles, identifying this risked devaluing the other important and often invisible work nurses undertake, including; organising services, facilitating effective communication between different providers and ensuring patient flow through services. Whilst this study identified and supported the diversity of roles nurses undertook with the organisation, within the context of TM it was evident that there was an enthusiasm for the SN role and aspirations for clinically focused careers. The experienced SNs (Gp8) and the wider consultation, described the SN role as an active career choice for many participants. Therefore, whilst in a different context to that described by Davies (1995), participants reflected a similar polo mint problem. It was evident that nurses within the case study continued to see themselves as pulled away from delivering direct patient care due to other work pressures. The desire to develop in their careers and yet stay

clinically focused is an important finding for TM within this case study.

5.3.2 Career Ladders

The analogy of a 'career ladder' was described from different perspectives within the data. The SNs (Gp8) proposed the concept of a career ladder, which enabled the SN to be valued at the centre of a professional nursing career framework. This reflected a model of a clinical career ladder as required within Magnet designated hospitals (ANCC, 2015) and presented a less hierarchical approach to career development. One participant had experienced a recent scholarship tour to the USA. She had observed a process whereby a SN could apply to be rewarded financially, for additional clinical skills and contribution whilst remaining in a bedside nursing role. She emphasised with strong feeling the positive benefits, '*…they're proud to be still clinical [aha] and they've got other roles too, but they're always a nurse…'* **(Gp8p10p4)**. Participants supported this concept of a clinical career ladder as a positive aspiration for TM in nursing.

As presented in chapter 4, one Executive described a preference for a 'career-climbing frame' rather than focusing on a 'career ladder', with less of a drive to move up an organisational hierarchy. The 'climbing frame' was described as offering greater potential for more career flexibility and movement across health care boundaries to develop more diverse nursing talents. The documentary analysis and Executive data had identified a lack of a TM strategy and a preference for a more consistent but flexible approach to TM, *'…we as an organisation have got to do everything possible to allow those individuals, those nurses to feel supported and enabled, rather than the reverse, through the way in which we as an organisation organise ourselves'* **(I1p3)**. The findings of this study identified the

importance of clear career development and pathways of progression.

All the Executive participants articulated the benefits of having a mentor to develop talent, guide and enable career development. Mentoring has been recognised as a helpful enabler, a 'ladder' within talent development in the NHS (Powell, 2014). In nursing, this terminology can cause confusion, with mentor being primarily associated with pre-registration student support (NMC, 2008). Having a mentor was not a concept widely associated with TM in nursing within the findings. This reflected a difference between senior leaders and clinical nurses' experiences and expectations of Talent Management. The DN described how *'…people don't see that there's a connection to 'this will help me achieve my ambition'?'* **(I3p2)**.

A more flexible vision of a career 'climbing frame' with less focus on narrow, hierarchical career progression is an important consideration within inclusive approaches to Talent Management. Research has also identified potential for different generational career expectations in nursing, emphasising again the importance of career development pathways, further research has been recommended (Jones et al., 2015). I suggest that the findings of this case study indicate a potential future frustration between the expectations and aspirations of NQ participants, motivated to progress into clinical careers and yet a lack of clarity in how to access these career pathways. This study identified that clinical specialists enjoyed their roles and had no desire to move on, or were unclear what other career options were open to them. Older, senior nurses may therefore 'block' these positions. The bottleneck scenario described by participants offers new insight in to potential challenges for TM within the case study organisation. In her seminal work 'Men and Women of the Corporation', Moss Kanter (1993)

identified the importance of understanding organisational structures and the power and opportunity afforded to different job roles. She described how within a large hierarchical organisation those with short career ladders, low promotion rates or lack of opportunity became '*stuck*' (Moss Kanter, 1993,p.136) within the system. They perceived they had nowhere else to progress to for future development and reward. This then influenced employee motivation and commitment to an organisation, which have subsequently been identified as important factors in TM (Ulrich, 2006).

In this study whilst individual motivators for career choices varied, opportunities for career development were inconsistent across the organisation and were frequently described as being directly influenced by the immediate line manager and clinical work pressures. The leadership style of the manager influenced the work environment and was consistently discussed as influential on how valued staff felt and the development of nursing talent. This will now be explored further within the final strand of discussion. This includes approaches to staff engagement, the manager's role as talent developer and the contextual nature of talent, which resulted in some individuals being regarded as organisational disrupters.

5.4 Feeling Valued and Engaged

When considering the challenges of attracting, developing and retaining talented nurses, the importance of nurses feeling valued threaded across all themes of the findings. This included; a perceived lack of recognition or reward for nursing talents, inconsistent access to professional development and career opportunities and clinical pressures with evidence of variable support in the workplace environment. This study provides new evidence that nurse participants identified quality audits, performance targets and increasing clinical workload as influential for TM in nursing. These pressures affected a manager's time to

nurture and develop talent and the ability to release staff for development opportunities.

This case study reinforced findings from existing research of the importance of employees feeling valued and engaged in the workplace (West et al., 2014;The King's Fund, 2015a). Participants in this study wanted to feel valued and treated as individuals. One participant observed that the NHS expects person-centred patient care, but then does not provide this person-centred approach for staff development. This was described as an important consideration for Talent Management. Maben (2008a) identified feeling valued as a major factor in employee commitment; this included having access to training opportunities, an appraisal and a career development plan.

Swailes et al., (2014) proposed that adopting an inclusive approach to TM, increased staff engagement and enabled the development of the wider workforce, which expands talent resources available within an organisation. Within this study, the level of engagement and value staff felt, frequently related to the opportunities and future prospects open to them, *'...I had that passion, but it wasn't nurtured.'***(Gp8p7p2)**. The TM literature parallels developments within health research that demonstrate how increased staff engagement and devolved decision making improves patient care. '*Staff who report high levels of engagement communicate this to patients in the way they deliver care and the outcomes that are achieved.*' (The King's Fund, 2014,p.8).

This study provides new evidence from a large NHS Trust including frontline clinical nurses, that reducing organisational barriers to change and engaging staff in decision-making at ward level, are viewed as important when developing TM in nursing. Within an inclusive approach to TM, the ethics of the more widely understood

exclusive approach to TM have been challenged (Swailes, 2013). It is suggested that the benefits proposed within an inclusive model for TM, result in opportunity for those not necessarily considered as talent within narrow definitions of existing hierarchical organisational structures. When considering the gendered predicament of nursing and BME discrimination in the NHS, this includes opportunity for both low status occupational groups and minority groups.

The findings of this study, similarly to the findings of Maben, Latter and Macleod Clark (2007) and Manley et al., (2011), suggested a variation in staff experiences influenced by local workplace environment. Valuing and retaining nurses requires investment and local workplace cultures vary within organisations and have a direct influence on both patient and staff experience (West et al., 2006; Manley et al., 2011; King's Fund, 2014). Executives recognised the importance of middle managers in creating an engaged culture and developing talent; '*…constantly thinking about the talent they've got and you can't systemise that, you can't capture it in a spread sheet.'* **(I2p3)**. There was a reluctance to implement more restrictive or exclusive TM processes within the organisation.

