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Developing Nursing Leadership Talent - views from the NHS nursing leadership for South East England

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Developing Nursing Leadership Talent - views from the NHS nursing leadership for South East England

Aim: This article explores the views of current National Health Service (NHS) nursing leaders on actions and resources required to develop and maintain nursing leadership talent.
Background: Although there is considerable talent and expertise within the nursing leadership community, there are numerous unfilled vacancies and identified gaps in competence and capability, with national analysis (Janjua, 2014) indicating nearly a third of NHS Directorial posts filled by interim appointments or vacant. Nursing Director posts are amongst those vacant for the longest.
Method: Semi-structured interviews were conducted with NHS Directors of Nursing, Chief Nurses, Directors of Quality and their deputies in South East England to explore the characteristics of their roles, development needs, barriers to applying or staying in post, future talent identification and support networks.
Results: Nursing leadership roles are perceived as demanding, poorly remunerated, isolating and representing a major increase in responsibility and career risk. Too much development is currently informal.
Conclusions: Talent identification and support needs to be timely, structured, based experientially and focused on building resilience and confidence. Coaching, mentoring and support networks are considered crucial.
Implications: Nursing leadership talent needs to be formally identified, developed and supported within organisations and networks should be maintained to reduce professional isolation and counter negative perceptions.

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Keywords: Nursing leadership, Directors of Nursing, talent, interviews, NHS, South East England.

Background

Directors of Nursing (DON), Chief Nurses and Directors of Quality serve as the professional leads for nurses and midwives in England. They assume executive level responsibilities within an NHS provider or commissioning role and oversee strategic and corporate planning for the provision of nurses and midwives as well as quality improvements in patient care and patient experience. Nursing leaders are currently faced with the challenge of creating opportunities to influence safe, high quality and compassionate care in the context of embracing the vision of *Next Steps on the Five Year Forward View* (NHS, 2017). This means that current and emerging nursing leaders must grow the competence and capability to further enable new ways of service delivery outside of traditional community or hospital boundaries and as part of sustainability and transformation partnerships in conjunction with local authorities. However, the impact of numerous unfilled vacancies and gaps in competence and capability are testing personal resilience to deliver safe services and lead quality improvements.

A NHS analysis (2015) indicated that 29% of Nurse Director posts were currently filled by interim appointments or vacant. This is against a wider context of 36% of NHS Trusts with 50-100 full time vacancies and 8% with 100+ vacancies and concerns that Brexit will further exacerbate shortages in nursing staff (Institute for Employment Studies - IES, 2016). The talent pool for future Nursing Directors appears limited and research indicates a low appetite for these roles amongst senior nurses (Janjua, 2014). At the same time, Director of Nursing posts appear harder to recruit than less senior nursing positions and there is a perception that the quality of talent in director posts has dropped overall (Janjua, 2014).

Research in the field has highlighted the need for a clearer discussion about nursing leadership talent and the profile and skills needed for senior nursing posts. According to Stanley and Sherratt (2010), leadership involves a myriad of responsibilities, both strategic and interpersonal, including: creating strategy and a vision for change; designing new ways of working to respond to changes and developing others; responding to the needs of customers and maximising organisational performance whilst maintaining staff morale; and working both within teams and across boundaries. This echoes the core qualities outlined in the NHS *Leadership Development Framework* (NHS, 2016) and resembles the scope of action for a DON role, which demands a complex mix of individual and interprofessional skills involving not only nursing expertise but also advanced knowledge of

management, human resources and customer relations as well as interpersonal skills. This has led Hewison (2009) to question whether we are expecting too much of our nursing leaders, placing too much emphasis on their skills as 'individual leaders', and call for in-depth discussion about the challenges and significance of the role in its wider organisational context.

Thompson (2016, 273) has argued for immediate action to prepare a new generation of nursing leaders, calling for more mentoring and support, the creation of more education and practice opportunities and the development of priority skills including developing vision, communication, integrity, understanding of healthcare and preparing leaders to be 'change agents' with the ability to work in interprofessional and cross-sectorial teams.

