An exploration of factors which affect employment retention in the UK mental health nursing workforce.

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Table of Contents

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Abstract

Introduction

There is evidence that the rate of mental health nurses (MHNs) leaving the profession in the UK has rapidly increased in recent years, leading to critical staffing shortages. These losses have detrimental consequences for service user's care and safety. A recent literature review highlighted that the factors affecting retention are likely to vary between clinical settings in mental health due to the differences in work environments and services they provide.

Aim

To identify any differences in registered MHNs intention to leave across different clinical settings within the NHS; and explore the experiences that influence retention in inpatient and community clinical settings.

Methods

An explanatory mixed-methods study design was used. A survey of MHNs across three mental health NHS Trusts gained 392 responses. The responses were analysed using descriptive and inferential statistics. Thirty MHNs were purposefully selected for individual interviews along with ten senior leaders to explore the experiences influencing MHNs intention to leave in different clinical settings. Qualitative data was analysed using thematic analysis and then integrated with the quantitative data in the form of a joint display.

Results

Almost wo thirds (n=246, 62.8%) of the sample indicated that they are considering leaving their jobs, with almost one third (n=112, 28.6%) considering leaving nursing all together. Clinical setting, Trust, staff grade, nursing experience, work-related stress, mental wellbeing, and age were significantly associated with intent to leave or stay to some extent. Five themes were generated from the qualitative data: *Disillusionment with Mental Health Nursing, The Impact of Leadership and Management, The Impact of the Work Environment, The impact of Training and Development,* and *The Impact of Staffing.*

Conclusion

The retention of MHNs should remain a priority of the National Health Service (NHS) Long-Term Workforce Plan and other workforce policies. Findings from this study can be used to

inform policy and retention strategies that can be tailored to inpatient and community mental health clinical settings.

Introduction

The nursing workforce accounts for over a quarter of NHS staff (Beech *et al*, 2019). With increasing demand, insufficient resources and deteriorating job satisfaction (Royal College of Nursing (RCN), 2021), this workforce is overstretched and depleting rapidly, now accounting for 45% of all NHS vacancies in England (The Health Foundation, 2020), approximating 41,000 vacant nursing posts (Buchan *et al*, 2019). The United Kingdom (UK) NHS is not in isolation as nursing shortages represent a global concern, with a 5.9 million shortage of nurses globally (Buchan *et al*, 2020), and the World Health Organisation (WHO) estimating a 12.9 million deficit in skilled health professionals made up of physicians, nurses, and midwives by 2035 (WHO, 2013). In 2021 56.8% of nursing staff indicated that they are planning on leaving their current post in the RCN employment survey (RCN, 2021), and 22,549 nurses, midwives, and nurses associates left the permanent register (Nursing and Midwifery Council (NMC), 2022). Despite a recent rise in the number of people joining the NMC register the number of people leaving it also rose significantly from 3,199 to 27,133 in 2021-2022 (NMC, 2022). Poor retention of nurses has severe implications on organisational costs, productivity, and quality of care and must be addressed (Buchan *et al*, 2018).

Mental health is a priority area identified within the NHS Long-Term Plan (NHS, 2019a), Interim NHS People Plan (NHS, 2019b), and Five Year Forward View for Mental Health (Mental Health Taskforce, 2016), with Mental Health Trusts accounting for 28% of all nurse vacancies (Health Education England (HEE), 2022). MHNs make up the largest group of professionals within mental health care systems around the world (International Council of Nurses (ICN), 2022), with critical shortages causing a detrimental impact on mental health care and treatment. Even with increased focus and efforts to recruit mental health nurses, their numbers rose by less than 0.5% in 2018 (Buchan *et al*, 2019). Alongside recruitment difficulties is the inability to retain MHNs currently in post, with nurses leaving their posts, the NHS, and the profession at an increasing rate. The National Retention Programme (NRP) was launched in 2017 by the NHS in response to these challenges. Under this scheme clinical mental health staff turnover has decreased from 14.3% to 13.4% (NHS Improvement, 2019b). Since the launch of the NRP the world was struck by the global coronavirus pandemic, which has had a profound impact on health and social care systems around the world disrupting nurse retention (Buchan *et al*, 2022). Whilst rates of MHNs leaving the profession decreased during

the initial stage of the pandemic demonstrating resilience and courage, rates quickly started to increase in 2021 to 6.9% which is similar to pre-pandemic rates (HEE, 2022). This is likely to be a result of the pandemic exacerbating the existing issues negatively affecting nurse retention and turnover, such as poor working conditions and excessive work pressure, which is now accelerating burnout and intention to leave (The Kings Fund, 2020; Buchan *et al,* 2022).

Poor retention reduces the ability of MHNs to meet mental health service user's needs leading to dangerous consequences for care and safety (Unison, 2017a); and is likely to deter people from wanting to join the profession. Therefore, HEE reports that the retention of existing MHNs must remain a priority of the NHS Long-Term plan and future workforce policies or else the profession could be lost with vacant nursing posts being filled by new non-nursing roles (HEE, 2022). Whilst there has been a steady increase in research related to nurse retention in recent years (Moseley *et al,* 2008; Chan *et al,* 2013; & Halter *et al,* 2017; Ball & Ejebu, 2021) this is not the case for research specific to the mental health nursing workforce, which may be used to guide and inform retention strategies. Therefore, retention of the existing mental health nursing workforce will be the focus of this thesis.

Definitions

Retention

Retention will be defined as 'MHNs remaining in their employment'. Turnover and intention to leave are indicators often used to assess and predict nurse retention. These terms will be defined as follows:

Turnover

There is no standard definition of turnover, so for the purpose of this project the definition set out in Buchan *et al*'s (2018, p.20) policy brief on nurse retention was chosen:

> *"Turnover, and the alternate terms of 'attrition' or 'wastage', is usually expressed in terms of the % of nurse staff of a particular workplace or system who have left the organisation (or have moved jobs) within the last 12 months. This is sometimes called the 'crude' annual turnover rate'."*

Intent to leave

Intent to leave refers to MHNs who are currently employed as an MHN, but contemplating leaving their current position, the NHS, or the mental health nursing profession. In a literature review conducted by Health Education England (HEE, 2014) on nurses leaving the profession, it was estimated at that time that around 10% of nurses were seriously considering leaving the nursing profession. Intent to leave can be a significant predictor of, and often translates into actual behaviours, contributing to turnover and nurse attrition within the NHS and profession. Intention to leave is often measured by self-administered questionnaires such as the NHS staff survey (NHS, 2020a).

Stakeholder and Patient and Public Involvement (PPI) consultations

Prior to the development of this research, I conducted several stakeholder consultations to explore the significance of the research problem, refine the research questions and methods. Due to the vast range of clinical settings in mental health NHS Trusts, I met with over twenty MHNs of different staff grades from different clinical settings (Male, Female and Older Adult Acute Inpatient units, Psychiatric Intensive Care Unit, Increasing Access to Psychological Therapies service, and Older Adult Community and Home Treatment Teams). There was an overwhelming sense of both frustration and emotional exhaustion across clinical settings, but the individual factors they would like addressed to improve their job satisfaction varied between settings. There was also a strong sense of hope and commitment to their careers if things could be improved.

My supervisor and I also held a PPI meeting with local service users to discuss the importance of the research problem to them. They expressed how the retention of MHNs is extremely important to them for consistency and quality of care. They described having as many as six different MHNs co-ordinating their care over the past year and explained how having to repeat their story time and time again causes frustration and in some cases re-traumatisation. They described how inconsistency of MHNs delays their recovery through needing to develop trusting relationships with new MHNs and then re-explain their experiences. This confirmed that the problem was not only relevant to MHNs themselves but the service users they care for and their clinical outcomes.

The next chapter continues to introduce the research topic and provides a review of the relevant existing literature.

Chapter 1 - Literature Review

This chapter will present a systematic review and thematic synthesis of the existing research focused on retention within the mental health nursing workforce. The review identifies and discusses the individual factors that affect MHN retention and suggests some recommendations for improvements and areas for future study.

Background

Mental health problems are a significant contributor to the overall disease burden worldwide (Mental Health Foundation, 2016). With more people being encouraged to seek help for their mental health problems, more people are now receiving care and treatment for mental health problems (CQC, 2017). Despite the mental health sector being identified as a priority, there has been a drastic 12% fall in MHNs between 2010 and 2017 in the NHS (CQC, 2017). Whilst there was an overall growth of 2% for the NHS England workforce from April 2016 to April 2017, there was a reduction of 190 (0.5%) MHNs (Buchan *et al,* 2017), with 11% of mental health nursing posts remaining vacant (HEE, 2017). There was also a reduction in nurses and health visitors (460, 0.2%) and community nurses (970, 2.9%), but there was notable growth in clinical support staff (2.5%), consultants (3.5%), and managers and senior managers (4.3%) (Buchan *et al,* 2017). These numbers continue to support the need to address the recruitment and retention of MHNs, as the workforce remains overwhelmingly understaffed with increasing workloads and high turnover rates (RCN, 2015). Urgent action is now required to reverse this trend and reduce the use of bank and agency MHNs (RCN, 2015), before patient safety is put at greater risk (Unison, 2017b).

Developing strategies focused on encouraging recruitment may be a futile occupation if retention is not addressed. Nurse turnover can be beneficial by bringing in new perspectives, ideas, and experience, but high turnover rates often come with high economic and non-economic costs (Dewanto & Wardhani, 2018). Instability of nursing staff leads to unstable nursing care, which increases the risk of care and treatment errors that can have grave effects of patient care and safety (O'Brien-Pallas *et al,* 2010). Whereas, relying on bank and agency staff, continuous recruitment, and orientation and training processes constitutes a large economic burden (Jones & Gates, 2007). In 2018 the NHS had reportedly spent £353 million on agency and bank staff (Buchan *et al,* 2019). More immediate emphasis should be placed on retaining the staff already in post. By doing this we can help to ensure that the current

profession is fit for purpose, and one that others aspire to join to aid retention and boost recruitment (Unison, 2017b).

Job dissatisfaction is strongly associated with poor retention (Happell, 2008; Ward, 2011; & HEE, 2014). Job satisfaction for MHNs is reportedly the lowest it has ever been, with many nurses emotionally and physically exhausted, leading them to consider leaving their profession (Unison, 2017b). This results in a negative cycle where the consequences of poor job satisfaction and turnover e.g., increased workload, pressure and working with temporary MHNs or inadequate numbers of MHNs leads to even more turnover (Jones & Gates, 2007). At the time this review was conducted the world had just begun to delve into the depths of a global pandemic. This placed even more pressure on the mental health workforce due to increasing demand and even more staff shortages due to shielding, sickness, and self-isolation guidance (British Medical Association, 2020). Evidence on the impact of the pandemic on the mental health nursing workforce is sparse. However, experiences of MHNs demonstrate how the pandemic has impacted on their way of working (increased workload and remote working); the care service users receive (receiving an inadequate service); introduced concerns around risk of infection and challenges related to a lack of adequate personal protective equipment (Foye, *et al,* 2021). It is therefore likely that MHNs' job satisfaction has further deteriorated and will continue to deteriorate as they continue to respond to the populations' mental health needs caused, and exacerbated, by the pandemic.

Much of the literature surrounding nurse turnover and retention relates to adult nursing (Moseley *et al*, 2008; Chan *et al,* 2013; & Halter *et al,* 2017). Whilst some research is focused on MHN retention there has not yet been a systematic review consolidating those factors that affect retention within this workforce. With the concern about the consequences of poor retention on patient care and safety, it is imperative to get a better understanding of the specific factors causing MHNs to leave or contemplating leaving; so that meaningful and targeted retention strategies can be put in place to resolve this current crisis.

Aim of the review

The aim of this review is to identify factors that affect the retention of MHNs, to inform retention strategies and identify areas for future research.

Review question

What factors affect registered nurse retention within the mental health nursing workforce?

Methods

This section will detail the processes undertaken to identify, select and appraise the existing literature focussed on factors affecting retention of MHNs. It will also explain methods of data extraction and synthesis used to generate findings used to inform a discussion.

Protocol

This systematic review and thematic synthesis adhered to the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines (Moher *et al,* 2009). This review was conducted by myself in 2019-2020 and subsequently published in the International Journal of Mental Health Nursing in 2021 (Adams *et al*, 2021).

Search strategy

Developing the review question

A novel and focussed research question was developed and refined through initially scoping the literature and identifying how much literature exists on the topic (Booth *et al*, 2016). A gap in the literature was identified, and following the PICO (Population, Intervention/Exposure, Comparison and Outcome) framework (Booth *et al*, 2016), a review question was developed as follows: What factors (I/E) affect retention (O) within the mental health nursing workforce (P)?