This case study provides new evidence supporting the importance of workplace culture when considering TM in nursing. All focus groups referenced the challenges of working in a large bureaucratic organisation that appeared to sometimes block changes, acting as a barrier; described in one group as the '*wall*' **(Gp5p10p3*)***. Conversely, due to the size of the organisation, one Executive described how it might appear '*amorphous*' **(I1p4)** to some nurses. This illustrated different perspectives of the organisation and potential expectations of TM in nursing. Clinical participants described organisational barriers that prevented talent development in nursing. The Executives identified the importance of creating a

culture where nurses felt connected and aligned to the organisation's values and purpose. This alignment of values has been described as enhancing feelings of purpose and connectedness within a group or organisation (Buchanan and Hucaynski, 1997). Within a large organisation where frontline staff may have very limited direct contact with Executive leaders, the importance of the local workplace culture and influence of the line manager (in the nursing hierarchy), is important in how employees perceive the culture of the organisation. When considering the need for employee commitment and contribution to maximise business performance within TM, this is an important consideration in nursing.

In addition to gender discrimination, the marginalisation and devaluing of minority groups has been described within the bureaucratic nature of organisations (Davies, 1995). The findings identified a specific concern raised by two BME participants during the wider consultation, that in some cases minority groups did not feel valued and did not have equal access to opportunities; '*…made to feel undervalued due to their cultural differences and scope for development is sometimes stifled*'**(TO3).** The lack of BME representation in more senior nursing roles was also identified as a concern by one of the Executives. This was triangulated with other case study data. A review of the staff survey identified evidence of a reduced satisfaction with development and quality of appraisals for BME staff when compared with non-BME staff. This presents an important finding within the case study organisation and is recognised wider in the NHS reinforced through national research (Kline, 2014) and legislation (NHS England, 2015). The findings offer new insight into the importance of recognising BME discrimination within the evolving context of TM in nursing, both within the case study and in the wider NHS. As already identified,

TM and what is defined as talent are contextual in nature and influenced by the style of leadership and culture of an organisation.

From a gendered perspective, reinforcement of bureaucracy with controls such as performance targets stifles the potential for autonomy of professions as traditionally defined (Davies, 1995). Within focus groups and consultation there were examples given of managers who praised nurses for achieving required quality standards such as ward audits. However, clinical participants did not regard this as valuing or developing talented nurses. It was seen as reinforcing hierarchy, organisational bureaucracy and reward for compliance with organisational targets '*…all people are interested in is the figures…*'**(Gp4p7p6)**. Staff Nurses (Gp8) also discussed the emotional and physical stresses involved in nursing, describing the need for self-protection; *'I'm going home crying my eyes out, because I've not given the best care to my patients, but they don't see that…'* **(Gp8p9p5)**. This supports findings of a well-established body of research on the emotional labour of nursing (Menzies Lyth, 1960; Smith, 1992; Henderson, 2001). The evidence continues in a context of increasing workloads and a national RCN survey illustrated increasing levels of stress within nursing (RCN, 2013; RCN, 2015a). This case study provides evidence of the importance of staff well-being integral to TM processes in nursing. In order to attract and retain talented nurses, clinical participants identified there was a need for managers to recognise pressures on staff and provide improved support for the wellbeing of SNs delivering direct patient care.

All focus groups reported feeling valued and engaged when they received positive feedback both from patients and managers. There was recognition of the important influence of the manager's role in creating a positive work environment, developing the potential of their team and spotting and developing individuals with leadership

and other talents. The Executives identified the critical role of managers as talent developers. Whilst WSs recognised a need to develop talent, they did not feel they had time to focus on this due to work pressures. Within focus groups it was also identified that a WS would be conscious that losing a staff member to a different department increased their own agency spend. This was not regarded positively in a culture where vacancies and turnover were seen as measures of ward performance. This study provides new evidence when considering TM as an organisational process within nursing. In the context of increasing national and international nursing shortages, managers who are concerned to retain staff at ward level may reduce talent development opportunities, such as training and secondments.

As identified by Executives, a more systematic and yet flexible approach to TM was required, recognised across the organisation. All Executives described the need for TM processes to be measured and visible within the organisation as integral for the success of TM in nursing, '*Making it important'* **(I3p5)** and '*…develop managers to see that as a legitimate part of their job*' **(I2p3)**. This was in contrast to the variable and more informal approaches to TM described by participants. The line manager particularly influenced participant's experiences and was also responsible for undertaking staff performance review. The annual individual performance review (IPR) meeting was one component of personal development that was discussed across the case study data sources and will therefore now be considered as a component of Talent Management.

5.4.1 Appraisal

Effective staff appraisal in the NHS has been linked with improved staff satisfaction and patient outcomes (West et al., 2002; West et al., 2011). In addition to assessing current performance, a manager should consider the future development and wellbeing of individual

employees (CIPD, 2014). The findings of this study described variable experiences of IPR, related to the knowledge, skills and attitude of the line manager. Participants across qualitative data sources in this study identified that managers needed greater knowledge of what motivated individuals and how to spot and develop potential talent. A range of personal motivators was identified including financial drivers, life work balance, family needs and individuals who were career-focused. Within TM, the need to explore individual motivators that influence career decisions is therefore presented an important consideration in nursing. This reflected findings from a previous unpublished dissertation study on TM in the organisation that involved more senior managers (Cargill, 2011). For nurse participants, there was a sense that the IPR was a 'tick box' exercise. The WSs described it as '*…a paper exercise*…' **(Gp3p8p8)**.

The evidence of a poor quality of appraisals reflected findings of a study of NHS managers undertaken by Powell (2014). It was also identified in the NHS Staff Survey (Picker Institute, 2014), as described in chapter 2 only 38% of staff said their appraisal was well structured, which included; helping them to improve how they did their job, set clear objectives for their work and left them feeling valued. On analysis, the NHS staff survey questions linked to appraisal, did not assess how managers supported talent spotting and future career development, being more focused on current and retrospective performance. This study contributes a new perspective to the TM literature from the public sector in the UK, of the importance of the quality of an appraisal within a TM process for nurses.

These study findings supported the position presented by the International Council of Nurses (2007) and Donner and Wheeler (2006) that individual nurses also have a level of responsibility for

their own career development. This was described by Executives '*…the individual should be the process owner of their own development…*'**(I1p1)** and clinical participants, '*you make your own opportunities*'**(TO1)**. However, across the findings the variable influences of an individual's motivation, manager support and organisational culture were seen to influence possibilities for TM in nursing. The reflects previous studies identifying the need for a supportive work environment, adequate nurse staffing, access to continuing professional development and coaching as important in the motivation and retention of NQ nurses (Maben et al., 2007; Hancock, 2014). Access to preceptorship including working with positive nursing role models, has been identified as important in the development of confident and competent NQ nurses (Whitehead et al., 2013). Careers guidance and support also as assist with nurse retention and increased job satisfaction (Maben and Griffiths, 2008; Philippou, 2014). Within a competitive context of nursing shortages, organisations that provide individualised careers guidance, may become more attractive as employers (Philippou, 2014). This study provides further support of the need for careers advice, but for the first time in relation to TM, identified there was evidence of a wider need including more experienced nurses and those at clinical bands 6 and 7, in addition to early career nurses.