Pollard et al (2005) have also advocated the benefits of establishing opportunities for effective interprofessional collaboration to develop leadership skills based on non-hierarchical team structures, clear communication channels, shared decision making and interpersonal acuity. Furthermore, Lawrence and Richardson (2014) have stressed the need for opportunities to enable exposure to different leadership styles.

Additionally, Rolfe and Chan (2007) have called for prospective leaders to be trained to be aware that their experiential skills are key attributes in nursing leadership posts and skills that combine practical nursing expertise (not just managerial competencies, talents and traits) supported by on-the-job learning should not be seen as in opposition to or inferior to pure managerial skills. Furthermore, Rodgers et al (2003) warn against focusing purely on a check-list of competencies to assess managerial potential and Castledine (2004) further urges nursing leadership to 'keep its roots in nursing' - a serious warning against the risks of adopting a purely managerial approach to the post, which may negatively impact the quality of the service provided and, ultimately, the quality of care.

The other key constraint to the development of future nursing leaders is the lack of a consistent system of succession planning and talent management. Across England there is the perception that these processes are often poor or carried out on an informal basis (Janjua 2014, Currie & Grundy 2011) with significant impacts being reported at the levels of recruitment and retention. The NHS national framework for action on improvement and leadership development in NHS-funded services also recognizes that NHS sustainability and transformation plans signal broad strategic changes across the NHS, creating new and specific staff development needs which must be addressed as a priority (NHS, 2016). Titzer et al (2013), drawing on a substantial body of evidence, have argued that succession planning should be deliberately integrated into organisational strategic plans and that proactive methods for identifying and developing potential leaders should be deployed, emphasizing the pivotal role of coaching and mentoring support and the allocation of resources in doing so. Indeed, Lawrence and Richardson (2014) argue that efficient strategic succession planning may offer numerous benefits including improved retention, increased staff engagement and the enhancement of financial performance. At the same time, the development of specialised education and training in the field of nursing leadership and management (Curtis et al 2011, Pollard et al 2005) may work as an essential lever for the development of professional expertise and career aspirations. Nevertheless, according to Thompson (2016) new generations of leaders remain dependent on existing nurse leaders and managers who are still viewed as 'gatekeepers' to support and development. On an interpersonal level, evidence also suggests that collegial networks may support practitioners to develop meaningful relationships, leading to a greater commitment and increasing staff retention (Belzer, 2003) as well as provide for shared knowledge, friendship and support (Bartol & Zhang, 2007). The NHS *National Framework for Leadership Development* in NHS-funded services also calls on support systems for learning at local, regional and national levels (NHS, 2016).

In the United States of America there is also a current and projected nursing shortage due to the ageing nursing workforce and a high turnover among nurse leaders. At the same time, this is complicated by the potential increase in demand for nursing services in the near future, and the uncertainty associated with political, economic and social factors that may force downsizing skilled leaders to achieve financial goals and other issues affecting health-care delivery worldwide (Westphal 2012, Huston 2008). As recently argued by Philips et al (2017) in the US context, effective talent management/ succession planning are regarded as an absolute necessity with nursing leaders (mainly nurse executives - senior leaders who act as advocates, strategic thinkers and get directly involved in resource allocation, quality initiatives and marketing decisions and supervise nurse managers - nursing leaders who often assume responsibility for one or more nursing units in acute care hospitals) being urged to act at all management levels. Trepanier and Crenshaw (2013, 980) have stressed many benefits such as improved

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retention rates, increased staff engagement and enhanced financial performance and Griffith (2012, 900) recommended the identification, recruitment, retention, development, coaching and mentoring of potential leaders as early as high school. Westphal (2012, 929) has identified the way in which nursing leaders have been achieving higher educational degrees and getting equipped with the necessary skills and competencies, mainly management skills. At this level, the creation of leadership development programs (*Leadership Academies*) has come to provide outcome-oriented learning experiences and programs for those who exhibit strong leadership potential (National Center of Healthcare Leadership 2010) and contribute significantly to strong overall organizational performance (Anderson & Garman 2014).