Database searches

A systematic search of six databases was conducted from their year of inception to November 2019: CINAHL, PsychINFO, MEDLINE, Web of Science (Core collection), Embase, and the British Nursing Index (BNI). Final search strategies were developed using the following key terms: ("Mental health nurs*" OR "psychiatric nurs*" OR RMN* OR "mental nurs*" OR RMHN) AND (Retention OR retain* OR remain* OR leav* OR attrition OR "intent* to leave" OR "intent* to stay" OR turnover OR "sustainable workforce" OR loyalty OR resign* OR shortage). Key terms were combined using Boolean operators 'OR' and 'AND'. Phrasing was used to ensure some of the key terms in the search appeared together to narrow the results generated. Truncation was used for key terms that could have more than one relevant ending. Examples of the search strategy for each database can be seen in Appendix A. No date limits were applied to ensure a sufficient number of results.

Grey literature and other resources

Although the BNI includes dissertations and theses it mainly covers papers published within the UK. Therefore, to supplement the electronic searches and minimise publication bias grey literature databases OpenGrey and Google Scholar were searched for any relevant unpublished studies including dissertations and theses. Reference lists from relevant studies and reviews were also screened for eligible studies.

Contacting authors

Primary authors were contacted to try and gain the full-text versions of unpublished articles that could not be located elsewhere.

Eligibility criteria

The eligibility criteria for this review can be seen in table 1.1.

Table 1.1 - Study eligibility criteria

Inclusion criteria	Exclusion criteria
Population • Studies focussing on registered nurses who specialise in mental health or work in mental health settings of any age, experience, or staff grade. *Setting* • Studies focussed on registered nurses working in any mental health setting. *Outcomes* • Studies reporting any findings on factors that affect the retention of registered nurses working within mental health settings. • Studies reporting findings on interventions or strategies that aim to affect retention. • Studies reporting findings on the predictive factors of retention. *Study design* • Any empirical studies including all study designs. • Studies were not excluded based on quality due to the paucity of research on this topic.	• Non-empirical research. • Non-registered nurses (including student nurses, enrolled nurses, and nursing associates). • Papers not written in the English language at full text.

Study selection

The search results generated from the databases were exported to Mendeley and duplications were removed. Titles and abstracts were screened simultaneously to identify relevant papers. Relevant papers were then screened at full text to identify eligible studies for review based on the predetermined eligibility criteria. Any uncertainty around the inclusion or exclusion of any studies were resolved through discussions with my supervisors, to minimise the risk of excluding relevant studies or including ineligible studies.

Data extraction

A simple standardised data extraction form was created based on the information required to answer the review question using Excel (see Appendix B). The form was piloted on four studies using different research methods to ensure that no important data was missing from the form, and that the form was not generating unnecessary data (Higgins and Green, 2011). I extracted all the data increasing the risk of data extraction errors (Higgins & Green, 2011). However, the data extraction form was discussed with my supervisors to minimise the risk of bias in the information being extracted.

Quality assessment

As the included studies comprised a range of study designs and methodologies, the Mixed Methods Appraisal Tool (MMAT) version 2018 and user guide was used to assess the quality of the studies (Hong *et al*, 2018). The MMAT can be used to appraise all types of empirical research including both experimental and non-experimental designs (Hong *et al*, 2018). The included studies were categorised and rated using the appropriate quality criteria. These ratings were then used to form a percentage score. Each of the quality criteria within each category will account for 20% of an overall score. Scores were accompanied by a summary of the quality by comparing the studies within and across categories. Mixed methods studies were rated using the quality criteria for mixed methods studies alongside the appropriate quality criteria for each individual study component.

Assessment of heterogeneity

Due to the broad eligibility criteria, a significant level of heterogeneity was expected. There was heterogeneity identified in the characteristics of the included participants as there were significant differences in the participant's gender, age, ethnicity, marital status, years of clinical experience, and qualification/education level. There was also significant methodological

heterogeneity, which consisted of variance in study design, methods, and outcome assessments. The aims of the studies differed significantly, as some studies had different foci but were included as they reported some outcomes relating to factors that affect retention. The different areas of focus meant significant diversity in the study designs and outcome measures. Study designs included cross-sectional, longitudinal, quantitative, and qualitative designs and a range of outcomes measures. This clinical and methodological heterogeneity would likely lead to significant statistical heterogeneity and inaccurate average effects, leading to misleading conclusions if a meta-analysis was conducted (Gagneir *et al,* 2012).

Data synthesis

A narrative approach was taken, and a thematic synthesis was conducted to identify and generate descriptive themes across all included studies. Framework synthesis was considered but discounted due to the limited amount of theory and research available on factors that affect retention in the MHN workforce. Applying a framework based on uncertain theory and limited by my own clinical experience may have resulted in key themes immersed in the data being overlooked (Snilstveit *et al,* 2012). Therefore, thematic synthesis was preferable to analyse the data from the existing literature without the constraints of predetermined themes.

Thematic synthesis is an effective method for combining the findings of research using different study designs and methodologies (Gough *et al,* 2017). It is also advantageous in its ability to organise and summarise the findings from a range of study designs including both qualitative and quantitative data (Pope *et al,* 2007). The review synthesis took an inductive approach (Pluye & Hong, 2014). Findings from quantitative studies were converted into qualitative form by a process often described as ‘qualitising’ or ‘data transformation’ (Dixon-Woods *et al,* 2005; and Pluye & Hong, 2014). This was done by transforming the statistics derived from survey/questionnaire responses and secondary datasets into textual data, to create a narrative of the results that can be synthesised alongside the qualitative findings (Heyvaert *et al,* 2016) (see Appendix C). The qualitised data along with the qualitative findings were then imported to Quirkos software for analysis (Quirkos 2.4.1). Thomas & Harden’s (2008) three stages of thematic synthesis were followed: I started by line-by-line coding of the findings of each study; I then generated descriptive themes through organising the codes into themes and associating themes with similar concepts; the final themes and subthemes were accompanied by a narrative analysis and then contextualised within the existing literature in the discussion section.

Results

This section will detail the results of the systematic search and study selection, including the reasons for the studies excluded at full text. It will then move onto a summary of the findings from the quality assessment and a description of the individual study characteristics, before moving on to present the findings of the thematic synthesis.

Search results and study selection

The search of the six databases retrieved 4428 potentially relevant papers. No additional papers were identified through searching grey literature or checking the reference lists of relevant papers. After duplicates were merged, the citations and abstracts were screened simultaneously for 2024 papers. This left 45 papers eligible for screening at full text. Primary authors for two of the studies were contacted to access the full text version of their papers for screening which were unable to be located otherwise (Walrath, 2011 & Hanohano & Dee, 2017). Walrath emailed the full-text version for screening. Hanohano did not respond, and I was unable to access the paper through an inter library loan, therefore, this paper had to be excluded at full text. A total of 22 papers were excluded at full text with reasons. This left 23 papers eligible for inclusion, see Figure 1.1 for an overview of the study selection process.

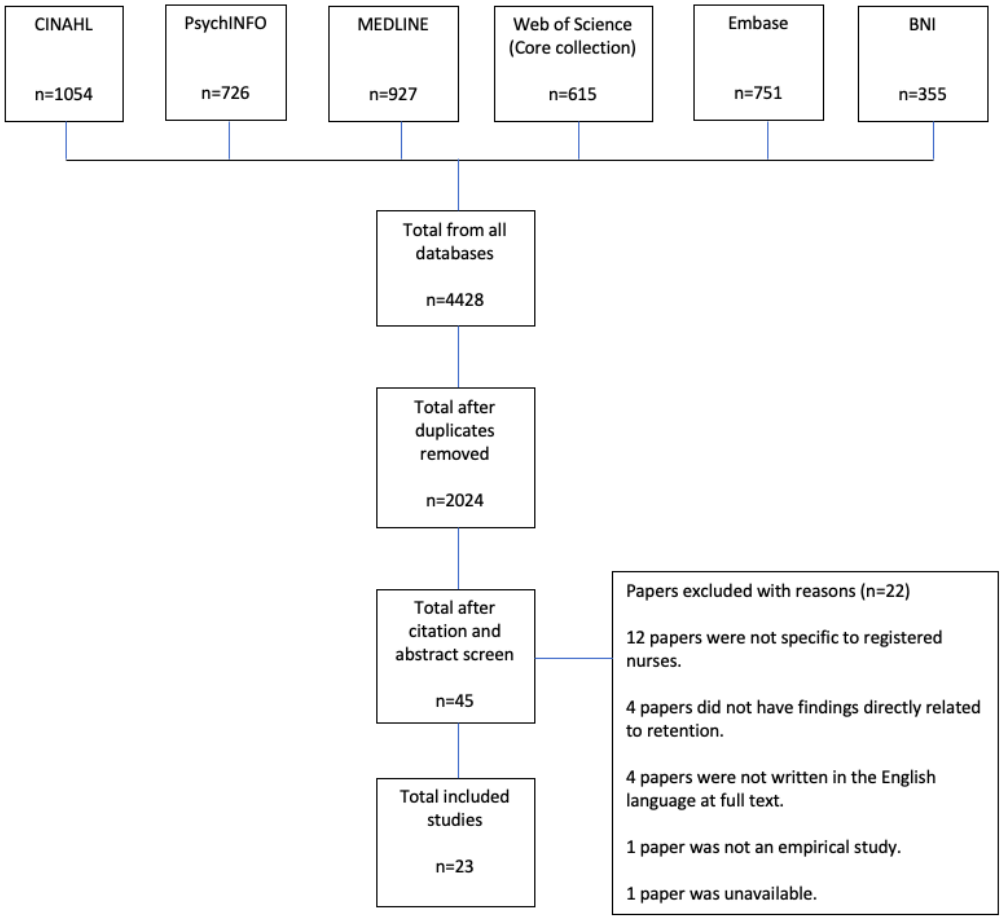

Figure 1.1 - Flow diagram

Description of the included studies

The detailed characteristics for the 23 studies can be seen in Table 1.2 (see Appendix D). Of the studies, 20 were published in journals and peer reviewed nursing magazines, and three were unpublished PhD theses located within the BNI. The studies span almost three decades from 1991-2019 including 18,918 mental health nurses. The studies were conducted in eight different countries, nine in the United States, six in the United Kingdom, three in Jordan, and one in Canada, China, Japan, Ghana, and Israel. It is important to note that there are differences in the nurse training programmes and health care systems across the eight countries.

The clinical settings included in the studies comprised of public funded organisations (NHS, state-run, and Ministry of Health settings) and private organisations. A total of 15 of the studies included a range of inpatient settings and six studies included a range of community-based settings which can be seen in Table 1.2 (Appendix D). Six studies did not specify the individual clinical settings (Robinson & Tingle, 2003; Sherring & Knight, 2009; Robinson *et al,* 2005; Hamaideh, 2011; Walrath, 2011, Murrels & Robinson, 1999).

The studies included a range of qualitative (n=4), quantitative (n=17), and mixed methods (n=2) study designs. Two studies were evaluating retention strategies. Rollins (2014) evaluated whether an increase in the length and content of an existing training programme undertaken in MHNs' orientation period impacted retention. The new Healthy Work Environment (HWE) programme was extended to eight weeks and included familiarisation to local polices and documentation, skill competencies, and seclusion and restraint training. Pelletier *et al* (2019) introduced a nurse residency programme for newly qualified nurses. The programme incorporated training on a vast number of clinical theories and practice, as well as topics that influence retention derived from the literature including introducing a social support system.

The aims of the studies varied with most of the studies (n=18) directly aiming to explore factors that affect retention, although the factors explored differed amongst the studies. The rest of the studies (n=5) had different aims and can be seen in Appendix D. These studies were included as they still generated some important findings on factors that affect retention. Due to the differences in study design and aims, the outcome measures also varied significantly. All the

qualitative studies used individual interviews and the quantitative studies used a range of validated and unvalidated questionnaires to explore different factors that affect retention.