When considering the multi-dimensional factors influencing the development of talent in nursing, the importance of individual motivators, the role of managers and creating an organisational culture where individuals felt valued have been described within the case study data. This reflects literature in the NHS focusing on the importance of increasing staff engagement (The King's Fund, 2014) a philosophy of collective leadership within organisations (West et al., 2014) and a positive workplace culture (Manley et al., 2011; Rafferty et al., 2015a). It also supports the findings of Maben

(2008a) who identified that feeling valued was a major factor in employee commitment. These factors were reinforced by Executives within the organisation, however, experiences, particularly of more junior nurses, did not always reflect an organisational culture that consistently lived those values. I will now go on to consider this more specifically and how local workplace culture was perceived to influence or inhibit the development of nursing talent.

5.4.2 Tall Poppies & Organisational Disrupters

This study has presented definitions of talent and the process of TM as socially constructed, influenced by organisational and local workplace culture. These findings reinforced how talent in one area may be seen as a disruption in another. This included consideration of the notion of nursing talent and ambition. To be accepted within the nursing team there was a need to conform to the ward culture. Talented nurses who did not conform risked being viewed as, '*…a discrepancy that needs to be got rid of…*'**(Gp6p9px)**. This supports findings of previous research involving NQ nurses, which identified that socialization into practice included '*don't rock the boat*' (Maben et al., 2006,p.472) and a process of '*organisational sabotage*' (Maben et al., 2006,p.469). This 'sabotage' included time pressures, role constraints, staff shortages, work overload and task orientation to deal with pressures. Melia (1987) described how clinical pressures required students and junior nurses to be '*…competent, but compliant…*' (p.162). These organisational constraints are described within this case study and continue to reflect Davies' (1995) analysis through the lens of nursing as a gendered occupation. The SNs in this study explored comparable experiences, they described; feeling overwhelmed with workload, requiring task allocation to manage clinical pressures, unable to utilise their professional knowledge to the extent they would aspire to. The participants viewed these factors as important when considering the

concept of TM in nursing. There was an aspiration to recognise and value the SN role, nurturing talent rather than feeling threatened by it.

McCallin et al., (2010) identified that some nurse leaders felt threatened by ambitious junior staff and were reluctant to prepare them for senior roles. Trepanier and Crenshaw (2013) also identified this as a barrier in nursing, where there was a real or perceived threat that the '*candidate was more competent than the mentor*' (p.984). Any scheme to develop future leaders was identified as needing to have strategic organisational support. This raises an interesting concept described over 20 years ago by Bent (1993,p.298) of how nurses '*eat their young*' and was highlighted by the DN in this study as a threat to the development of nursing talent; '*we rely heavily on the ward sisters not to have 'tall poppy syndrome', we rely on them not to chop off the legs of the ambitious go getting nurses*'**(I3p1)**. She described a sense of threat felt by some nurses when faced by a junior colleague with talent and ambition. In the findings there were examples given by junior nurses, where managers were described as able to 'block' and 'crush' talent if it did not fit the expectations of a workplace.

The tendency for '*self-hate and dislike of other nurses*' (Speedy, 2002,p.127) is described as reflective of a gendered view of professions. The failure of nursing to be recognised as a cohesive group, operating in a masculine organisational system results in the devaluing of nursing work. There is greater likelihood of in-fighting within disadvantaged groups who cannot influence the wider system they are in (Bent, 1993; Speedy, 2002). Wake (2013) suggested this presents a contradiction for nursing, creating a 'tall poppy' paradox, reflected here within the case study. Nursing is seeking confident, high profile leaders and yet nurses seem to dislike individuals who seek attention on themselves or their achievements.

The findings from focus groups and wider consultation illustrated a preference for recognising talented teams rather than high fliers. In addition, the groups of more senior nurses reflected on the term 'ambition' as a less favourable description of talent in nursing '*…it's an ambition thing rather than doing good for the service*…' **(Gp5p3p2)**. Ambition was described as pushing individuals forward rather that talent, '*…it feels like it's all about ambition doesn't it a lot of the time (yeah, yeah) you know, who's got the most ambition to succeed*…'**(Gp3p3p7)**. This did to an extent, reflect the concerns of the DN, that ambitious nurses may risk being chopped down if they did not conform to an expected workplace culture.

The findings show that nursing talent is contextual and that the need for conformity potentially suppresses talent and innovation. There was evidence that reflected Schien's (1992) observation of a need to understand reward and punishment systems within an organisation, to establish underlying assumptions of the culture. Also practitioner literature that suggested large bureaucratic organisations were not natural homes for mavericks; "*…we have squeezed-out some of our most gifted people*." (Finzel, 2007,p.74). As discussed within chapter 2, within the NHS the ambition for innovation to transform healthcare and meet the challenges faced by the NHS is advocated (NHS England, 2014). Conversely this is within a managerial culture in the NHS, with an increasing number of national targets to improve productivity and efficiency. This requires the majority of staff to conform and comply, potentially reducing opportunities for innovation. The case study findings indicated a gap between these policy intentions and professional aspirations encouraging radical innovation at a national and organisational level, and the experiences described by individual nurses.

CHAPTER 6: Recommendations and Conclusions

6.1 Introduction

As this study is a DHSci I have specifically analysed the implications for practice and recommend implications for developing an inclusive approach to TM within nursing in the case study organisation. Three recommendations are proposed, these are; clearer career pathways, considering inclusive approaches to TM in nursing and exploring opportunities to define nursing excellence.

6.2 Clearer Career Pathways

The findings of this study identified a need for greater clarity in nursing career pathways and more visible and consistent access to post-registration development opportunities. These recommendations are reflected within the national Shape of Caring Review (HEE, 2015) and gives confidence that these findings are not local to the case study organisation, but may be generalised more widely for nursing in England. Within the case study findings there was evidence of a need for independent careers advice, consistent access to clinical education, preceptorship for NQ nurses and greater recognition and valuing of the SN role as a career choice in its own right. This study presents new evidence that in TM there is a potential risk for the SN role to be viewed as a step on the ladder through to other nursing careers. Staff Nurses identified possibilities for a new, innovative and enabling clinical career framework for SNs, rewarding contribution at ward level. This reflected characteristics of a career-climbing frame described by one of the Executives, encouraging lateral movement and development. There is a need to consider how the SN role is recognised and valued in the organisation in order to retain talented SNs at the bedside in direct clinical care roles**.** The findings also offer a new contribution to the TM literature within an NHS case study, of the

need to improve the skills of nurse managers as talent developers and appraisers.

6.3 Explore Inclusive Approaches to Talent Management

The case study data provides new evidence of the need to explore an inclusive approach to TM within nursing in the organisation and identified potential benefits of increased staff engagement. From the perspective of a gendered occupation, traditional organisational bureaucracies are seen to reinforce masculine stereotypes and disadvantage minority groups (Davies, 1995). Exclusive, elite models of TM may serve to perpetuate an existing organisational culture. From an alternative paradigm, advocating inclusivity and utilising devolved nursing management structures within TM, offers the possibility of recognising and developing greater diversity in talents. These findings identified that an important component of TM for nurses was feeling valued and engaged in the workplace.