This research project, funded by NHS England and conducted in partnership with the University of Greenwich, aimed to explore the views of NHS nursing leaders in South East England on the development of nursing leadership talent. This research provided an opportunity to pool the expertise and experiences of existing nursing leaders and identify areas for change as well as methods to enhance provision and support for the development of nursing leadership and networks across the South East region and nationally.

Study design

The present research study employed a qualitative design aiming to explore the views of current NHS nursing leaders on actions and resources required to develop and maintain nursing leadership talent (Corbin and Strauss 2008).

An interview framework was devised between researchers at the University of Greenwich and within the NHS to address the principle research questions:

1. What are the existing learning opportunities and development needs of current DON and other nursing leaders?

2. What is needed to facilitate successful succession planning for future DON and what barriers do nursing leaders face to applying for DON roles or staying in post?

3. How effective are existing professional/quality networks of nursing leadership and what existing or alternative networks may be used locally, regionally or nationally?

The use of individual semi-structured telephone interviews made it possible to conveniently access a sample with high time commitments and from a very wide geographic area South (Southeast England which covers the counties of Kent, Surrey, East and West Sussex as well as two unitary authorities - Medway and Brighton and Hove). The South East contains a number of rural areas often with limited access to public transport and real extremes of affluence and deprivation. The region has a population of 4.5 million people spread across 3600 square miles expected to increase 8.1% by 2024 (Office of National Statistics 2018) and is served by 21 Clinical Commissioning Groups (CCGs) [1], 13 acute trusts [1] covering 21 hospitals, along with 6 community health providers, 3 mental health providers, around 600 General Medical Practices, nearly 900 pharmacies, and over 750 dental practices (NHS 2018).

Participants

The sample size was based on the population of senior nursing leadership staff including deputies and directors from across all providers and commissioners in South East England (n= 81 according to the internal staff lists from March 2016). A large (40%) purposive sample size was chosen although only 18 agreed to participate who worked in three different organisations[1]: Trusts (10), CCGs (6) and NHSE (2) and in a number of different roles[2]: Clinical Commissioning Groups (CCGs) Chief nurses (7), NHS Trust Directors of Nursing (8) and deputies (1) and CCG and NHS England Directors/ Heads of Quality/Governance (2) The participants were in the current role for less than one year (2); one year (6); two years (5); three years (4) and four years (1). Most of them held qualifications or attended learning opportunities[3] which have equipped them to take the current role: academic qualifications (including Postgrad, MA, PhD) (7); *Leadership Academy* (13); *King's Fund* (3) and *Florence Nightingale Scholarships* (3); other opportunities, mainly short leadership courses and development programmes (14). Additional information[4] about the interfaces between the roles and salaries can be found below.

NOTES:

[1] **Organisations:**

CCG - Clinical Commissioning Groups. These are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Trust - Organisation within the English NHS generally serving either a geographical area or a specialised function.

Acute trust – Hospital trust that provides secondary health services within the English NHS.

NHSE - National Health Service England.

[2] **Roles:**

Chief nurses - Governing Body Board Member; registered nurse accountable for the quality standards of commissioned health services. They will set and deliver on strategic quality priorities.

Directors of Nursing - Executive level role in NHS Trusts; Board Members and accountable for nursing professional leadership, patient safety and quality; clinical quality governance and patient experience within their organisation.

Directors/ Heads of Quality/Governance - Role variance within Clinical Commissioning Groups or NHS England. The Director of Nursing in NHSE is responsible for developing a strategic approach to ensuring people have a positive experience of care and treatment and that people are cared for in a safe environment across systems; as well as providing local professional leadership to nurses and midwives.