Quality assessment

Studies were categorised into four study designs: 'qualitative' (n=4) (Alexander *et al,* 2015; Musto & Schreiber, 2012; Stacey *et al,* 2011; & Karlowicz & Ternus, 2009), 'quantitative non-randomised' (n=2) (Rollins, 2014 & Pelletier *et al,* 2019), 'quantitative descriptive' (n=15) (Alsaraireh *et al,* 2014; Jiang *et al,* 2019; Walrath, 2011; Ito *et al,* 2001; Murrels & Robinson, 1999; Bamber, 1991; Robinson & Tingle, 2003; Sherring & Knight, 2009; Yanchus *et al,* 2017; Robinson *et al,* 2005; Hamaideh, 2014; Hamaideh, 2011; Baum & Kagan, 2015; Kagwe *et al,* 2019; & Yanchus *et al,* 2015), and 'mixed methods' (n=2) (Agyapong *et al,* 2015 & Gunn, 2015). The details of the individual assessments for each individual study can be seen in Appendix E. All four qualitative studies met 100% of the quality criteria. One of the quantitative non-randomised studies met 80% of the quality criteria, but did not report on possible confounders (Rollins, 2014). Whereas Pelletier *et al's* (2019) quantitative non-randomised study only met 60% of the quality criteria. This study had a response rate of 33% due to attrition over time. Five of the quantitative descriptive studies met 100% of the quality criteria (Ito *et al,* 2001; Murrels & Robinson, 1999; Robinson & Tingle, 2003; Robinson *et al,* 2005; & Hamaideh, 2011). Six quantitative descriptive studies included a sample that was not representative of their target population due to small sample sizes (Walrath, 2011; Sherring & Knight, 2009; & Kagwe *et al,* 2019), and samples from single clinical settings which were not representative of MHNs working in other clinical settings in different areas (Alsaraireh *et al,* 2014; Jiang *et al,* 2019; & Bamber, 1991). Seven of these studies were at risk of non-response bias judged by low response rates ranging between 35-65%, with no documented reasons for non-response or statistical compensation reported (Walrath, 2011; Bamber, 1991; Sherring & Knight, 2009; Yanchus *et al,* 2017; Hamaideh, 2014; Kagwe *et al,* 2019; & Yanchus *et al,* 2015). Two of these studies did not use measurements that are validated or pre-tested (Bamber, 1991 & Kagwe *et al,* 2019). One used a measurement that was not specific to the topic under study (Yanchus *et al,* 2017). The two mixed methods studies were of low quality. Neither study presented an adequate rationale for the use of a mixed methods design, or any information on how or when data integration occurred. The quantitative component met 80% of the criteria for one of the studies (Agyapong *et al,* 2015), in contrast to the qualitative which met 60%. Whereas, in Gunn's (2015) study the qualitative component met 100% of the quality criteria and only 60% of the quantitative descriptive criteria.

Findings

Job satisfaction was a widely applied code and citied in seven studies (Alsaraireh *et al,* 2014; Jiang *et al,* 2019; Ito *et al,* 2001; Bamber 1991; Yanchus *et al,* 2015; Baum & Kagan, 2015; & Yanchus *et al,* 2017). Most (n=5) demonstrated that a decrease in overall job satisfaction scores was associated with an increase in intent to leave their current positions. Two demonstrated a reverse trajectory that nurses with higher overall job satisfaction scores were more likely to stay in their jobs (Jiang *et al,* 2019 & Bamber, 1991). Whilst it is evident that overall job satisfaction has a profound effect on intent to leave and retention rates, identifying the individual aspects of job satisfaction that affect retention will be more useful for directing future study and retention strategies. All identified factors were grouped into four main themes: Individual Characteristics, Working within Mental Health Services, Training and Skills, and Work Environment.

Theme 1: Individual Characteristics

This theme is made up of three sub themes: Demographic characteristics, Experience and employment related factors, and Values.

Demographic characteristics

Age is the most significant of the demographic characteristics, with seven studies identifying an association between age and intent to leave (Alsaraireh *et al,* 2014; Jiang *et al,* 2019; Ito *et al,* 2001; Robinson *et al,* 2005; Bamber, 1991; Murrells & Robinson, 1999; & Baum & Kagan, 2015). Whilst most of the studies found that as age increases intent to leave decreases, Robinson *et al* (2005) found that younger nurses that are aged between 20-29 and have children were less likely to report intention to leave.

For gender, two studies found male MHNs had higher intent to leave (Alsaraireh *et al,* 2014 & Jiang *et al,* 2019). Conversely, one study found no significant difference by gender on intention to leave (Baum & Kagan, 2015). Marital status was identified as a factor in two studies with MHNs with single status being more likely to intend to leave their current positions (Alsaraireh *et al,* 2014 & Jiang *et al,* 2019).

Ethnicity was cited in two studies, one study conducted in Israel finding no difference between ethnicity and intent to leave (Baum & Kagan, 2015), another from the UK reporting a tentative

finding that white Irish and British women were more likely to continue nursing up to ten years post qualification (Robinson *et al,* 2005). Jiang *et al* (2019) found that MHNs with better self-rated health were less likely to leave their jobs, whilst MHNs with a higher level of education were more likely. One study found that MHNs with type A personalities were significantly more likely to leave (Bamber, 1991).

Experience and employment related factors

Bamber (1991) and Alsaraireh *et al* (2014) found that MHNs who had left their jobs were less experienced overall than those who stayed in their jobs. This may be explained by a finding in Alexander *et al's* (2015) qualitative study stating:

> *"As new* [mental health nurses], *participants reported starting out much more ambitious and idealistic; with experience, they had adopted a tempered realism."* (Author – Alexander *et al,* 2015, p.451).

This suggests that with experience some MHNs are able to reconsider what success means to them and their service users and feel that they are able to make positive differences to people's lives (Alexander *et al,* 2015).

Less time spent in employment was also associated with MHNs intent to leave. Two studies reported MHNs who had spent longer in their current job were more likely to stay (Ito *et al,* 2001 & Jiang *et al,* 2019). Robinson *et al* (2005) found MHNs who entered nursing with a degree and spent less time in their current job had greater intent to leave, whereas those entering nursing with qualifications that were not degree sufficient and had spent less time in their current job were more likely to stay. Alternative employment options are also a factor (Ito *et al,* 2001).

Values

Exploring how values affect the practice experience of MHNs has been the focus of one study (Stacey *et al,* 2010). They found that when MHNs' values conflicted with their organisation's values which restricted their ability to practice in line with their own values, they contemplated leaving.

Theme 2: Working within Mental Health Services.

This theme is made up of three sub themes: Perception of the job, Factors related to practice, and Clinical setting.

Perception of the job

The majority of MHNs in Gunn's (2015) study reported that the exciting (84.48%) and rewarding (n=53, 91.38%) nature of the job was their reason for remaining in mental health nursing, with one MHN stating:

> *"I have worked in many areas of nursing, but this is the most rewarding job I have ever had"* (Participant in Gunn, 2015, p.60).

A MHN in another study also explained how the non-economic rewards of the job had contributed to their longevity in mental health nursing:

> *"…the hook for me is seeing success, no matter how small or how large"* (Participant 3 in Alexander *et al*, 2015, p.452).

Career pride was a theme that emerged through the findings of Alexander *et al's* (2015) study, where MHNs described needing to overcome negative stereotypes held by other professionals and recognise their value, in order to develop career pride and remain in the field.

Stigma associated with working in mental health services was identified in three studies as a factor that almost always negatively affected retention of MHNs (Agyapong *et al*, 2015; Alexander *et al*, 2015; & Gunn, 2015). However, a MHN in Gunn's (2015) study reported that they responded to stigma by returning to the profession to care for mental health service users:

> *"I returned to MH nursing because I am helping these patients get better that other nurses can't because they have a stigma about it."* (Participant in Gunn, 2015, p.60).

Factors related to practice

Patient-initiated violence, fear of assault, and perceived risk of assault were factors identified that impact on MHNs' intent to leave (Jiang *et al*, 2019; Ito *et al*, 2001; & Kagwe *et al*, 2019). More than half (n=38, 53.5%) of CPNs in Agyapong *et al's* (2015) study had contemplated

leaving the profession as a result of concerns regarding risk (service-users risk to themselves or others, or risk to the MHNs themselves).

Moral distress (Musto & Schreiber, 2012 & Hamaideh, 2014), emotional exhaustion (Sherring & Knight, 2009 & Yanchus *et al*, 2017) and burnout (Bamber, 1991 & Gunn, 2015) were associated with leaving or intent to leave. Moral distress arises when a nurse makes a moral judgement about a service user's care or treatment and knows the right thing to do; however, constraints such as the institution or resources (including human resources) make it difficult or impossible to act in accordance with that judgement (Jameton, 1993). MHNs reported experiencing moral distress after events that involve the safety of adolescent service users, which impacted their perceived ability to keep service users safe and caused some to leave or consider leaving their job (Musto & Schreiber, 2012). One study identified that a higher level of emotional exhaustion increased the likelihood of MHNs contemplating leaving the NHS (Sherring & Knight, 2009).

Being able to provide successful care and treatment, no matter how small the improvement, and remain hopeful for service users was identified in two qualitative studies (Alexander *et al*, 2015 & Karlowicz & Ternus, 2009). MHNs in one study describe their positive experiences of caring for service users which is what influenced them to remain in mental health nursing:

> *"You know what keeps me there? ... [Tells story of veteran with PTSD, and his family, who had a successful treatment experience] . . . So, to see that change, that keeps me engaged and that stays in my mind because, I think, as we go forward, there's going to be more and more and more and more people and families like his. . . That's what keeps me engaged in psych. That's my story!"* (Participant 4 in Alexander *et al*, 2015, p.451).

Clinical setting

Interestingly, two studies reported differences in MHNs' intention to leave across different clinical settings. One study found that working on closed wards was associated with higher intent to leave mental health nursing than working on open wards in the hospital under study (Baum & Kagan, 2015). Another study found that nurses working in male acute units in the hospital under study had the highest turnover intentions and MHNs working in long-term female units had the lowest turnover intentions (Alsaraireh *et al*, 2014). Unfortunately, several

studies did not specify the individual clinical settings in which the MHNs were working, including the four studies conducted within the UK NHS.

Theme 3: Training and Skills

This theme consists of two sub themes: Pre-registration nurse training and Continuing professional development (CPD).

Pre-registration nurse training

Course preparation was a significant factor associated with plans to remain working within the NHS (Murrells & Robinson, 1999). Two studies found that nurses prepared with a bachelor's degree, or qualifications sufficient for degree entry, were less likely to remain in nursing than those with other types such as associate degrees, access courses, or direct entry tests (Alsaraireh *et al,* 2014 & Robinson *et al,* 2005). Beyond course preparation, one study identified that the length and quality of nurse preceptorships were factors that can cause newly qualified MHNs to consider leaving (Robinson *et al,* 2005).

Continuing professional development

Three studies demonstrated an association between MHNs' intention to leave and the ability to develop and maintain their skills post-registration (Robinson *et al,* 2005; Kagwe *et al,* 2019; & Alexander *et al,* 2015). MHNs described being part of a team that encourages and enables them to enhance their skills was a reason they remained working within the profession (Alexander *et al,* 2015 & Gunn, 2015). Additionally, being able to use their skills to practice autonomously was a factor that indirectly predicted MHN's turnover intentions through job satisfaction (Yanchus *et al,* 2015).

In two studies, a lack of CPD opportunities was a contributing factor to MHN's intentions, or actual decisions, to leave their first job (Robinson & Tingle's, 2003 & Robinson *et al,* 2005). MHNs in Karlowicz & Ternus' (2009) study reported that they favoured organisations to promote more CPD to improve retention. Two studies identified that a lack of in-service training and education negatively affects retention (Bamber, 1991 & Karlowicz & Ternus, 2009). Whilst most of these studies found that an inability to enhance their skill set negatively affected MHNs' retention, fear of losing nursing skills was also a reason cited for nurses to consider leaving their job working in one mental health hospital (Kagwe et al, 2019).

Theme 4: Work Environment

Work environment is the largest theme broken down into six sub themes: Working relationships, Leadership, Organisational culture, Salary, Work schedule and resources.

Working relationships

An association between working relationships and intent to leave or stay was reported in seven studies (Kagwe *et al,* 2019; Robinson & Tingle, 2003; Karlowicz & Ternus, 2009; Robinson *et al,* 2005; Gunn, 2015; Jiang *et al,* 2019; & Alexander *et al,* 2015). Kagwe *et al* (2019) found that all aspects of working relationships were significantly associated with the MHNs' intent to leave. Karlowicz & Ternus (2009) reported mixed findings related to team dynamics, with currently employed MHNs expressing positive experiences of feeling part of the team, and former MHNs reporting negative experiences and feeling outcast. A qualitative study was able to provide a deeper understanding of what aspects of positive working relationships influence MHNs' decisions to remain in the profession (Alexander *et al,* 2015).

> *"Participants appreciated the sense of belonging and cohesion that the team fostered, and connected that to why they have remained in the specialty"* (Alexander *et al,* 2015, p.451).

Another study found that MHNs satisfied with the Trust and coordination between physicians and nurses were more likely to stay in their jobs (Jiang *et al,* 2019). In two studies civility, defined as *"courteous and considerate workplace behaviors within the workgroup"* (Yanchus *et al,* 2015, p.222), was shown to indirectly impact on turnover intention through job satisfaction (Yanchus *et al,* 2015 & 2017).

Leadership

Aspects of leadership were identified in seven studies as factors that affect retention. Receiving support from line managers (Robinson *et al,* 2005), effective communication (Walrath, 2011), high quality supervision (Karlowicz and Ternus, 2009) and leadership opportunities (Alexander *et al,* 2015) all aided retention.