Executives in this study identified that local managers may be narrow in their perspectives of what constituted talent and within the case study organisation there was no wider organisational approach to this. Talent management should be developed as a responsibility within all managers' job descriptions. There was a risk inherent within silo thinking in specialties or wards, that the skills and talents required for a future nursing workforce, both within the changing environment of the acute hospitals and community setting, were overlooked. Nurse leaders need to consider TM wider than the boundaries of their own ward or specialist areas and the talents needed in nursing.

6.4 Defining Nursing Excellence and Positive Nursing Image

Nurse participants were proud of their roles but felt unrecognised and undervalued; they did not necessarily recognise their own talents and strengths. They did not have readily accessible points of

reference to describe talent and excellence in nursing. Through discourse they shared experiences and built a perspective of nursing talent. They described nurses who were clinical leaders, role models and patient advocates. In this study the importance of a positive image of nursing within TM related to attracting new recruits and retaining existing staff. The findings of this study provide support for those of Price and McGillis Hall (2013) who identified the need for nurses to influence changes in media representation of nursing; presenting a new image of nursing as a positive career choice that requires intelligence, empathy and greater clarity of the rewards and challenges faced.

As presented within chapter 2 and the discussion, in spite of evidence from a wider international context of improved nurse and patient satisfaction, the Magnet Recognition Program® (ANCC, 2015) for nursing excellence has not been pursued within the UK other than one organisation (Aiken et al., 2008). Within a business focused NHS, consideration of the desired outcomes of nursing excellence including improved patient outcomes and increased nurse retention, offers opportunities for TM in nursing. I recommend the potential for exploring the aspirational Magnet standards for international nursing excellence, in the organisation. These standards include a requirement for increasing SN engagement, investment in education, clear career ladders and measuring continual improvement in nursing empirical outcomes.

6.5 Impact In Practice

The findings of the study informed the development of the organisational Nursing and Midwifery Strategy 2014-17. The Magnet Recognition Program® (ANCC, 2015) standards were utilised as a framework for mapping standards of nursing excellence and identifying gaps for improvement. The Nursing and Midwifery Strategy 2014-17 included; clear aims associated with the inclusive

development of talent in nursing, increasing staff engagement, further development of nurse led research, evidence based practice and measurement of empirical outcomes, an organisational communication strategy and a positive media campaign for nursing. This has influenced the promotion and recognition of nursing talents and encouraged a more positive public image of nursing locally. A Peoples' 'Nurse of the Year Award', developed in partnership with community stakeholders including the local newspaper, encourages community engagement in nominating and voting for individual nurses, recognising excellence in a diversity of nursing talents.

The implementation of an inclusive model of shared governance, including 34 'Unit Practice Councils' across the organisation has increased RN engagement, front line decision-making, impacting positively on improvements in safety and quality in patient care and developed clinical leadership skills and potential at the bed side. The success of this has been recognised through a two national awards.

A summary of these research findings formed a contribution to the national consultation on nurse education (HEE, 2015) and helped to influence the recommendations. These include recognition of the importance of develop aspirational standards for excellence in care and an identified objective to explore the standards for nursing excellence as developed by the ANCC and assess how they may be applied within an NHS context (Appendix 7).

The recommendations for Directors of Nursing include the importance of focusing on inclusive TM as a nursing workforce priority, integral to effective recruitment and retention. Directors should ensure that TM is viewed as important at every level within their organisation, a cyclical and continuous process aligned with the strategic nursing objectives. This includes reviewing existing processes for the effectiveness of staff engagement, feedback and

clinical leadership development within nursing. Directors are advised to review and develop processes for recognition and reward of nursing excellence and ensure a focus on transparency and openness in access to education, career development opportunities and clearer nursing career pathways. For BME nursing staff specifically, the importance of career development and increased representation in nursing leadership roles. In addition, central to effective TM is the need to recognise and value the critical importance of the line manager as 'talent developer', ensuring adequate skills training and support for this aspect of their role and high quality staff appraisals.

6.6 Recommendations For Future Research

The study has identified TM as an under researched area in nursing and yet one of importance in the field of nursing leadership and workforce development in the NHS. Recognising the contextual nature of TM, further study within different case study settings would be recommended including;

- Exploration and evaluation of inclusive approaches to Talent Management in nursing, to start to develop an evidence base for practice.
- Further study and evaluation of means to effectively value and retain the Staff Nurse role as direct care nurse, including longitudinal and cross-sectional methodologies.
- Further study into nursing career pathways and careers guidance
- Further study to identify and recognise excellence in nursing

6.7 Contribution to the Literature

The study offers a contribution from the public sector, whereas the majority of TM literature continues to be from the private sector (Gallardo-Gallrado and Thunnissen, 2016). The primary purpose of

this study was to gain new insight and knowledge in to how TM was emerging as a concept in nursing. The participatory approach enabled the contribution of clinical nurses exploring their views and experiences of TM, identifying what they see as important. Involving employees within an organisation, offers a new contribution to the evolving literatures relating to inclusive TM within the wider business and HRM context. In addition I have analysed the organisational context within which the participants work, including Executives' perspectives. This case study has identified that the concept of TM in nursing was not widely understood by nurse participants. There was not felt to be a culture either locally or nationally where nursing talent was recognised. This study identified further evidence of a lack of clear career pathways in nursing and concerns relating to the image of nursing as a gendered occupation.

The findings presented the diversity and contextual nature of nursing talent as described by participants within the case study. This reflected the findings in TM literature on the importance of context and an organisational approach to Talent Management (Tansley, 2011). The study identifies possibilities for exploring inclusive approaches to TM in nursing. This adds further support to the existing literature that reflects the importance of increased staff engagement, maximising the diversity of talents within the whole workforce. Participants expressed the importance of feeling valued and maximising job satisfaction through greater engagement and involvement of staff in decision-making at ward level. In addition, there was the importance of a supportive, skilled manager and effective personal appraisal to maximise talent development in nursing.

6.7.1 Research Limitations

A weakness of a case study approach is that findings cannot necessarily be generalised to other settings (Yin, 2009). I have

presented TM as a concept that is contextual in nature. A large organisation may have very different challenges for example than a smaller organisation, or a different healthcare context. The intention was not to generalise findings, however the literature review, policy context and wider sharing of my initial findings through regional, national and international conference presentations (Appendix 6), reflected similar issues were evident elsewhere in nursing and were not limited to the case study organisation. This suggests opportunity for wider learning than within the case study.

As an insider researcher there are limitations and a risk of bias (Denzin and Lincoln, 2011), but also benefits are outlined for a case study approach. Within case study an insider research has been shown to be helpful providing more in depth, additional knowledge of the case (Yin, 2009). Mitigating actions were taken to enhance trustworthiness and transparency in the research process as discussed within chapter 3.

Within the boundaries of the case study the focus for data collection was clinical RNs and identified Executives with responsibility for TM strategy. Senior nurse managers were excluded from focus group data collection, as this study intentionally aimed to access the more hard to reach group of clinical nurses who constituted the majority of the nursing workforce, rather than the management hierarchy who had been involved in a participatory workshop and research study on TM the previous year. The exclusion of other registered healthcare professionals from the study was also intentional as it risked dilution of findings and did not related directly to the gendered occupation of nursing, and the research aims. Non-registered nurses were also excluded, as the focus was the RN role.