[3] **Academic preparation:** The essential person specification expects nurses at this level to be a registered nurse with a minimum of a Master's Degree or equivalent level of practice in a health related subject.

Leadership Academy - NHS body that offers leadership development opportunities.

King's Fund - independent charity that offers a range of development programmes for all stages of leadership

Florence Nightingale Scholarship - a leadership scholarship offered by the Florence Nightingale Foundation (FNF) - a charity organisation in the UK that provides scholarships to nurses, midwives and other health professionals.

[4] **Additional information:**

Interfaces between the roles: You would expect Executive level Directors of Nursing to be NHS Trust Board Members and accountable for Professional Leadership, Patient Safety and Quality, Clinical Quality Governance and patient experience within their organisation. Chief Nurses/Head of Quality/Governance in Clinical Commissioning Groups would be accountable for the quality and safety of commissioned services from a variety of providers within a specified geographical footprint.

Salary levels: Executive Nurse Directors in Clinical Commissioning Groups or in NHS Trusts will generally be paid on agenda for change Band 8d/9 up into Very Senior Managers pay which is ordinarily less than Medical Directors.

Ethical considerations

Participants received a letter/email from the research team lead inviting them to participate along with an information sheet and provided informed consent to be interviewed and were informed of their right to withdraw at any time. Consent forms were stored under secure lock and key in office filing cupboards and separately from any interview transcripts, in which participant's identities were protected by pseudonyms. Interview transcripts and recording files were placed under password protection. The study was authorised by the NHS England South East, Kent, Surrey and Sussex and approved by the Research Ethics Committee of the University of Greenwich (UREC/ 16.2.5.6).

Data collection and analysis

The telephone interviews were tape-recorded and each lasted approximately 45 minutes. Deductive thematic analysis was performed by one of the researchers and then reviewed by two more researchers. An analytical framework was developed based on the research questions. The perception was that all categories were saturated by looking at the 'property and dimensional level' of data (Corbin and Strauss 2008, 75). The methods employed to ensure data saturation had been achieved included having a saturation grid (wherein major topics were listed on the vertical and interviews to be conducted were listed on the horizontal).

Findings and Discussion

The participants' answers described their individual views as key informants: 'those whose social positions in a research setting give them specialist knowledge about other people, processes or happenings that is more extensive, detailed or privileged than ordinary people' (Payne and Payne 2004, 134).

Research findings have been organised into the following categories: characteristics of the role, development needs, barriers to applying for or staying in post, future talent identification and support networks.

Characteristics of the role

Interviewees reflected that the key characteristics of nursing leadership roles involved a significant level of difficulty, responsibility and commitment and included: time pressures, accountability issues, rising demands, professional isolation, variable remuneration and distance from clinical skills. Roles were characterised by long hours which interviewees reflected resulted in a significant personal commitment and difficulties in achieving work-life balance:

> *'Roles are perceived as roles where you can't have work/life balance. Or whether your work/life balance is such that you're happy for work to take up 80%, if not 90%...'*

Many interviewees felt both professionally and geographically isolated in their roles and expressed a need for greater support at executive board level but also in the form of development support to build resilience and manage the professional aspects of the role.

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Director of Nursing (DON) and other comparable leadership roles were also acknowledged as being accountable at the highest level and participants discussed the pressures this placed on them, emphasizing the notion of the nursing leader as an 'individual leader' (Hewison, 2009). As well as taking on significant responsibilities, the demands of staffing, management, high-level decision-making and reporting were consistently high:

> *'Directors of Nursing aren't supported well at the board, [they] are the first people to go if there's an issue, are always the backstop for any quality issues and hold a lot of responsibility'*

At the same time, many interviewees viewed the DON role as one of the lowest paid executive roles in the NHS and significantly lower than other executive board positions. Participants frequently mentioned lacking consultative support within their organisation to support decision making. Some DONs also felt physically isolated, lacking the time to travel long distances to engage with networks, training and access support of other DONs.