A lack of supervisory support consisting of guidance, feedback, and interpersonal support was associated with intent to leave or turnover in two studies (Yanchus *et al,* 2017 & Ito *et al,* 2001). Similarly, inadequate support, especially in times of high acuity, was significantly associated with intent to leave (Kagwe *et al,* 2019). As well as line management, MHNs should

have the opportunity to engage in clinical supervision for support and skill development. An unsatisfactory amount of clinical supervision was identified as a factor sufficient to cause newly qualified MHNs to contemplate leaving their job (Robinson *et al,* 2005).

Organisational culture

MHNs in Karlowicz & Ternus' (2009) study reported that changes within their organisations' attitude and culture should be addressed to improve retention. Organisation's procedural justice concerning performance appraisal was identified as a factor that can predict MHNs' turnover intention through job satisfaction in one study (Yanchus *et al,* 2015). Likewise, being given an opportunity for feedback prior to any disciplinary action was significantly associated with lower intent to leave (Kagwe *et al,* 2019). MHNs who had left their jobs in Bamber *et al's* (1991) study reported being significantly more dissatisfied with the quality of decisions made by management.

The role of MHNs within an organisation was identified as a factor that can affect retention in two studies. A role that allows MHNs to utilise their diverse set of skills (including dispensing medication) and spend a satisfactory amount of time with service users can increase job satisfaction and improve retention within the profession (Karlowics & Ternus, 2009 & Gunn, 2015).

Retention strategies were put in place and evaluated in two organisations committed to retaining their MHNs across two studies. Both studies found positive results with a new Healthy Work Environment orientation training programme significantly increasing retention rates for one organisation (Rollins, 2014); and a new Nurse Residency Program for new graduates was associated with less nurse turnover for another (Pelletier *et al,* 2019).

Salary

Salary was one of the most widely applied codes across seven studies (Jiang *et al,* 2019; Alsaraireh *et al,* 2014; Agyapong *et al,* 2015; Gunn, 2015; Robinson *et al,* 2005; Kagwe *et al,* 2019; & Karlowicz & Ternus, 2009). Jiang *et al* (2019) found that MHNs with a higher monthly income on average are more likely to remain in their job. Despite job security with a permanent contract being a factor for staying in their first job, a salary that did not reflect their level of responsibility was a reason sufficient for MHNs to leave or contemplate leaving in one study

(Robinson *et al*, 2005). MHNs in Karlowicz & Ternus' (2009) study suggested pay scales and other incentives should be addressed within their organisation to improve the retention.

Work schedule

Work schedule was explored in four studies. Shift times had no significant impact on MHNs' intent to turnover in one study (Alsaraireh *et al*, 2014). MHNs working over forty hours per week (Jiang *et al*, 2019) or part-time hours (Baum & Kagan, 2015) were more likely to contemplate leaving. More than one-third of MHNs in Robinson *et al's* (2005) were dissatisfied with the combination of work hours and time spent with partners, spouses, or on responsibilities for their children, and these factors were sufficient for MHNs to contemplate leaving their first mental health nursing job. MHNs in Karlowicz & Ternus' (2009) study reported that they would like scheduling and work hours to be addressed within their organisation to improve retention.

Resources

Newly qualified MHNs reported that unsatisfactory staffing levels, including amount of qualified to non-qualified staff, was a sufficient reason to consider leaving their first job (Robinson *et al*, 2005). Similarly, the ratio of MHNs to service-users was not a reason for MHNs to remain in mental health nursing in Gunn's (2015) study.

Workload and having adequate time to complete their work was significantly associated with MHNs' likelihood of searching for an alternative job and intent to leave in Kagwe *et al's* (2019) study. MHNs' satisfaction with the amount of time spent on paperwork was positively related with intent to remain in the profession in (Robinson *et al*, 2005).

Discussion

This review was concerned with the individual factors that affect the retention of MHNs. Job satisfaction is a significant factor here, and this broad concept has been dissected into four interrelated themes: Individual Characteristics, Working within Mental Health Services, Training and Skills, and Work Environment. It is likely that no single factor occurs in isolation and a combination of factors across these four themes may account for an increased risk of intention to leave. The most effective retention strategies will need to address multiple yet specific factors to improve job satisfaction.

The most significant individual characteristic that impacts retention identified within this review is age. This finding is corroborated by the review conducted by Health Education England (HEE) (2014), which also found that younger nurses are more likely to leave the profession. Newly qualified nurses entering their first job were also found to be at significant risk of leaving. This also mirrors the review by HEE (2014), which found turnover rates are highest in nurses' first and second year of practice. Younger and newly qualified MHNs are more likely to possess many other factors identified in the other themes, such as less nursing experience and time spent in their current job, increasing their risk of intention to leave. Therefore, developing retention strategies aimed at supporting MHNs in their first and second year of practice should be considered a priority on the workforce agenda. Future research may want to focus on the factors specifically affecting newly qualified nurses' intent to stay or leave in their first jobs. This will help to gain insight into MHNs' experiences and identify any shortfalls of the preceptorship programmes that support MHNs with the transition from student to qualified nurse, to improve their experience and job satisfaction.

The second theme was more unique to the mental health nursing speciality. Caring for some of society's most vulnerable people with complex conditions is seen as exciting and rewarding, which is a significant factor in attracting and retaining MHNs. However, continuously caring for people with mental health problems can lead to safety concerns, emotional exhaustion, moral distress, and burnout which negatively affects well-being, and in turn, retention. It is likely that if nurses possess some of the individual factors from Theme 1 e.g., limited nursing experience and less time spent in their job, they will be more vulnerable to some of the factors present in this theme. This highlights the relationships between the factors across themes and the impact that one factor could have on other factors increasing the influence on MHNs intention to leave or stay.

Interestingly, different clinical settings were identified as factors that affect retention. This suggests that factors affecting retention differ not only by organisation, but also by specific clinical settings within organisations. Therefore, one-size fits all retention strategies may lead to unhelpful and unnecessary efforts that reap few benefits, by missing important factors in different settings. There is currently an absence of literature detailing retention rates for individual clinical settings within Mental Health NHS Trusts (DHSC, 2020). With the vast range of care environments within the NHS Mental Health Trusts, it will be important for future

studies to identify if MHNs' intent to leave differs across clinical settings within the NHS, and explore the experiences influencing intention to leave, so more tailored and meaningful retention strategies can be developed.

The complexities of mental health care and the vast amount of specialist services within mental health requires significant training, and experience, to be able to practice competently and autonomously. Pre-registration training, adequate preceptorships, sufficient in-service training and CPD opportunities are significant factors that affect retention. Similarly, the absence of CPD opportunities was cited as a top reason for NHS staff leaving in the NHS long term plan (NHS, 2019a). Pre-registration training, preceptorships, and CPD are important to all MHNs for acquiring developing their skills. However, skill development of newly qualified nurses often comes through working alongside more experienced MHNs who support them in direct clinical practice. Therefore, retaining experienced nurses is imperative to combat some of the factors affecting retention of newly qualified nurses. Organisations need to ensure they have enough adequately experienced preceptors to meet the standard for preceptorship (DoH, 2010). Moreover, they need to guarantee preceptors spend enough time with their preceptee to build positive relationships and enhance skill development opportunities (Matua *et al*, 2014). Thereafter, regular in-service training and CPD opportunities specific to their clinical setting to enable skill development would improve MHNs' confidence and ability to work autonomously, which will enhance job satisfaction and improve retention. Future studies focussed on the retention of MHNs currently in post will elicit information that could be used to the implement immediate changes that can prevent current MHNs from leaving. This will help to ensure the workforce is fit to support new nurses coming through.

Work environment constituted the largest of themes identifying multiple factors on all levels within organisations. It is clear from these findings that MHNs want to work in an organisational culture that values their role and demonstrates that through respect, procedural fairness and meaningful salaries. These findings suggest that the organisational culture must also foster strong leadership, promote positive team dynamics, and be sensitive to and address MHNs' concerns about the work environment, such as unmanageable workloads, demanding work schedules, ineffective clinical supervision, and insufficient resources including staff, in order to increase nurses' intent to stay in their jobs, their organisation and the profession as a whole. Improving the working environment is crucial for NHS Trusts given that 55% of nurses stated they feel confident they could find a similar job with better work environments and

salaries elsewhere (RCN, 2019). Furthermore, it is evidenced that nurses who believe they have better job opportunities elsewhere are more likely to consider leaving (Ito *et al,* 2001). Work environments will vary between clinical settings in mental health; therefore, this compliments the need to explore the factors affecting retention related to the work environment across different clinical settings to improve job satisfaction and retention of all MHNs.

Limitations

The majority of the studies used cross-sectional designs of single hospitals at one point in time, some with small sample sizes unrepresentative of their target populations with poor response rates, limiting the generalisability of the results to other clinical settings and populations. Although a strength of this review is its inclusion of a sufficient number of studies conducted all over the world, different countries have different nurse training programmes and healthcare systems. This limits the generalisability of some of the findings in this review to MHNs working in the UK and more specifically the NHS. For instance, fear of losing nursing skills was identified as a factor associated with intent to leave in one study (Kagwe *et al*, 2019). This study was conducted in the US where you do not need a separate qualification to specialise in mental health nursing, and these nurses may want to return to an area of adult nursing where they will need to utilise a different set of skills. This finding is not generalisable to MHNs in the UK as they specialise in mental health nursing from the outset and cannot practice as adult nurses without sufficient training.

Another limitation is that the factors identified in this review are from studies that span almost three decades. Healthcare is an everchanging environment in all countries which will inevitably lead to changes in the factors affecting retention of healthcare workers. Mental health nursing will have changed significantly over the past three decades in most countries. Some of the changes for MHNs in the UK reported by Gournay (2005) include: a shift in focus within community services (community teams are caring for and treating people with more severe and enduring mental health problems than before), this has led to a shift in the service user population in inpatient services; more people in inpatient services are now more likely to be detained under the Mental Health Act and have dual diagnoses giving rise to violence and aggression seen in these services; education and training has changed with more recent nurses likely to be graduates and more focus placed on psychosocial interventions to help equip nurses adapt to their new roles. Therefore, some of the factors in this review may not be as important

for today's workforce but some may be more significant than before e.g., factors relating to in-service training, CPD opportunities, and risk of assault.

Conclusion

Most themes in this review (Individual Characteristics, Training and Skills, and Work Environment) identify similar factors that affect retention of the adult nurse workforce (Chan *et al*, 2013 & Moseley *et al*, 2008). However, it is clear from this review that MHNs encounter some factors unique to working in mental health services such as the perception of the job (exciting, rewarding, career pride, and stigma), factors related to practice (risk, moral distress, emotional exhaustion, and successful care and treatment), and different clinical settings detailed in theme 2, which suggests that retention strategies should be specific to each nursing speciality. Beyond nursing speciality, it has become apparent that the factors identified within this review are likely to vary between clinical settings in mental health due to the differences in work environments and services they provide. This review highlighted several gaps in the literature, areas for future study, and important factors to consider. It is important that future studies now set out to explore what factors exist in which clinical settings to create more tailored retention strategies, which can then be applied on a clinical setting level across all mental health NHS Trusts, to generate better outcomes.

The majority of the studies in this review used quantitative measures that only capture the factors included in the outcome measures used, thus the factors identified in this review are not an exhaustive list. There is scope for studies using qualitative methods to further explore the factors affecting MHN retention to identify any important factors that may have been missed. It will be important to focus on MHNs currently in post to generate findings that can be used to prevent further loss. Missing from the current literature is the voice of senior leaders who inform policy around retention. It will be important to gain the perspectives of senior leaders to identify if there are any factors affecting retention of MHNs at an organisational level that are missed by MHNs; and to explore any previous, current, or planned retention strategies in order to provide tangible recommendations for change and inform effective retention strategies.

The gaps identified in this review that will inform the research included in this these are:

- There is scope for studies using qualitative methods to further explore the factors affecting MHN retention to identify any important factors that may have been missed by the domination of quantitative methods used in the field.

- It is currently unclear if there are any differences in retention/intention to leave in mental health clinical settings within the English NHS.
- There is a need to further explore which factors affecting retention/intention to leave exist in which mental health clinical settings.
- The perceptions of senior leaders on MHN retention and their strategies to address retention are missing in the research literature.

Chapter 2 - Methodology

The previous chapter provided an international overview of the existing literature on the retention of MHNs. The review identified the following gaps within the literature and areas for future study:

- There is scope for studies using qualitative methods to further explore the factors affecting MHN retention to identify any important factors that may have been missed by the domination of quantitative methods used in the field.
- It is currently unclear if there are any differences in retention/intention to leave in mental health clinical settings within the English NHS.
- There is a need to further explore which factors affecting retention/intention to leave exist in which mental health clinical settings.
- The perceptions of senior leaders on MHN retention and their strategies to address retention are missing in the research literature.