6.8 Personal Reflection

Learning over the duration of the study has been captured through a reflective diary. I started the research journey following an encounter with a NQ nurse. I had limited knowledge of TM sparked by personal reading, rather than a professional perspective. I wanted to learn from the business literature, to capture new ideas for developing and retaining highly motivated nurses. In answer to the original question posed by the NQ SN, it became evident that nursing career pathways were available, however they were neither clear to identify, nor easy to access. They required an individual to be self-motivated, to seek out opportunities and were often described within the case study as ad hoc, linked to 'who you know'. During 2011 I undertook a study tour of three Magnet designated hospitals in the USA. That started to shift my thinking in relation to TM as a culture change, developing excellence in nursing and a workplace environment where staff felt valued and engaged, rather than focusing on developing high potential individuals. My personal journey through evolving research and practice experiences has revealed to me potential benefits of a more inclusive approach to TM, developing diversity and untapped employee potential. My written reflections noted the changing context and unprecedented influence of The MSFT Public Inquiry (2013), focusing negative public attention and government interest on nursing and the NHS.

I have been inspired by the strength of feeling expressed by participants at all stages of the study, notably the commitment of nurses to keep the patient at the heart of what they do and their enthusiasm for clinical nursing careers. Staff Nurses both within the focus groups and wider consultation wanted to develop in their clinical specialisms and be valued for their experience and knowledge. I was shocked and humbled by the experiences shared by some BME nurses. The disadvantage in career development was

not something I was conscious of at the start of the study and reflected my own naivety about racial discrimination in the workplace. This learning had a profound effect on my perception of inclusivity in TM and a need for action relating to BME nurses' development.

I have experienced significant personal growth through this research journey and reflected on the predicament of nursing as a gendered occupation and also considered my own experiences throughout my career. I reflected on the process of developing a case to access a job share in the early 1990s in order to continue in my career as a WS, whilst having children. I have also considered points throughout my career where I have had to debate, (often with those who have little insight into nursing as an occupation, but also sometimes with those within healthcare) why I, as a nurse, needed to develop my knowledge through academic study. This was firstly at degree, then masters level and now through to doctoral level. I have made more sense of an experience at a social gathering when questioned in disbelief by a guest, 'why on earth does a nurse need to do doctorate?'. Through the theoretical position of this study, the perspective of nursing as a gendered occupation, associated with caring and therefore requiring low intelligence is more evident to me now through my own lived experience than I had realised.

6.9 Conclusion

The study aimed to gain new insight in to TM as a concept within nursing, to explore clinical nurses' perceptions and lived experiences of TM; to contribute to the development of TM in nursing within one acute NHS Trust and a wider emerging debate on TM in nursing. These aims have been met. This thesis offers a new contribution to a discourse of TM within nursing. It bridges the literatures of nursing, business and human resource management. These findings

present the pressing need to value, recognise and develop nursing talent and explore possibilities for inclusive approaches to TM in nursing. The research journey started with a question from a NQ nurse, which led to analysis of what nursing could learn from business about Talent Management.

In chapter 1 I outlined the unprecedented financial and workforce challenges facing the NHS. This includes increasing public expectations of care, treatment and increasingly complex healthcare needs of an aging population. The role of the nurse in addressing these challenges was highlighted as central to national healthcare policy. However nursing as a gendered occupation is still challenged by stereotypical images, primarily associated with female caring responsibilities and a lack of recognition of nursing talent. With 92% of the nursing workforce still being female, gender and the professional predicament of nursing as described by Davies (1995) was presented as the theoretical position for the discussion and enabled a more detailed analysis of the findings. Within national workforce planning, the nursing workforce has historically been viewed to an extent as replaceable, with limited career pathways. The consequences of this gendered perspective of the nature of caring, the negative image of nursing and the extent to which this may influence new recruits to nursing have been described.

Within the case study, whilst there was evidence of good practice in relation to staff development, there was inconsistency in individual experiences. There is opportunity for the organisation to consider possibilities for TM and how nursing talents can be recognised and developed for maximum benefit. Talent Management can provide a language to bridge the gap between what matters to nurses and the business side of the organisation. In chapter 2 I presented how TM was not just concerned with one aspect of human resource management, such as succession planning or recruitment. Talent

Management was identified as a dynamic, multifaceted concept involving; defining talent, attracting, recruiting, developing and retaining talented employees. This is as a result of global finance and workforce challenges, population demographic changes and increasing advances in technology. The findings of this study provide a unique insight in to clinical nurses' perspectives within a public sector UK context, on the concept of TM, currently under-explored in the healthcare literature.

In chapter 3 I presented the contextual nature of TM and how an absence of literature relating to TM in nursing had led to an exploratory case study design. This enabled investigation of the phenomena within an organisational context. The primary research questions were structured to facilitate understanding relating to components of the TM process as described by Tansley et al., (2007). This included; how talent was defined within nursing and how nurses could be attracted, retained and developed within an organisation? The analysis of the data also considered if there was a difference in the views of senior leaders and clinical nurses in terms of career aspirations and expectations of TM within the case study organisation. To this end the objectives have been achieved.

The findings identified three themes; nursing as talent, ward leadership and culture and career development. These themes and the extent to which participants shared positive or negative experiences of TM were also influenced by three factors within the case study context; the individual's motivations, the skills of the manager and the organisation or workplace culture. This was set within a wider social, policy and professional context. In chapter 5 three strands of discussion were presented; nursing talent as a contested concept, the invisibility of nursing careers and the need for nurses to feel valued and engaged. There are therefore some ongoing challenges that require consideration. The contextual

nature of talent and the lack of visibility of nursing work and careers reflect that of a gendered occupation. Staff Nurses wanted greater recognition of the importance of their role delivering patient care at the bedside. In addition, a contradiction was evident between what healthcare policy advocates about needing innovation and radical individuals within the NHS. The experience of nurse participants both within the case study and wider research suggests a greater need for a 'face to fit' within an organisational system driven by targets, standardisation and compliance.

There are possibilities for TM in nursing, but this is not widely studied and yet there is a clear definition and vision proposed for TM within the NHS. As an emerging concept there is a risk of localised and fragmented approaches to TM in the NHS. The NHS is not necessarily seen as one system with increasing competition and a plurality of providers. This is resulting in competition for the most talented staff, and those with skills in shortest supply. Within a global context of changing population demographics, workforce and financial challenges, recognising, valuing and developing the full potential of the nursing workforce is essential. Talent Management, an integral component of this process, requires leadership and an effective means of; defining and valuing the diversity of talents required, effective workforce planning, investment in recruitment and retention, increased staff engagement, continuing professional development, succession planning and evaluation of impact. The introduction of more effective TM in nursing offers new opportunities, both locally within the case study and the wider healthcare context and requires further research and evaluation.