Participants also reflected that DON roles distanced nurse leaders from direct contact with patients and the clinical environment and some also expressed a desire not to lose these skills or become out of touch with clinical practices, which resonates with Rolfe and Chan's (2007) emphasis on the importance of practical nursing skills as a foundation to nursing leadership roles.

> *'I think it's just about knowing how to, learning how to keep on top of everything, just keeping all the plates spinning at the same time and not letting anything fall which is really really hard, to just try and be visible as well as strategic at the same time is really really difficult'*

Interprofessional relationships with the executive board were seen as crucial to combatting isolation and those who appeared to feel less isolated testified to good support from their executive board. Others expressed a lack of understanding from executive boards as to their role and management capabilities, highlighting the importance of creating supportive networks that demonstrate the value of the DON role and the need for a system wide approach to supporting nursing leaders.

Current development needs

Overall, the majority of interviewees had engaged with and reflected positively on leadership training programmes and professional development courses such as through the NHS Leadership Academy and other funded study opportunities. Many had also attended academic programmes (postgraduate level, MA or PhD). Research has identified that specialised leadership initiatives support professionalisation and constitute evidence of the move towards higher standards, increased autonomy, responsibility and recognition for the profession (Pollard et al 2005). However, when asked about their current professional development needs, interviewees indicated that they had gained or wanted support from both internal and external sources to aid development including:

- *Coaching and mentoring* - from within as well as outside the NHS was considered useful. Over half of interviewees were using or had used mentors.
- *Peer support* - from colleagues, executive board and others performing different roles at the same grade.
- *Further study* - including academic, leadership courses and workshops – although it was acknowledged that this might require considerable financial investment.
- *Experiential* - opportunities to gain experience and exposure to executive level work through shadowing and secondments (temporarily changing roles within the same organisation).

This echoes research by Curtis et al (2011, 344) which suggests that 'where leadership has been taught and integrated into nursing it has a positive impact on nurses' 'leadership skills and practice' and stresses the need for a robust training programme that combines internal and interpersonal support and development opportunities as well as access to external and academic resources.

According to participants, desired key areas for development included: role specific skills such as leadership, managing finance, implementing policy changes, integrating strategic and operational issues and workforce planning; attitudes and approaches to role, such as motivating staff, building personal resilience and working collaboratively; and support for transitions to more senior roles. Experiential development was considered particularly important in facilitating transitions and providing the necessary experience for senior nurses to move into executive roles or to transition from community nursing to acute nursing roles. Many interviewees described

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seeking out or proactively asking for development support, suggesting there may be an emphasis on individuals identifying and meeting their own development needs, with those who do not ask at risk of having their needs unmet.

These areas of development have also been pointed out as essential by Rolfe and Chan (2007,768) when advocating the development of leadership competencies such as 'enabling teamwork, articulating vision, understanding context, being responsive and flexible, achieving delivery and influencing change' and are consistent with the recently created framework for action on improvement and leadership development in NHS-funded services which presents a significant contribution on the areas of skill-building improvement, leadership development and talent management (NHS 2016). Creating a skill set to work across systems and improve the pathway of care is key to future leader's success, however, the key issue remains the provision of access to required training and the creation of a supportive environment to facilitate it.

Barriers to applying for or staying in post

Barriers to taking up or remaining in DON and comparable posts were practical, in terms of resourcing and facilitating opportunities to build relevant experience; personal, in terms of self-belief and support; and perceptive, in terms of the reputation of the role. Interviewees reflected that their role can be perceived by others as thankless, pressured, isolating, time consuming, a major step up in responsibility and pitted with frustrations.