This research study aims to fill these gaps by identifying if there are any differences in retention rates of MHNs, currently in post, across different NHS clinical mental health settings. Secondly, it will aim to explore the experiences that affect MHNs intention to leave across different clinical settings; and finally, it will aim to capture the voices of senior leaders to provide a more holistic view of the research problem. This chapter will outline and justify the research questions and aims, study design, and methods used for this research study entitled: An exploration of factors which affect employment retention in the UK mental health nursing workforce.

Research Questions

- How does intent to leave or stay for the mental health nursing workforce differ across NHS inpatient and community clinical settings?

- What experiences contribute to intent to leave or stay for the mental health nursing workforce across different NHS inpatient and community clinical settings?

- What are the perspectives of senior leaders within the NHS on the experiences affecting retention of mental health nurses across different inpatient and community clinical settings?

Research aims

1. To identify any differences in MHNs' intent to leave across different inpatient and community clinical settings, and identify factors associated with intent to leave for the NHS mental health nursing workforce.
2. To explore the experiences that affect intent to leave/stay across different inpatient and community clinical settings.
3. To gather the perspectives of senior leaders on the experiences affecting the retention of mental health nurses and any tried or planned retention strategies.

Philosophy

This study utilised a mixed methods approach. A mixed methods research approach involves the interplay of three key components: philosophy, the research design, and methods (Creswell, 2014). Quantitative and Qualitative paradigms are the two main paradigms defined by different ontological (what is real) and epistemological (how knowledge is gained) positions (Slevitch, 2011). Quantitative paradigms are derived from positivism which is based on the ontological position that there is one objective truth that is not associated with human perception (Slevitch, 2011). The epistemological assumptions of positivism are that a researcher can discover the complete truth and knowledge by studying subjects or a phenomenon without influencing them, and often use experimental methodologies investigating large samples independent of their context, which can be generalised (Singh, 2019). The qualitative paradigm based on constructivism and interpretivism is grounded in the ontological position that there are multiple subjective truths and realities that are not independent from context and are gleaned from people's interpretation or construction of reality (Slevitch, 2011). The epistemological assumptions of this paradigm are that researchers can only offer their interpretations of the truth and knowledge; and understanding the context in which individuals are placed is essential for gaining knowledge using qualitative methodologies such as case studies and ethnography (Singh, 2019).

Having explored different philosophical assumptions, I could not completely align myself with positivism or constructivism and it became clear that my own views and beliefs sit within the

pragmatic paradigm. My beliefs sit within the pragmatic view that knowledge is ever changing as is it shaped by our continuously growing repertoire of individual experiences (Kaushik & Walsh, 2019), and that we take actions based on this knowledge and then judge its truth based on the consequences of those actions (Cornish & Gillespie, 2009). Pragmatism is documented in the literature as a favourable paradigm when conducting mixed methods research (Creswell & Plano-Clark, 2017). Pragmatists argue that it is impossible to discover the truth within a mono-paradigmatic position, and therefore, reject the notion that research studies must fall within either a positive/post-positivist or constructivist paradigm alone (Kivunja & Kuyini, 2017).

Two approaches to applying paradigms to mixed methods research are discussed in the literature (Hall, 2020). One is the multiple paradigm approach also referred to as dialectical pragmatism, in which researchers equally consider the philosophical assumptions of both qualitative and quantitative paradigms (Johnson & Gray, 2010). For example, Creswell and Plano-Clark (2017) suggest that for an explanatory sequential mixed methods design, researchers could apply the assumptions of post-positivism for the quantitative phase and then shift to constructivism for the qualitative phase, and interpretations of the results can be based on both sets of assumptions. However, this approach was discounted as there is no guidance in the literature on how to address incompatible paradigms and deal with conflicting assumptions (Hall, 2020). The second approach is the single paradigm approach, in which one paradigm and its assumptions are used for both quantitative and qualitative strands of research studies and will be applied for this study (Hall, 2020). Pragmatism is problem-focused and grounded in the notion that the research question is of utmost importance, and researchers should use the most logical and practical methods that will best address the research question (Tashakkori & Teddlie, 1998). Therefore, in line with the assumptions of the pragmatic paradigm, research methodologies and methods that were best suited to address the research questions and generate knowledge on the research problem were adopted in the design of this study.

Methodology

Study design

A non-experimental, cross-sectional, two-phase explanatory mixed methods design was employed to complete this research. Mixed methods research is defined by Creswell (2015) as:

> *"An approach to research in the social, behavioural and health sciences in which the investigator gathers both quantitative (closed-ended) and qualitative (open-ended) data, integrates the two, and then draws interpretations based on the combined strengths of both sets of data to understand research problems."* (Creswell, 2015, p.2).

The use of a mixed methods approach is suitable to a study for which a single source of data would be inadequate in generating sufficient data to answer the research questions (Creswell & Plano Clark, 2011). A sequential design provided a design in which the strengths of both quantitative and qualitative research methods were able to provide a meaningful insight to the complex research problem (Morgan, 2014).

The sequencing of the methods was based on the needs of the research questions and an explanatory sequential mixed methods design was deemed most appropriate for this study. The study used quantitative research methods to collect and analyse quantitative data followed by qualitative research methods to collect and analyse qualitative data. The quantitative phase (Phase 1) was employed to identify the scope of the problem by investigating nurses' intention to leave or stay across different clinical settings, and the qualitative phase (Phase 2) was used to explain the quantitative findings and provide a more detailed understanding of what experiences affect nurses in which clinical settings. Each phase was equally as important to the study, but the qualitative phase was dependent on the data generated in the quantitative phase (Creswell & Plano Clark, 2017). Both phases were cross-sectional in nature and collected data from one point in time, as opposed to a longitudinal design which would collect multiple data sets over an extended period of time (Ruel *et al,* 2016). See Figure 2.1 (page 34) for a flowchart of the procedures that were used to implement the explanatory sequential design.

Phase 1: Overview

During phase 1 quantitative data was gathered via a survey to identify the differences in MHNs' intent to leave or stay in their current positions, the NHS, and the profession, across different clinical settings. The survey also aimed to identify any associations between demographic, background, wellbeing, Trust and clinical setting variables, and MHNs intent to leave or stay. The second purpose of the survey was to illuminate interesting areas that warrant further inquiry (clinical settings with particularly high or low levels of intent to leave/stay). The participants from which these interesting results are collected formed the basis of the qualitative sample.

Phase 2: Overview

Phase 2 set out to explain the quantitative results by exploring through individual interviews why MHNs intend to leave or stay, by understanding the experiences that influence intention to leave to provide a deeper understanding of the research problem. Additional interviews with senior leaders were incorporated into Phase 2 to provide an additional dimension and contribute to a more holistic explanation of the quantitative results.

Data integration

Although a mixed methods design can bring the advantage of being able to capitalise and combine the strengths of different research methods, careful consideration of how these methods are connected and integrated is necessary to reap the benefits of using mixed methods in comparison to one method alone (Morgan, 2014).

Data integration occurs on three levels within mixed methods studies: study design, research methods, and interpretation and reporting (Fetters *et al*, 2013). At the study design level, a two-phase explanatory sequential design was selected, which informs the order of data collection and analysis (QUANT before QUAL). Data integration at the methods level includes how the two data sets were linked. For this study, the data was linked by 'connecting' the data sets through sampling (using Phase 1 findings to inform the sample for Phase 2) and 'building' (using Phase 1 findings to inform the basis for exploration in Phase 2) (Fetters & Molina-Azorin, 2017).

On the interpretation and reporting level the analysed data was structured using a 'contiguous approach', which is where the findings from both data sets are presented in different subsections within the results section of the report (Fetters *et al*, 2013). I present the analysed quantitative data in the first part of the results section (Chapter 3 and 4), and the findings from the thematic analysis in the latter part of the results section (Chapter 5). I then bring the data sets together in the form of a joint display where I present the statistics regarding intent to leave/stay and the corresponding identified influencing experiences in a table (Chapter 6) (Gutterman *et al*, 2015). In the discussion section I reflect on how the mixed findings relate to each other and draw new insights from the joint display by comparing MHNs intent to leave/stay and the influencing experiences across different clinical settings.

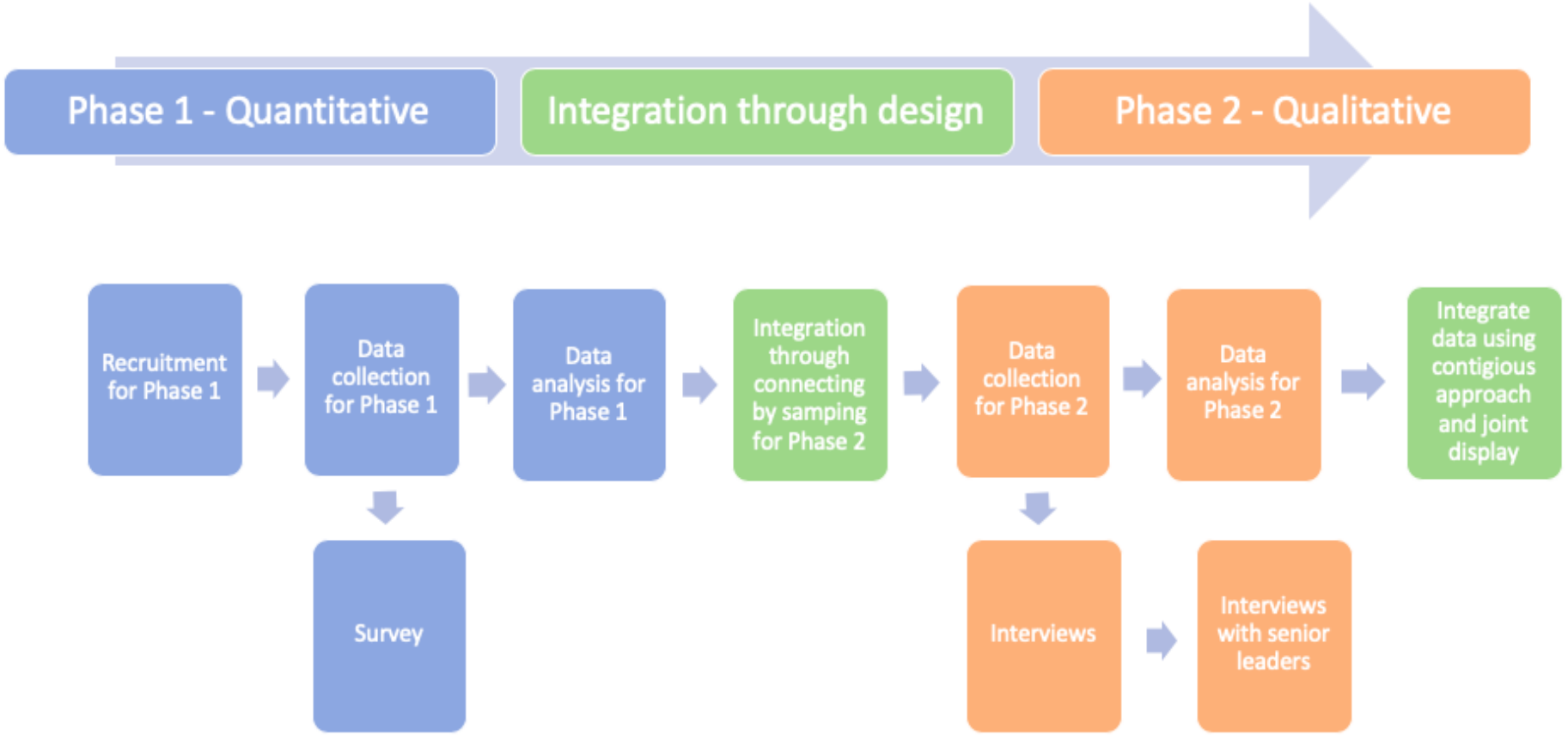

Figure 2.1 - Study design flow diagram

Ethics

Ethical approval was sought from the University Research Ethics Committee (REC) (Appendix F) and the Health Research Authority (Appendix G). Following the principles of the Declaration of Helsinki ethical consideration was given to all aspects of the project including study design, recruitment, participant information sheets (PISs), consent procedures, anonymity and confidentiality, potential risk of harm and benefits to the participants, researcher and society, and the management of data (WMA, 2018).

Beauchamp and Childress' (2001) four basic principles were also used as a guide for the professional ethics and conduct of this project to protect the participants and researcher. *Nonmaleficence* and *Beneficence* were considered from the start of planning this project through to completion. Whilst this project does not carry the risk of physical harm, the possibly of psychological harm needed some careful consideration. This posed an ethical dilemma caused by a conflict of two ethical principles, as although there was a risk of potential psychological harm, which violates nonmaleficence (do not cause harm), risk management plans were put in place to minimise the risk of harm and promote well-being, whilst trying to maximise the benefits of the research to the participants and society preserving beneficence (providing benefit) (Beauchamp, 2019). *Respect for autonomy* was inherent in the consent procedures, by ensuring participants were given the sufficient information and time to understand that information, so that they can make an informed decision about their participation. Issues of *Justice* (treating people fairly and equally) arise at various steps throughout the research process. For instance, a decision was made to invite all MHNs working in a clinical role and multiple recruitment strategies were used to increase accessibility and ensure the recruitment process were fair, so that all MHNs in the three Trusts had an equal chance to participate (Kahn *et al,* 2018).