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Wong, C., Spence Laschinger, H., MacDonald-Rencz, S., Burkoski, V., Cummings, G., D'Amour, D., Grinspun, D., Gurnham, ME., Huckstep, S., Leiter, M., Perkin, K., MacPhee, M., Matthews, S., O'Brien-Pallas, L., Ritchie, J., Ruffolo, M., Vincent, L., Wilk, P., Almost, J., Purdy, N., Daniels, F., Grau, A., (2013) Part 2: Nurses' career aspirations to management roles: qualitative findings from a national study of Canadian nurses. Journal of Nursing Management 21 pp.231–241.

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Appendix 1 Moderator Guide

Focus Groups

Moderator Interview Guide

Introductions, context, ground rules for group, final confirmation consent

Ice breaker exercises – Defining the Top 4 characteristics of talent in nursing – on individual 'post its' each participant to write 4 characteristics of nursing talent. Post its then transferred on to flip chart paper round room. Participants to share with one other colleague key words they utilised and then group feedback on summary from flip cart utilised as part of introductions

Definitions of Talent management from the literature on flip charts round room . Individuals to indicate with coloured pens red, amber, green. Whether they agree or disagree with statements.

1) What are your views on how we define talent in nursing?

2) What can you tell us about your own experiences of Talent management?

3) What do you see as the challenges of attracting, developing and retaining talented nurses at NUH?

4) What strikes you as important about this topic?

5) What are your views on the Department of Health's nursing career framework?

6) What are your own career aspirations and expectations?

7) What helps or hinders opportunities for the development of talent in nursing?

Appendix 2 Ethics Letter

Direct line/e-mail
+44 (0) 115 8231063
Louise.Sabir@nottingham.ac.uk

The University of Nottingham
Faculty of Medicine and Health Sciences

Medical School Research Ethics Committee
Division of Therapeutics & Molecular Medicine
D Floor, South Block
Queen's Medical Centre
Nottingham
NG7 2UH

Tel: +44 (0) 115 8231063
Fax: +44 (0) 115 8231059

11th June 2012

Mrs Sue Haines
Assistant Director of Nursing
Nursing Development
Nottingham University Hospitals NHS Trust
Derwent House
City Campus
Hucknall Road
Nottingham
NG5 1PB

Dear Mrs Haines

Ethics Reference No: J10042012 Talent Management SNMP
Study Title: Talent Management in Nursing – An Exploratory Case Study of One Large Acute NHS Trust.
Lead Investigator: Mrs Sue Haines, Assistant Director of Nursing NUH Trust, DHSci Student School of Nursing, Midwifery and Physiotherapy (SNMP)
Academic Supervisors/Chief Investigators: Dr Stephen Timmons, SNMP, Dr Hannah Noke, Nottingham University Business School.
Duration of Study: 1/5/2012-31/05/2013 (1yr) No of Participants: 63

Thank you for your letter dated 9th June 2012 responding to the issues raised by the committee. These have been reviewed and are satisfactory and the study is approved.

Documents received:

- ecformSHfinal3 April12.doc
- protocol_final_version ethics committee 2 April 2012.docx
- informationsheetfocusgroupSHfinal3April.doc
- informationsheetonetooneSHfinal3April.doc
- ecconsentformSHfinal3April.doc
- One to One Interview Guide 3 April.docx
- Focus Group Interview Guide 3 April.docx
- Ethics response June 2012.docx 09 June 2012

Approval is given on the understanding that the Conditions of Approval set out below are followed.

Conditions of Approval

You must follow the protocol agreed and any changes to the protocol will require prior Ethics' Committee approval.

This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be

performed on the study which may arise in the process of publication and peer review.

You promptly inform the Chairman of the Research Ethics Committee of

(i) Deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subjects.

(ii) Any changes that increase the risk to subjects and/or affect significantly the conduct of the research.

(iii) All adverse drug reactions that are both serious and unexpected.

(iv) New information that may affect adversely the safety of the subjects or the conduct of the study.

(v) An End of Project Progress Report is completed and returned when the study has finished.

Yours sincerely

Dr Clodagh Dugdale
Chair, Nottingham University Medical School Research Ethics Committee

Medical School Research Ethics Committee
Membership 2010/2011

*denotes attendance at 19th April 2012 meeting

Chair	Dr Clodagh Dugdale, University Teacher in Sports and Exercise Medicine, Division of Orthopaedic and Accident Surgery, School of Clinical Sciences.*
School	**Representative**
Biomedical Sciences	Dr Vince Wilson, Reader and Basic Scientist.* Dr Liz Simpson, Chief Experimental Officer.*
Molecular Medical Sciences	Dr David Turner, Clinical Associate Professor in Microbiology.
Community Health Sciences	Dr Rachel Murray, Lecturer, Epidemiology and Public Health Medicine.* (left the room when I19042012 MEND 7-13 EPH CHS)
Clinical Sciences	Dr Abdol Nateri, Lecturer, Pre-Clinical Cancer Studies Division of GI Surgery
Graduate Entry Medicine, Derby	Dr Caroline Chapman, Associate Professor, Breast Surgery.*
Clinical Sciences Human Development	Professor Harish Vyas, Consultant & Special Professor in Paediatric Intensive Care Unit and Respiratory Medicine, Children's Respiratory Unit, E Floor, East Block, QMC Campus, Nottingham University Hospitals Trust.*
Primary Care	Dr Richard Knox, General Practitioner/ Part-time Lecturer Division of Primary Care, QMC Campus* (left room when M19042012 PC CHS considered)
School of Nursing, Midwifery and Physiotherapy	Dr Jayne Brown, Senior Research Fellow University of Nottingham, Sue Ryder Care Centre
Lay (Out of Faculty)	Professor Nigel White, Professor of Public International Law, School of Law, University of Nottingham.* Lydia Davies-Bright, PhD Student, School of Law. Dr Mary Stephenson, Research Fellow, SPMMRC, School of Physics and Astronomy.*
Medical Students nominated by ISC	To be appointed, 3rd Year Medical Student
Postgraduate Student Member	Prema Nirgude, PhD Student, IWHO, Division of Psychiatry Catrin Middleton, PhD Student, Breast Surgery, Graduate Entry Medicine, Derby.*
Administrator	Mrs Louise Sabir, Division of Therapeutics & MM, School of Clinical Sciences*

Appendix 3 Consent Form and Participant Information

Nottingham University Hospitals NHS
NHS Trust

Nursing Development
City Hospital campus
Derwent House
Hucknall Road
Nottingham
NG5 1PB

Tel: 0115 969 1169 ext 56629
Email: jacqui.green@nuh.nhs.uk
Secretary Nursing Development
www.nuh.nhs.uk

The University of Nottingham

CONSENT FORM
(Final version 1.0: date)

Title of Study: Talent Management in Nursing: An Exploratory Case Study of One Acute NHS Trust

REC ref: 12NU004

Name of Researcher: Sue Haines

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated 16 July 2012 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the focus group will be recorded and that anonymous direct quotes from the focus group may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

July 2012 Final Version 1.0

The University of Nottingham

Nursing Development
City Hospital campus
Derwent House
Hucknall Road
Nottingham
NG5 1PB

Tel: 0115 969 1169 ext 56629
Email: jacqui.green@nuh.nhs.uk
Secretary Nursing Development
www.nuh.nhs.uk

Participant Information Sheet
Focus Groups
(FINAL Version 1 / Final version 1.0: 16 July 2012)

Title of Study: Talent Management in Nursing: An Exploratory Case Study of One Acute NHS Trust

Name of Researcher(s):Sue Haines sue.haines@nuh.nhs.uk
Supervisor: Stephen Timmons Stephen.timmons@nottingham.ac.uk
School of Medicine and Health Sciences Research Ethics Coordinator:

We would like to invite you to take part in our research study. This is being undertaken as a dissertation study towards a Doctorate in Health Science (University of Nottingham). Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear. Thank you for reading this and take time to decide whether you wish to take part or not.