It was also perceived by some that DONs can be held wholly accountable for any organisational failings, with the risk of dismissal high. Interviewees stressed that for nurses there would be a particular concern that dismissal would lead to loss of professional registration and ultimately the end of their careers, which may fuel reluctance to consider a DON role. This may reflect Hewison's (2009) argument that in the UK, nursing leaders are often seen as 'saviours' with the system having high expectations about their ability to overcome difficulties and achieve excellence without reasonable support and co-management of responsibility being available. Furthermore, some felt that positive aspects of the DON role were outweighed by negative portrayals in the press and the failure to counter these myths internally affected application rates for roles:

> *'there's a lot of negative people or people are having a more negative experience of working in the NHS and that's not helped by the press you know, so you know, morale is lower so you have to adapt your leadership to try and influence and raise morale'*

At both a practical and personal level, moving from a deputy DON role or other management role to a DON role was perceived as representing a big leap in responsibility in many Trusts with few workforce opportunities to scale up gradually. The transition from deputy to DON was also viewed by some as a significant shift from operational to strategic thinking, something which may not always be fully appreciated until the individual is in post. Moving between a Community Trust and an Acute Trust was also perceived as a difficult transition with Acute Trusts seen as being reluctant to take on DONs without acute nursing experience. These issues were believed to increase the risk of new DONs feeling unprepared and overwhelmed once in post.

At the same time, DONs and deputies reflected a lack of opportunity for deputies and others to be released from their duties to gain experience, or, for example, undertake rotational roles that enable chances to gain financial or board level experience. There was also a perceived lack of funding for development and support currently available for deputies in terms of mentoring or training:

> *'I think unless people are supported in the role people won't stay, and you know in terms of exposure to the role, as a deputy you get a bit of exposure to it when you cover for sick leave or annual leave or whatever, but you don't actually get to do it until you get to do it.'*

DONs also reflected that some staff might lack the confidence to apply for DON roles, feeling that they do not have the right skills, or wrongly believing that the post may be earmarked for another member of staff, again lending weight to Rolfe and Chan's (2007) assertion of the need to highlight the benefits and importance of prior nursing experience. However, some interviewees felt that promising staff were not suitably encouraged or supported to apply for promotions, with some being actively told they do not have the necessary skills to prevent them moving on from a role they perform well, or others finding it difficult to find suitable local positions. Only

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one interviewee mentioned a lack of diversity amongst existing senior leaders and a lack of applications from black and minority ethnic (BME) candidates.

Identifying future talent

According to interviewees, current methods for identifying future nursing talent could be structured but were often centered around 'who you know', i.e current employees and contacts, reflecting Titzer's (2013) assertion that succession planning practices 'are lacking' and the systematic evaluation of succession planning is 'limited'. These reflections were also consistent with the findings of the Kings' Fund (Janjua, 2015) where most respondents considered that 'talent management and succession planning were often poor or carried out on an informal basis' and this was seen as a 'key reason for an inadequate pipeline of aspiring senior leaders'.

Interviewees revealed that the methods used for identifying talent included mainly direct approaches – ie. through appraisals, proactive discussions with staff about career goals and tailoring support to meet the development needs of staff; or to a lesser extent passive approaches through networking, information sharing and observation, such as discussion between DONs around secondment opportunities, writing to staff about current opportunities, observing other managers in wider roles or talent spotting via mentoring and coaching.

Flaws identified by interviewees in current methods of talent spotting included taking a 'tick-box' approach to handling job applications, meaning certain qualified candidates may be excluded from interviews because they were not at the required grade level, despite having the relevant skills and leadership experience to do the role. This suggests that, as well as Rolfe and Chan's (2007) assertion that prospective leaders need to be trained to be aware that their core nursing skills can contribute to their efficacy as leaders, current leaders must be made aware of the broad key competencies that make a candidate suitable for a role.