Informed consent

For Phase 1, implied consent was used to gain MHNs' consent for participating in the online survey. Participants were sent a PIS along with the link to survey. Implied consent was achieved by asking the participants to agree to a statement at the beginning of the survey to indicate voluntary consent to participate in the study. Participants had to actively agree to this statement to begin the survey, if participants did not actively agree it was assumed that they did not consent and would not complete the survey (Gordon, 2016). At the end of the survey participants were asked for their consent to be contacted for participation in Phase 2. If they

did consent, they were then asked to provide their preferred email address. Example copies of the PIS and consent form can be seen in Appendix H and I.

For Phase 2 participants that had agreed to be contacted were sent an email invitation with the PIS and consent form attached. Participants were given up until the end of data collection to consider participation and respond to the email. Before all the interviews began, I answered any questions they may have had regarding the study and PIS and went through the consent form with the participant to check they were still happy to participate. Participants who chose to do face-to-face interviews completed and signed the consent form themselves. For those that chose telephone or virtual interviews consent was collected remotely by gaining verbal consent at the start of the interview and then signing the consent form on their behalf. Photo copies of the consent forms were then stored on the University's U:Drive and the paper copies were shredded.

Confidentiality and anonymity

Participants and teams were only identifiable to me so that they could be contacted if they were selected to take part in Phase 2. Individuals, teams, and Trusts are not identifiable in this thesis and will not be identifiable in subsequent publications. Trusts are described in a non-identifying manner such as, Trust 1, 2 and 3. Workplace descriptors used in the CQC reports will be used to gather the data and broad terms such as 'community settings', 'inpatient settings' and 'other settings' were used to explain the results of the different clinical settings. Participants were assigned a number and these numbers were used when presenting any direct quotes in the findings. This way readers will not be able to identify what findings came from what specific Trust, team, or individual. To further maintain confidentiality all data has and will continue to be securely stored in line with the GDPR Data Protection Act. The full data management plan can be seen in appendix J.

Methods - Phase 1 (QUANT)

Quantitative research is inductive in nature and can be used to investigate relationships between key variables (Davies, 2020), with an emphasis on objectivity and an aim to reduce the impact of the researcher (Morgan, 2014). Quantitative methods such as surveys can be used to generate large numerical data sets that can be statistically analysed to provide results that can be replicated and generalised (Creswell, 2014).

Sample and sampling

Selection of NHS Trust

Two NHS Mental Health Foundation Trusts, one in an urban area in the north of England and one in a rural area in the south of England, were initially selected for participation based on their differences in number of important aspects. These include differences in the levels of deprivation, population density, and demographics, which is likely to generate an interesting comparison and provide rich context to the research problem. Deprivation and demographic differences will likely influence the rates of different types and severity of mental health problems encountered by the MHNs and differences in services provided by the Trusts (Menta Health Foundation, 2016). This may contribute towards different demands and pressures placed on MHNs affecting their job satisfaction and retention. The Trusts also have a range of quality outcomes based on recent CQC ratings with one Trust achieving an overall rating of 'Good' and one achieving 'Inadequate'. I am also familiar with both Trusts having worked as a MHN in both, which was beneficial to the effective and efficient navigation of this project.

Shortly after all ethical approvals were obtained and the project was adopted onto the National Institute for Health Research (NIHR) Clinical Research Network (CRN) portfolio, the Research and Development (R&D) team of an inner-city London Trust identified the project on the NIHR Open Data Platform and asked if they could participate. This was discussed with the supervisory team and a decision was made to include this Trust in the study as it offered a different location, population demographic, and CQC rating that will inform an interesting comparison to the original two Trusts. Minor amendments were submitted and approved (see appendix K) to add them as an additional site. For confidentiality purposes the Trusts will be referred to as Trust 1, Trust 2, and Trust 3 throughout the thesis.

Sample size

A desired sample size was calculated based on the total number of mental health nurses working within all the Trusts which totals 3581 (Trust 1 – 538, Trust 2 – 1179 and Trust 3 - 1864). These were the numbers Trusts reported to NHS Digital in 2019 using data from Electronic Staff Record. A sample size calculator for the survey software used in this study was used to generate the desired sample size with a margin of error set at 5% and confidence level of 95% https://www.qualtrics.com/blog/calculating-sample-size/. This suggested the ideal sample size was 347. This was then divided equally between the three Trusts making their individual recruitment targets 116 participants.

Sampling technique

All MHNS within the three included Trusts formed the sampling frame. All MHNs in two of the Trusts were approached using pre-established email distribution lists including all registered MHNs in the Trust. This allowed all MHNs in those Trusts an equal opportunity for being selected as the sample (Sharma, 2017). A convenience sampling approach was used in Trust 3 where an established mailing list of all the MHNs did not exist. Convenience sampling has some advantages in that it is inexpensive and less time-consuming which is beneficial when conducting a PhD study. Despite the advantages, it is important to note that non-probability sampling strategies can limit the generalisability of the results to the sample studied, and this limitation will be drawn upon in the discussion chapter of this thesis (Bornstein *et al*, 2013).

Inclusion/exclusion criteria

This study requires participants to be registered mental health nurses currently working in a clinical setting within the NHS (see table 2.1).

Table 2.1 - Participant eligibility criteria

Inclusion criteria	Exclusion criteria
• Registered MHNs of any staff grade. • Working in a clinical role within one of the included NHS Trusts.	• Student nurses • Nursing associates • Non-registered nurses • MHNs that work in a non-clinical role.

Recruitment

All eligible MHNs within the two of the Trusts with pre-established email distribution lists were invited by email to participate to maximize the chances of achieving the desired sample size. MHNs in the third Trust were also recruited via email. An anonymous link to the survey was created and added to an email invitation with the PIS attached (a copy of the email invitation can be seen in appendix L). Each Trust had different recruitment strategies outlined in table 2.2 in appendix M.

Response rate

Obtaining sufficient response rates, particularly from registered nurses, can be a challenge (Cooper & Brown, 2017 & Corner & Lemonde, 2019). Several stakeholder consultations were conducted at the development stage of the project and methods of data collection were discussed. The majority of the stakeholders reported that they would be more likely to complete an online questionnaire due to the ease of the method and their ability to access it both from home and work. Some stakeholders reported that they might be more likely to complete the questionnaire if it was placed in front of them in paper form, but they would be very unlikely to return it by post. Using this information and discussions with my supervisors an online survey was the selected method, as they are advantageous due to low cost, and efficiency in distributing surveys and receiving responses from a large number of respondents across a large geographical distance (Wright, 2005). Whilst online surveys increase the speed of the response rate, a considerable amount of time needs to be allocated to resolving any technical issues and obtaining email addresses of the participants (van Selm & Jankowski, 2006). As well as faster responses, online surveys have been found to achieve high response rates amongst the nursing population (Jones, 2017). However, sample bias amongst the respondents may exist, as some MHNs will be more likely to respond to online surveys than others, which can over represent certain viewpoints and limit the generalisability of the findings (Ball, 2019).

In their study of survey techniques that affect response rates for nurses, Corner & Lemonde (2019) recommend that the researcher should try to be present when conducting the survey to answer questions, and explain the purpose of the survey and research, to improve response rate. It was not possible for me to physically hand out all surveys but involving gatekeepers such as service managers, R&D teams, senior leaders, and research champions with the distribution of the surveys likely improved the response rate (Khamisa *et al*, 2014). I did however, visit/contact some of the inpatient settings to promote the study due to particularly low response rates from the inpatient settings. The survey was accompanied by a PIS which explained the purpose of the survey and included my contact details so I could be contacted with any questions (Ruel *et al*, 2016). The R&D team or individual team leaders sent further email reminders to prompt responses from services that had low numbers of responders to further improve the response rate. Incentives were considered as there is evidence to suggest they can increase response rates for online surveys (Sue and Ritter, 2012). However, no incentives were offered in this study, as it has been found that incentives do not improve response rates for

nurses (Corner & Lemonde, 2019), and can introduce a form of selection bias by attracting a majority of a certain type of participant (Sarantakos, 2013).

Survey development

A survey was selected as they are better suited to studies exploring relationships between variables and less suited to studies exploring causality (Muijs, 2012). Surveys are also beneficial in their ability to produce generalisable findings to the wider population, as they are conducted in real life settings as opposed to experimental studies where the environments are tightly controlled (Muijs, 2012). A self-administered online survey was selected as they are beneficial for gathering quick responses from a large sample as opposed to postal surveys (Jones *et al,* 2013).

The online self-administered survey was created using Qualtrics software. The survey consisted of a manageable number (22 items) of closed ended questions to minimise respondent fatigue (Ben-Nun, 2011). The survey included demographic and background questions, questions about mental wellbeing, as well as questions relating to intent to leave, which were used to identify if there are any relationships between demographic characteristics, mental wellbeing, clinical setting, and intent to leave. The survey can be seen in appendix N. There was no existing survey that includes all the items required for gathering the necessary data to answer the research question for this phase of the study (How does intent to leave or stay for the mental health nursing workforce differ across NHS inpatient and community clinical settings?). Therefore, already validated, and published questions and scales were used alongside questions informed by the literature review to mitigate the need to develop all new items (Boynton and Greenhalgh, 2004).

Many of the questions were taken directly from the NHS Staff Survey (NHS, 2020a) with permission (12 questions relating to demographic information and intention to leave or stay). Pre-existing questions from the NHS Staff Survey (NHS, 2020a) were used as there is no need to re-develop questions that already exist and have been pre-tested for reliability at first use (Mathers *et al,* 2007). By using these questions, I was able to compare my findings with those of the NHS survey 2021 and other studies that have used these questions to inform an engaging discussion.

It was important to capture the mental wellbeing of the sample to examine the relationship between intention to leave and mental wellbeing. Therefore, I obtained a licence to use the

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) (Tennant *et al*, 2007), which is a 7-item scale used to gather data on participants mental wellbeing. A significant positive relationship had been found between psychological wellbeing and job satisfaction, which ultimately impacts MHNs' intent to leave (Olatunde and Odusanya, 2015). Therefore, it was important to capture the mental wellbeing of the participants to identify if any relationships exist between nurses' mental wellbeing and intent to leave. The SWEMBWS was selected due to its validity and robustness when applied to clinical settings (University of Warwick, 2020) and can be seen in figure 2.2.

Short Warwick Edinburgh Mental Wellbeing Scale (S) WEMWBS

Below are some statements about feelings and thoughts.

Please select the answer that best describes your experience of each over the last 2 weeks.

	None of the Time	Rarely	Some of the Time	Often	All of the Time
I've been feeling optimistic about the future	**1**	**2**	**3**	**4**	**5**
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Figure 2.2 - SWEMWBS

Additional background questions (questions pertaining to staff grade, time spent in current job, working hours, nursing qualification, and years of mental health nursing experiences) were informed by the literature review, and a final question requesting consent to be contacted for participation in Phase 2 of the study, and a text box for participants to add their preferred email address was included. Once completed, the survey was pilot tested to identify any spelling or

grammatical mistakes, ambiguous questions, and other problems affecting responses (Jones *et al*, 2013). To assess an instrument's adequacy, it is reported that a sample of 10 participants may be sufficient (Hertzog, 2008). The survey was pilot tested on a sample of 15 MHNs who were not included in the main study. After the pilot test some minor spelling mistakes were ammended, and whilst there were no reported ambiguous questions an additional multiple-choice answer needed to be added to the question regarding MHN qualifications. There were no concerns or suggested changes for the PIS.

Data analysis

Data cleaning

The full data set was exported from Qualtrics to SPSS Data Editor (version 27.0.1.0). The responses were screened for any ineligible responses and responses with significant missing data relating to the research question. Each of the variables were then renamed and labelled to aid analysis. The level of measurement was assigned to each variable. The responses for background and demographic questions generated categorical data that had no intrinsic ordering and therefore a nominal measure was applied. For Likert scale variables an ordinal measure was applied. I then recoded some of the values, for example, for people who had selected 'other' for the type of service they work in. Their responses were recoded under the appropriate service descriptor value after discussion with supervisors.

Descriptive statistics

Descriptive statistics were used to summarise the sample and survey responses by calculating frequencies and percentages for all nominal and ordinal variables. These statistics were presented in tabular form with an accompanying commentary.