What is the purpose of the study?

The aim of the study is to gain your views as a registered nurse on, and experiences of, Talent Management in nursing.

Review of published literature highlights Talent Management (TM) as process through which a business attracts, develops and retains high potential and high performing individuals. It is a comparatively new concept within the NHS and what minimal literature there is primarily focuses on identifying and developing individuals for senior NHS management positions. Nursing needs to attract, identify, develop and retain talented clinical practitioners, researchers, educators and managers of the future, to achieve national healthcare policy priorities, and to ensure that key positions are filled with high potential and inspiring individuals.

This study aims to investigate registered nurses' experiences, perceptions and expectations of TM at NUH. This includes for example, your experiences and views of recruitment, retention and career development opportunities. It will be undertaken over a 10 month period July 2012- May 2013

Why have I been invited?

You have been invited to participate as a registered nurse employed by NUH. The study aims to involve nurses in clinical roles from a range of different Directorates and specialties. We are inviting 50-60 participants like you to take part in focus groups of between 7-9 participants. Different focus groups will be held for newly qualified nurses and more experienced and specialist nurses.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

As a research volunteer you are invited to participate in one focus group interview, lasting approximately 90 minutes, involving other registered nurses in a similar role to yourself, but from across different Directorates within the Trust. The focus group will be facilitated by an experienced facilitator. The interview will be audio taped and then transcribed for analysis. An additional facilitator will also be present to work the audio equipment and take notes of key points raised. From the audio tape analysis key themes will be developed. Focus group participants will have opportunity to individually review findings and feedback as to whether views have been accurately captured. You will have an option of one to one follow up if you would like further opportunity to discuss issues raised.

Expenses and payments

Participation is entirely voluntary and participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks in taking part in this study.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help identify areas for further research and help inform future planning and practice for implementation of an improved approach to TM in nursing.

What happens when the research study stops?
What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study may be looked at by authorised persons from the University of Nottingham who are organising the research, or academic examiners. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study

The findings of the study will only be reported in anonymised forms. There will be wider consultation in the Trust on themes identified from all the focus groups and interviews as part of the study. This is likely to be after May 2013 once data gathering and analysis has been completed. Findings will be written up as an examination requirement for the DHSci programme and presented in peer review journals and at conferences in the year after finalising the study. To ensure anonymity in publications all names of people and organisations will be changed

Who is organising and funding the research?
This research is being organised by the University of Nottingham and is being funded by Sue Haines a part time student on the DHSci programme.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the University of Nottingham Medical School Ethics Committee and Nottingham University Hospitals Research and Development department.

Further information and contact details

Chief Investigator:

Dr Stephen Timmons

University of Nottingham,

School of Nursing, Midwifery and Physiotherapy,

Queens Medical Centre

Phone:01158230897
Email: Stephen.timmons@nottingham.ac.uk

Principal Investigator:

Sue Haines
Nursing Development
Nottingham University Hospitals NHS Trust
University of Nottingham, DHSci student ntxsh7@nottingham.ac.uk or via nursing development sue.haines@nuh.nhs.uk

Thank you for considering taking part in this study.

Participant Information Sheet
One to One Interviews
(Final version 1.0: Approved by R&D)

Title of Study: Talent Management in Nursing: An Exploratory Case Study of One Acute NHS Trust

Name of Researcher(s):Sue Haines sue.haines@nuh.nhs.uk
Supervisor: Stephen Timmons Stephen.timmons@nottingham.ac.uk
School of Medicine and Health Sciences Research Ethics Coordinator:

I would like to invite you to take part in a research study. This is being undertaken as a dissertation study towards a Doctorate in Health Science (University of Nottingham). Before you decide we would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Please do ask if there is anything that is not clear. Thank you for reading this and take time to decide whether you wish to take part or not.

What is the purpose of the study?

The aim of the study is to gain your views as a senior executive leader at NUH on Talent Management in nursing. This study is an exploratory case study and aims to investigate both the views of executive directors with specific responsibility for leadership and talent management, and also experiences, perspectives and expectations of registered nurses' at NUH. It will be undertaken over a 9 month period August 2012- May 2013

Review of published literature highlights Talent Management (TM) as process through which a business attracts, develops and retains high potential and high performing individuals. It is a comparatively new concept within the NHS and what minimal literature there is primarily focuses on identifying and developing individuals for senior NHS management positions. Nursing needs to attract, identify, develop and retain talented clinical practitioners, researchers, educators and managers of the future, to achieve national healthcare policy priorities, and to ensure that key positions are filled with high potential and inspiring individuals.

Why have I been invited?
You have been invited to participate as a senior leader at NUH with key leadership responsibilities for development and talent management in the organisation. Participation is voluntary and if you do decide to take part you will

be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

The study aims to involve senior executive leaders in one to one interviews and registered nurses in clinical roles from a range of different Directorates and specialties in focus group interviews. We are inviting 50-60 participants to take part in focus groups of between 7-9 participants. Different focus groups will be held for newly qualified nurses and more experienced and specialist nurses.

What will happen to me if I take part?

You are invited to participate in a one to one interview facilitated by myself. The interview will be audio taped and then transcribed for analysis. From the audio tape analysis key themes will be developed. You will have opportunity to review findings and feedback as to whether your views have been accurately captured. There is further follow up opportunity to discuss issues raised if you identify that this is required.

Expenses and payments

Participation is entirely voluntary and participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks in taking part in this study.

What if there is a problem?

In case you have a complaint regarding anything to do with the study, you can initially approach the lead investigator. If this achieves no satisfactory outcome, you should then contact the Ethics Committee Secretary, Mrs Louise Sabir, Division of Therapeutics and Molecular Medicine, D Floor, South Block, Queen's Medical Centre, Nottingham, NG7 2UH. Telephone 0115 8231063. E-mail louise.sabir@nottingham.ac.uk."

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study may be looked at by authorised persons from the University of Nottingham who are organising the research, or academic examiners. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. In any information disseminated as learning from the study, the case study organisation will be anonymised and participants personal identifiers removed so that individuals cannot be recognised from it.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

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The findings of the study will only be reported in anonymised forms. There will be wider consultation in the Trust on themes identified from all the focus groups and interviews as part of the study. This is likely to be after May 2013 once data gathering and analysis has been completed. Findings will be written up as an examination requirement for the DHSci programme and presented in peer review journals and at conferences in the year after finalising the study. To ensure anonymity in publications all names of people and the organisation will be changed

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by Sue Haines a part time student on the DHSci programme.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the University of Nottingham Medical School Ethics Committee and Nottingham University Hospitals Research and Development department.