It was acknowledged that DON roles differ, and employers should be able to deviate from rigid job description frameworks to 'sell' a role based on its particular qualities. Furthermore, the previously identified barriers to applying for roles, including perceptions of the difficulties that role entailed and building staff confidence to apply, needed to be addressed formally:

> *'I think nursing has quite a narrow view on what you have to have to be a good Director of Nursing (…) I don't think we're very good at looking for transferable skills necessarily'*

Similarly to Thompson's (2016) assertions on the key facets needed to develop nursing leaders, interviewees suggestions to enhance and support the development of future nursing leadership talent included facilitating greater experience, providing greater managerial and team support and proactively offering courses and coaching.

In terms of experience, providing opportunities for secondment, shadowing, interim senior roles and opportunities to deputise for line managers with autonomy to make high level decisions to gain 'actual' experience was considered important, and making this a formal element of development could ensure that these opportunities are open to all aspiring directors:

> *'… lots of things you don't get to go to as a deputy until you're a director, and then you have no previous exposure to it and it's a massive learning curve'*

Rotation through different roles to diversify experience was also suggested. This is something that was noted as happening effectively with other medical colleagues such as registrars. As per Thompson (2016), interviewees also suggested that opportunities for coaching and mentoring should be made available including opportunities to be 'buddied' up with staff from similar roles for support. Similar opportunities to enrol in leadership and management courses should be provided as with current DONs and creating a formalised network for aspiring leaders could help build support as well as identify talent and make them aware of new opportunities.

Interviewees also stressed that managers needed to be proactive in having regular conversations with staff about their aspirations and development needs, to start early and take time to grow staff into more senior posts: Managers also needed to find out what motivated individual staff in their roles and be upfront and honest in discussions, with structured support offered to develop future talent as soon as possible. At the same time, interviewees mentioned the need to make sure deputies have plans and opportunities for development.

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Interviewees further suggested that support for leadership talent must come from all levels including the executive board. There was also a need to promote positive role models to counter negative perceptions of the role, one interviewee suggested sharing 'personal journey' stories from people in the role to reflect diversity and individual qualities as well as the need for 'myth busting' information in the nursing press to explain what DON roles are really like:

> *'… so my job, to incentivise people, is to role model it, in a really positive way, that encourages people to think that might be something I'd like to aspire to be. I think that's the only way because, by virtue of the nature of the job, you don't want to burden people with what the job entails, because a lot of it isn't great, it'd put people off, so it's role modelling the positive aspects of it'*

Developing and building support networks

Interviewees made use of a large and varied number of informal and formal networks for information and support at national, regional and local levels. However, the physical distance between organisations could make it hard to meet in person, attend conferences and make the most of some formal networking opportunities. Conferences and professional fora were most often cited at a national and regional level. National networks were accessed face to face or online and were largely related to obtaining high level strategic and policy information, but were also sources of 'inspiration' and insight from the most senior nursing leaders. Regional networks were also viewed as useful at a strategic level but were furthermore important sources of peer support and facilitated connections with other local nursing directors reducing isolation. However, the South East region is geographically large and many felt unable to attend 'regional' meetings regularly due to distance.

Local networks consisted of online fora and telephone meetings, but also enabled face-to-face support due to geographical closeness, with opportunities to self-start new networks amongst smaller groups e.g. in Kent and Medway. Informal networks established by individuals or small groups of DONs were frequently cited as crucial to providing both emotional support, information and 'sounding boards' for strategy and ideas. These networks comprised a wide range of sources: managers, colleagues, informal connections with other DONs (locally, regionally and nationally), trusted peers, and people with similar levels of responsibility in other NHS departments or external organisations. Colleagues from academic and training courses were also frequently cited as useful, mirroring the variety of support reflected as needed for development.

Barriers to forming and engaging with networks included: finding time to attend meetings including face-to-face informal ones; distance from colleagues and networks which made attending meetings difficult - however interviewees found phone and face-to-face meetings particularly useful; the time and commitment required to organise networks and meetings, which impacted abilities to set up smaller bespoke networks without administration; and gaps in provision - in particular there was a perception that there are currently no dedicated networks for deputy DONs and other aspiring nursing leaders.