SWEMWBS

SWEMWBS scoring and analysis guides were referred to and a new variable was computed by adding all respondents individual scores together to generate a meaningful total raw score. Raw scores were then converted to metric scores using the conversion table for SWEMWBS by creating a new variable and manual input. This was done so that comparisons can be made across different studies. Histograms, along with skewness and Kurtosis were used to check the distribution of the continuous data. The scores approximated to a normal distribution allowing for parametric analysis (Warwick Medical School, 2021). Descriptive statistics were used to calculate the mean metric score. A benchmarking approach was taken, and the scores were divided into categories calculated in comparison with the Patient Health Questionnaire (PHQ-

9) and Generalised Anxiety Disorder assessment (GAD-7) (Warwick Medical School, 2021). Scores <17 represented probable depression or anxiety, 18-20 represented possible depression or anxiety, 21-27 represented average mental wellbeing, and 28-35 represented high mental wellbeing.

Crosstabs and inferential statistical analysis.

After consultation with a statistical consultant from the University's Statistical Service Unit, ordinal data were recoded to create categorical variables. For example, intent to leave variables were recoded into different variables by combining values 1 (Strongly disagree) and 2 (Disagree) into a new value labelled 'No' (no intent to leave), value 3 (neither agree nor disagree) remained the same and values 4 (Agree) and 5 (Strongly agree) into a new value labelled 'Yes' (intent to leave). These categorical variables were created to present clearly who is intending on leaving and who is not to provide a more meaningful analysis.

The categorical variable capturing nurses working within different services did not produce reasonable results through statistical analysis due to small frequencies within some of the categories. For example, there was only one respondent from wards for people with a learning disability or autism. Therefore, the categories of the variable consisting of the different services were collapsed into three categories 'Community settings', 'inpatient settings' and 'other clinical settings' to provide meaningful analysis. Small frequencies in some of the categories for the variables relating to ethnic background, marital status, religion, and gender also did not produce reasonable results and needed to be collapsed into broader categories.

Cross tabulation (crosstabs) was used to identify and summarise any relationships within the data specifically relating to intent to leave. A Chi-square test of association using a significance level of 0.05 was used to identify any statistically significant associations between the variables containing categorical data. Cramer's V was used to find out the strength of any associations, between variables with more than two categories identified through the Chi-square test, by referring to table 2.4 to establish the effect size (Kim, 2017). The degree of freedom was determined by taking the row or column with the smallest number of categories and then subtracting 1 from the number of the categories. When the assumptions of the Chi-square test could not be met due to more than 20% of cells with expected values less than 5, and Fisher's exact tests were not feasible, due to having contingency tables larger than 2x2, the Monte Carlo method based on 10000 sampled tables with a random starting seed and 99% confidence

interval was used. The Monte Carlo method generates a reliable unbiased estimate of the true *p*-value and is not constrained by assumptions of the asymptotic method (Mehta and Patel, 1989). Post-hoc z-tests (Bonferroni method) study the association between variables and find out which, if any, categories/column proportions differed significantly from one another. The results of these tests were presented in the form of subscript letters in the individual results tables. If categories/column proportions differed significantly they would contain different subscript letters.

Regression analysis was considered to explore the relationships between two or more variables to find out which factors are the most important and which can be disregarded. However, the research aim was focused on associations between two categorical variables to illuminate factors associated with intention leave, rather than important predictor variables. Therefore, the Chi-square test was an appropriate choice of analytic test. Although multiple regression analysis could have enhanced the findings by predicting and explaining causal influences (Jeon, 2015), my lack of confidence and familiarity with using the technique influenced my decision not to incorporate this type of analysis.

Table 2.4 - Cramer's V effect size (Cohen, 1988)

Degree of freedom	Small	Medium	Large
1	0.10	0.30	0.50
2	0.07	0.21	0.35
3	0.06	0.17	0.29
4	0.05	0.15	0.25
5	0.04	0.13	0.22

Methods – Phase 2 (QUAL)

Qualitative research is inductive in nature often with a goal to generate theory or hypotheses, with an emphasis on subjectivity, context and acknowledging your own influence on the research process and findings produced (Morgan, 2014). Qualitative research employs smaller samples and strives to explore and understand participants' experiences and perspectives of a research problem, by generating in-depth, rich, and descriptive non-numerical data and interpreting the meaning of that data (Creswell, 2014).

Sample

Purposeful sampling was used to identify information rich cases based on predetermined criteria. Criteria were centred on MHNs from inpatient, community and other clinical settings

with survey responses indicating high intent to leave their current clinical setting, and their organisation, the NHS, or nursing profession altogether, and those with no intent to leave their current clinical setting. The criteria to determine high intent to leave were participants who selected agree or strongly agree to all statements relating to intent to leave their organisation; and those indicating they are considering leaving their job and indicating what their most likely destination will be. The criteria to determine low intent to leave/high intent to stay were participants who selected disagree or strongly disagree to all statements relating to intent to leave their organisation and those indicating that they are not considering leaving their job. This allowed for an in-depth follow-up explanation of their survey responses (Palinkas *et al*, 2015; Patton, 1990). The predetermined criterion for the senior leaders was the need to be able to provide insight into the retention of MHNs and any tried, current, or planned retention strategies. In addition to the predetermined criteria, participants were also selected based on their willingness and ability to articulate their experiences relating to their survey responses to provide a detailed insight into the research problem (Palinkas *et al*, 2015). Like convenience sampling, purposeful sampling reduces the external validity of the study by limiting the generalisability if the results beyond the study sample and this will be drawn upon in the discussion section of the thesis (Andrade, 2021). An iterative approach to selecting MHNs by selecting a small sample of approximately three MHNs from each setting in each Trust and then re-sampling was used, to ensure a variation of MHNs with different demographic, background characteristics and intentions to leave or turnover, and with an aim to achieve theoretical saturation (Palinkas *et al*, 2015).

Data saturation is thought to occur when no new data was being generated, and subsequently, no new codes or themes were being generated (Fusch & Ness, 2015). Despite data saturation being labelled the 'gold standard' for deciding on the size of a qualitative sample, Braun & Clarke (2021) do not recommend the concept of data saturation for reflexive analysis as, along with Low (2019), they believe that data saturation is based on flawed logic as new insights will be generated as long as new data are being collected. Instead, they suggest using the concept of 'information power' to guide the processes of data collection and evaluate sample size by reflecting on five items that can impact information power: *'study aim, sample specificity, use of established theory, quality of dialogue, and analysis strategy'* (Malterud *et al*, 2016, p.1754). The broad study aim and limited established theory for the retention of mental health nurses specifically, and the exploratory nature of the analysis strategy would suggest the need for a larger sample. However, the quality of the dialogue was strong due to my knowledge of the

topic and how well my participants were able to articulate their experiences. This coupled with purposefully sampling participants with highly specific characteristics required a smaller sample to achieve sufficient information power. Malterud *et al* (2016) suggests that the findings of a study determines whether the sample fostered sufficient information power to generate new knowledge relating to the study aim, therefore, information power for my study sample is discussed whilst reflecting on sample size in the discussion section of this thesis. I aimed to recruit approximately 30 participants in total, 15 from community and 15 from acute settings.

Recruitment

Nurses who had consented to be contacted for phase 1 of the study via the survey formed the pool of potential participants for phase 2. MHNs with high intent to leave or stay were purposefully selected for interview. These MHNs were invited via the email address they provided on the survey. The email contained the participant information sheet and consent form. If nurses wished to participate, then they would respond to the email to arrange a date and time for the interview to take place. Some nurses had already left their jobs and were no longer contactable with the email address provided, and some did not feel able to recount and articulate their reasons for their responses due to being emersed in their new job.

Senior leaders were identified by the R&D teams within the Trust based on the predetermined eligibility criteria (ability to provide insight into the retention of MHNs or any tried, current, or planned retention strategies). This included Chief Executives, Deputy Chief Executives, Chief Nursing Officers, leaders within the People Directorate, Head of Human Resources, Retention leads, Directors of Nursing, and Heads of Service. The R&D teams facilitated introductions with the senior leaders and an email invitation containing the PIS and consent form was sent directly to them. If they wished to participate, they often asked their secretaries to liaise with me to arrange a date and time to complete the interviews.

Data collection method – Interviews

Individual interviews were used to elicit in-depth and detailed experiences of each participant that explain the reasons behind their intention to leave (Given, 2008). Individual interviews provided the participants a private and safe space to share any sensitive topics or experiences related to the research problem (Gill *et al,* 2008). Individual interviews also allowed more flexibility around interview date, time, and how and where the interview was conducted, which aided the recruitment of nurses with busy schedules that participated in this study enriching the

dataset (Baillie, 2019). The interviews were semi-structured to allow for several key questions tailored to the survey responses to be explored, whilst having the freedom to pursue any interesting and relevant topics that came up in more detail (Galletta, 2013). The interviews lasted between 20-60 minutes dependant on how many different experiences contributed to their intention to leave/stay and the amount of detail they went in to. An example interview guide was developed and submitted for ethical approval which can be seen in appendix O. To minimise threats to the validity and reliability of the interviews leading questions were avoided. In addition, active listening skills were used such as summarising, and asking for clarity when necessary. A pilot interview was conducted with a MHN who completed the survey during the pilot test and was not included in the main study (Alshenqeeti, 2014). The pilot interview highlighted the need to include an initial broader question (*Could you please describe your role within you current clinical setting?*) to get a better understanding of the context within which the MHN worked, and to get them thinking about the aspects of their role that may or may not have influenced their survey responses. Once developed, the interview guides for senior leaders were also submitted for ethical review and approved (see appendix P).

Focus groups were considered due to their ability to collect data from multiple people at one time. However, this method was discounted, as whilst providing access to a larger number of participants at one time, individual interviews can often elicit more detailed data about each participants experience (Given, 2008). This is in part-due to group settings giving rise to fear of judgment, upsetting others, or negative consequences that can place restraints on participants ability to talk freely and honestly, which could limit the data generated to what is socially acceptable to the group, rather than an actual representation of the research problem (Acocella, 2011).

Participants were given the option of face-to-face, virtual, or telephone interviews. Providing multiple interview options both in person and remote was partly based on COVID-19 and the related restrictions and risk, but also to accommodate MHNs' busy schedules and increase participation. Face-to-face interviews are considered to be 'gold standard' as they can provide very rich datasets owing to the nonverbal language and cues and stronger rapports that keep responses flowing (Oltmann, 201). However, face-to-face interviews are often restricted to local geographical areas and can feel invasive to the participant and ensue social pressure (Oltmann, 2016). Virtual interviews are the most similar to face-to face interviews as they share multiple advantages that come with being able to see one another during the interview (Keen

et al, 2022). Virtual interviews are advantageous as they are not restricted by location of the interviewee, but they can bring about technological challenges and limit participation to those who can access the virtual platforms (Carter *et al*, 2021). Telephone interviews are also advantageous for conducting interviews across a large geographical area (Oltmann, 2016). They can be conducted in the comfort of the participants own home, with minimal interruptions, which could produce more productive interviews (Gill *et al*, 2008). Despite some disadvantages associated with telephone interviews, such as difficulties with rapport building and the absence of visual cues that could lead to less detailed responses (Irvine *et al*, 2012), the anonymity they offer can have a positive effect on disclosing information and displaying emotion (Azad *et al*, 2021). The advantages of telephone interviews, such as increased anonymity and allowing more individuals a fairer chance to participate, are deemed more important than the disadvantages; concluding that telephone interviews can be considered a valuable first choice interview method to gather participants lived experiences by Azad *et al* (2021).

Data analysis

Thematic analysis is a process used to code qualitative data, identify, and analyse patterns within a qualitative data set, which are referred to as themes that organise, describe, and interpret aspects of a research problem from the perspectives of the participants (Boyatzis, 1998). Thematic analysis sits within the qualitative research paradigm and can provide a rich, detailed, and nuanced account of the qualitative data set grounded in participant's experiences (Nowell *et al*, 2017). For the data set derived from the MHNs an inductive data-driven thematic analysis was carried out whereby codes were constructed from the raw data. An inductive approach likely increased the interrater reliability due to how close the codes were to the raw data, as well as increasing the appreciation of the data by being able to capture the more intricate aspects of the data and highlight perspectives that may have been silenced through a deductive theory-driven approach (Boyatzis, 1998). A hybrid approach using both deductive and inductive coding was applied when analysing the data derived from the senior leaders which will be explained in more detail later in this section. Familiarising myself with the data from the MHNs helped to inform the interview guide for the interviews with the senior leaders which was subsequently submitted for ethical review. Developing the interview guide after the initial phase of data analysis of the MHN dataset meant that as well as gaining senior leaders' own understanding of the factors that affect MHN retention, I was also able to gain their perspective on some of the key factors emerging within the data.