Further information and contact details

Chief Investigator:

Dr Stephen Timmons

University of Nottingham,

School of Nursing, Midwifery and Physiotherapy,

Queens Medical Centre

Phone:01158230897
Email: Stephen.timmons@nottingham.ac.uk

Principal Investigator:

Sue Haines
Nursing Development
Nottingham University Hospitals NHS Trust
University of Nottingham, DHSci student ntxsh7@nottingham.ac.uk or via nursing development sue.haines@nuh.nhs.uk

Thank you for considering taking part in this study.

Appendix 4: One to One Interview Guide

One to One Semi Structured Interview Guide

Introductions, context, confirming consent

From your experience what do you see as the key components of Talent Management?

What are the most important aspects of Talent management at NUH?

What strikes you as important about this topic?

How would you define talent in nursing?

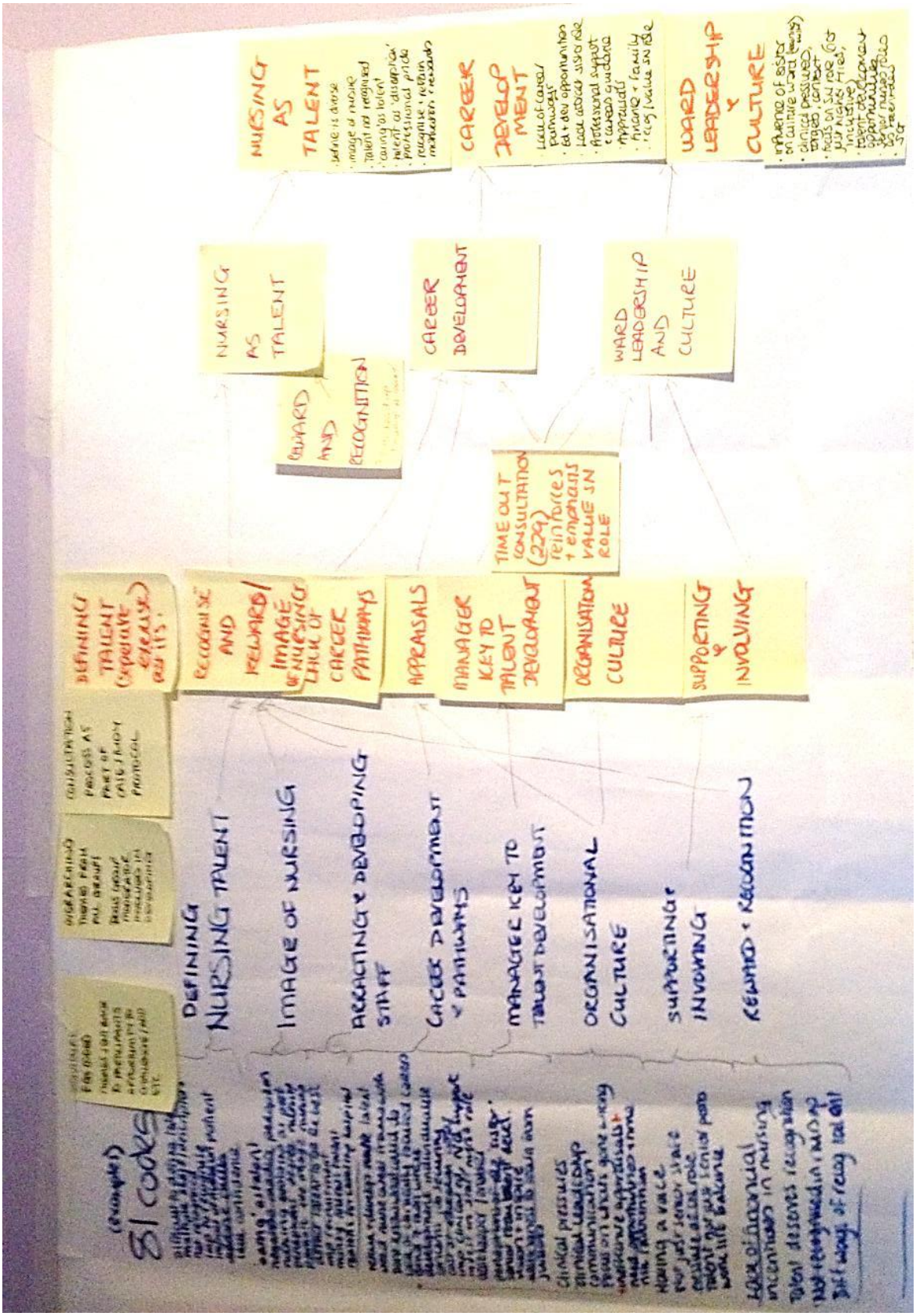
What characteristics would you use to identify talent in nursing?

What do you see as the challenges of attracting, developing and retaining talented nurses?

What are your views on the Department of Health's nursing career framework?

What helps or hinders opportunities for the development of talent?

Appendix 5: Final Themes Post Consultation



Appendix 6: Presentations and publication

Haines S (2013) Applying Talent Management to Nursing, Nursing Times 109 (47) pp.12-15

Haines S (2015) Talent Management in Nursing An Exploratory Case Study Of One Acute NHS Trust RCN International Research Conference April 2015, East Midlands Conference Centre.

Haines S (2015) Talent Management in Nursing- Developing Nursing Leadership and Career Pathways: Staff Nurse Perspectives RCN Education Conference March 2015, East Midlands Conference Centre.

Haines S (2014) Applying Talent Management To Nursing. Inclusive Talent Management Conference. East Midlands Leadership Academy, Health Education West Midlands and East of England. 6 March 2014, Birmingham ICC.

'Talent Management and Career Development in Nursing' Nurse Specialist Conference (February 2014) Nottingham University Hospitals.

Haines S (2013) Talent Management in Nursing National Junior Leadership Academy (August 2014) University of Nottingham

Haines S (2013) Talent Management In Nursing An Exploratory Case Study of One Large Acute NHS Trust. 'Engage, Enthuse, Empower' Annual Research and Education Meeting 13 June 2013, National College for School Leadership. (Presentation prize winner)

Haines, S (2013) 'Talent Management in Nursing' Health Education East Midlands Local Education Training Board, Nursing and Midwifery Workforce Summit (October 2013)

Appendix 7: Letter from Director of Nursing & Deputy Director of Education & Quality

NHS
Health Education England

Department of Education and Quality

St Chads Court
213 Hagley Road
Edgbaston
Birmingham
B16 9RG

Our Ref: LBP/CF/0406201501

4th June 2015

Dear Sue,

I would like to thank you for your ongoing contribution to the national Shape of Caring review and consultation. Your research findings have provided an interesting and new insight in to the concept of talent management in nursing and the importance of aspiring to centres of excellence in nursing practice in the UK. I am looking forward to working with you and colleagues at Nottingham University hospitals as we take forward wider national consultation following the review, seeking perspectives of key stakeholders on developing centres of nursing excellence.

I wish to every success as you write up your thesis,

Yours sincerely,

Professor Lisa Bayliss-Pratt
Director of Nursing & Deputy Director of Education and Quality
Health Education England

Developing people for health and healthcare

www.hee.nhs.uk
hee.enquiries@nhs.net
@NHS_HealthEdEng