Participants suggested specific strategies to build local support networks including:

Localisation - Creating smaller local networks within regional networks could help create smaller 'regional' networking areas to facilitate opportunities for more regular face-to-face meetings and increase opportunities to set meetings in a 'local context'.

Peer support networks - Establishing less formal, 'talking shop' style networks which individuals could tap in to for peer support; and distributing lists of relevant local contacts to enable individuals to build up their own personal networks.

Networks for those transitioning to more senior roles - Establishing formal networks for individuals new to the DON/ Chief Nurse role, buddying networks or allocated senior support for new deputy DON and aspiring leaders to ease transition into roles and help individuals to build up realistic impressions about the role from different sources.

Overall, these suggestions are aligned with the underlying principles of the recent NHS national framework (NHS 2016), which suggests that NHS strategy may be aligned the needs of senior nursing leaders. However, the barriers to support identified by interviewees suggests that these needs are still to be addressed and strategies implemented.

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Emerging insights and recommendations

Interviewees painted a picture of senior nursing leadership roles as demanding, highly individually accountable and at times isolating. The requirements for emerging and current talent are many, including to establish effective ways of growing a different skill set, capability to lead quality across systems and operate outside of traditional organisational boundaries; through new models of care and transformation of services. Although there are clearly efforts being made to support nursing leaders with access to development training and a number of interviewees were making proactive efforts to engage or offer mentoring and peer support, more needs to be done to formalise the process of identifying recognising and developing nursing leadership talent, both to develop those in deputy roles and those already in the most senior roles.

Based on the insights of interviewees, key facets for development include:

- *Timeliness*

Existing leaders and upcoming talent need development opportunities sooner to motivate, build confidence and ensure that they have all of the skills necessary to take on the most senior roles.

- *Practical experience*

Gaining on-the-job experience in different roles and in high-level decision making should be built in to deputy director roles to help them diversify their skills and build an accurate picture of roles at the next level, not just through leadership courses or coaching.

- *Personal support and personalization*

Director roles can be isolating and leaders need personal support from peers, mentors and coaches from both within and outside of the NHS to build resilience. Line managers should look to the individual development needs of staff and make sure they have the time ring-fenced for this support.

- *Networking*

Networking is both important for peer support, information and development. Specific networks should be provided for deputies and others in transitional stages, recognising the particular challenges of scaling up to more senior roles. A greater localisation of formal networks may also enable increased attendance at face-to-face meetings across a large region.

- *A whole team approach*

It is important for senior nursing leaders and the executive boards they operate within to develop a mutual understanding of one another including the need for deputies to gain experience at board level and experience the political and corporate aspects of the role. Successful development of DON and other nursing leaders may include development work with executive board members as well.

Nursing leaders have highlighted that they require professional, developmental and personal support to deliver on increasingly complex and demanding roles within an NHS that is itself facing major challenges and organisational change. More must be done to formalise opportunities for senior nursing leaders to learn, build networks and gain varied experience to enable them to adapt to current and future demands, particularly those wishing to make the leap to more senior roles.

Limitations and future research

The sample is very small, restricted to a geographical area and based on the key informants who voluntary agreed to participate. Furthermore, the participants were relatively inexperient (all under four years and the majority with one or two years in the role) although the turnover in this group is so great that this level of experience is generally the norm.

A more robust sample would strengthen the overall study and allow the findings to be generalizable to other groups of nursing leaders. The analysis is based on responses to questions designed to address a limited context. Different questions focused on the specific attributions of the different leadership roles involved would reveal additional data.

More research is needed to provide solid evidence regarding nursing leadership talent management in different and evolving organisations and across systems such as evolving Strategic Transformation Partnerships. The subject also needs to be studied from the perspective of those aspiring to be leaders (specific motivations, needs, challenges and expectations). Another relevant area for future research could involve the perspective of the institutions/ organisations involved in developing knowledge and preparation in the area leadership (qualifications/ courses) to deal with the challenges of leadership talent.

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