Despite the lack of literature pertaining to thematic analysis in comparison to other qualitative methods such as grounded theory (Nowell *et al*, 2017), following the process guidelines of reflexive thematic analysis set out by Braun & Clarke (2021) helped to ensure the trustworthiness of the analysis through using a systematic, robust, and rigorous process. Reflexive thematic analysis is an analytic method that involves ongoing critical reflection on the influence the researcher has on the research process and its findings and consists of six phases detailed below (Braun & Clarke, 2021). I will now describe each phase of the analytical process across the six phases.

'Phase 1 – Familiarising yourself with the data set'

In this phase I began by listening to all the audio tapes and reading and re-reading the transcripts making notes of any potential codes ready for the more formal coding process. Due to the overwhelming amount of data with multiple experiences that contributed to the MHNs' intent to leave and stay their clinical setting, Trust and the profession, I decided to first familiarise myself with all the data from the inpatient settings making notes under subheadings: 'Clinical setting', 'Trust', 'NHS', and Nursing Profession, followed by the data collected from MHNs working in the community settings (See appendix Q). This enabled me to start to detect patterns within the data and provided me with a sense of how the data differed across the two types of setting. This first stage along with discussion with my supervisors helped me to create ideas around how I could structure the analysis going into the next phase.

'Phase 2 – Doing coding'

Using Quirkos software (Quirkos 2.4.1) I systematically coded all the data from MHNs working within inpatient settings followed by community settings. I took an inductive approach to coding the data set derived from the MHNs to generate themes driven directly from the data (Braun & Clarke, 2021). I took an inductive approach as I did not want to allow any preconceived ideas based on the literature and existing knowledge to restrict the analytic process and cause me to miss any new ideas, concepts, or theories (Braun & Clarke, 2006). Code labels were words or short phrases that captured meaning within the data pertinent to answering the research question. Codes were applied to small segments of data as well as entire paragraphs. Some segments of data had multiple meanings within them and therefore multiple codes were applied. Semantic codes were used to capture directly expressed surface level meaning within the data, for example the code 'Progression' was applied to segments of the

data that directly mentioned a desire or ability to progress as a reason for staying or leaving. Whereas latent codes were used to capture any underlying implicit meanings beyond the obvious (Braun & Clarke, 2021).

'Phase 3 – 'Generating initial themes'

It was initially important to understand what constitutes a theme:

> "A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p.82).

I started to explore the codes and group together codes with similar meanings. I started to develop broad ideas that could be candidate themes consisting of a central organising concept such as 'Safety and Risk Issues' that several different codes could be clustered around such as 'violence and aggression', 'high-risk cases in the community', and 'feeling unable to raise safety concerns'. I generated a large number (around 10) provisional themes at this point and started to consider the story being told about my data set that answers my research question. I started to map the themes visually by hand to identify any links between potential themes and subthemes (an example of this process can be seen in appendix R). Albeit difficult, I tried not to become too attached to the provisional themes knowing that some maybe lost or collapsed along the analytic journey.

'Phase 4 – 'Developing and reviewing themes'

In this phase I started to evaluate the richness of each theme by ensuring they had a distinctive central message and stripped back the repetition to stop themes from merging into each other. During supervision it became clear that I had over-emphasised certain aspects of the data, some themes did not have clear boundaries, some were too thin, and I was still unsure of the story my data was telling. I revisited my thematic map and completely restructured the analysis by generating new themes, collapsing old themes, and discarding some altogether. For example, a new latent theme was generated: 'disillusionment with mental health nursing' and safety and risk issues were collapsed into this new theme as a subtheme 'the responsibility of managing risk'. The story I was trying to tell became clearer and through my iterative analysis, and I was able to demonstrate a logical connective narrative between the themes that enabled me to provide an answer to the research question: What experiences contribute to intent to leave or

stay for the mental health nursing workforce across different NHS inpatient and community clinical settings?

'Phase 5 – 'Refining, defining, and naming themes'

I refined my themes by restructuring them into an order that would best tell the story to the reader. I defined my themes by first writing bullet points of what data each subtheme in each theme would contain. I was then able to define each theme, by explaining the boundaries, uniqueness, and contribution to the overall analysis of the theme. I presented this information in supervision to tell the story out loud and gather an outside perspective on the refinement and definitions of the themes before writing. As I began writing I started to give the themes their names ensuing that they were informative, concise, and gave light to the themes analytical direction and meaning.

See figure 2.3 to see a thematic map displaying an example of how a theme was generated. It shows how codes with similar meanings formed subthemes, that were distinct from one another but connected by a central organising concept, that were grouped together to form a main candidate theme.

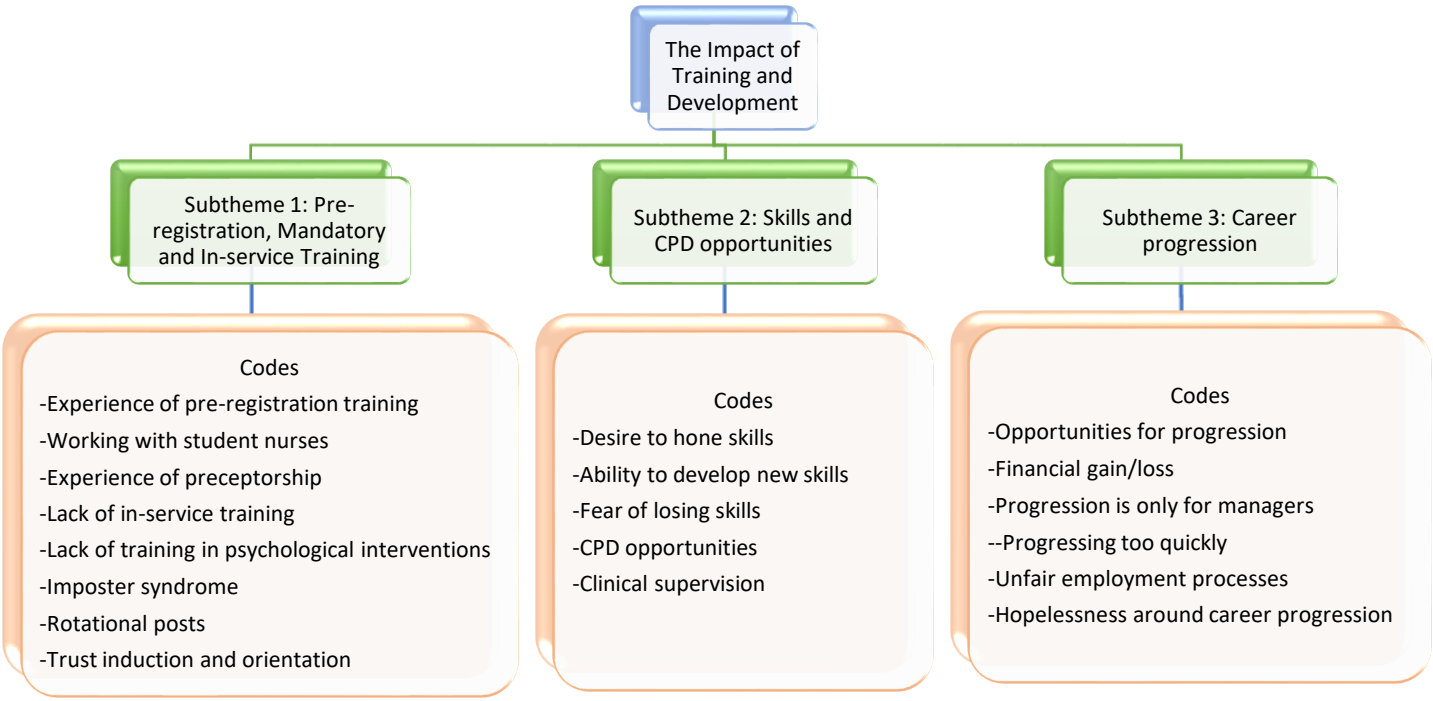

Figure 2.3 – The Impact of Training and Development – Theme development.

Senior leader data

I analysed the senior leader's data set secondary to the data collected from the MHNs. After all the interviews with senior leaders were completed and transcribed, I repeated Braun and Clarke's (2021) first two phases of thematic analysis (Familiarisation and doing coding). I took a hybrid approach to coding this data set using both deductive and inductive coding. I utilised a deductive approach as whilst I was familiarising myself with the data, I started to notice strong connections to the theoretical ideas generated through the MHN's data set (Braun and Clarke, 2021). Thus, I used the codes developed through the analysis of the MHNs data set to provide a foundation (or framework) for code and theme development of the senior leader data set. The inductive process allowed for any new ideas, codes, and themes outside of the predetermined codes and themes to be developed for a more complete analysis (Roberts *et al*, 2019). Although new codes were generated from the perspectives of senior leaders no new themes were generated. I used a weaving approach to present the two sets of qualitative findings, which involved combining the qualitative data from the MHNs and senior leaders on a theme-by-theme basis (Fetters *et al*, 2013).

Reflexivity

Reflexivity is an ongoing process that involves trying to understand how the role of the researcher and research processes influence the research outcomes through reflection (Nadin and Cassell, 2006). Reflexivity can enhance the rigour, quality, and trustworthiness of the research by serving as a methodological audit (Finlay, 2012). I am a qualified MHN with seven years' experience across a range of clinical settings in both the NHS and private sector. I have worked in one of the NHS Trusts included in this study and I am currently employed as a bank nurse in another. This constitutes being an insider researcher, which is defined as a member of the population being studied (Braun & Clarke, 2021). Being an insider can be advantageous for the research process by having a deeper awareness around the research problem and the lives of my participants, which helps to keep participants at the centre of the research agenda (Hayfield & Huxley, 2015). For example, when selecting the data collection method my knowledge of the research problem led me to discount focus groups based on the realisation that group discussions may have prevented important data related to the research problem, such as team dynamics and issues with management, from being generated. Another advantage was the ability to develop a good rapport with my participants after disclosing that I too am a nurse. This allowed them to feel more comfortable and talk more openly about their experiences with the belief I would ensure their voices are heard (Saidin & Yaacob, 2016). Despite the

advantages, it was important to keep my distance to maintain rigor and objectivity (Greene, 2014). To achieve this, I engaged with the research process reflexively to be aware of, and reflect on, the influence I may have had on the research and its outcomes (Attia & Edge, 2017). I used regular critical reflection within supervision to evaluate how my decisions, actions and approaches to the research process may impact on my research and its findings (Chavez, 2008).

Despite the advantages there are some disadvantages to being an insider researcher. Like Kanuha (2000) the most difficult part of the methodological process to maintain my distance and objectivity was within the data collection process. As I have inside knowledge on the research problem and my own experiences in relation to it, it was important not to assume that my participants share that experience during the interview process. It was also difficult to not become distracted by my own similar experiences and enter conversation with my participants. However, being too focussed on maintaining distance and objectivity sometimes prevented me from attaining more detail around complex aspects of the research problem through fear of leading. This lack of detail led to difficulties when interpreting the data, as being an insider does not guarantee a better understanding of participants experiences due to differences in other personal and contextual characteristics (Bridges, 2002). Critical reflection and discussions in supervision helped me to identify and distinguish between what information belongs to me and what information was derived from the research to minimise any subjective bias I may have introduced to the interpretations (Probst, 2015). I was able to reflect on my assumptions and expectations and how these were influencing the knowledge being generated (Braun & Clarke, 2022). During moments when I continued to question my interpretation of meaning within the data, I chose to keep the reporting of this particular data descriptive to avoid misinterpretations based on my own experience. I found that the greatest drawback of being an insider researcher was participants' assumptions that we had shared understanding around certain topics, and therefore, did not feel the need to share their experience aloud. This coupled with my lack of curiosity due to believing I understood what they meant and how they felt based on my own experiences often led to data only existing in my mind and not in the transcripts that could be taken forward to analysis. As I became aware of this happening through reflection whilst listening back to the audio recordings and during the transcription process, I was able to remind myself to step back and ask the participants to explain what they meant and illicit more detailed data going forward.

Chapter 3 – Phase 1 Survey Results – Descriptive statistics

This chapter will present the response rate for the individual Trusts and descriptive statistics summarising the sample and survey responses. The results will be presented in tabular form with an accompanying commentary. Frequencies and percentages were calculated for all the dependant and independent variables. These are presented in this chapter to provide an overview of the data. This frequency review also helped to make sure there were no data errors and identify any variables or values that needed recoding.

Response rate

I received 436 responses in total. From looking over the data it was clear there were some ineligible responses and responses with significant missing data which resulted in 44 responses being removed from the data set with reasons displayed in table 2.3. The responses with significant missing data were removed if they did not provide responses to the questions most important to the research question (questions related to intent to leave and clinical setting). On reflection the order of the questions had a significant impact on the need to remove data and if the most important questions (those relating to intent to leave and clinical setting) had been first, I may have been able to use the data that was provided in the incomplete survey responses. However, there were also concerns over whether those who did not complete the survey still consented to the use of the data they did provide. Therefore, after a discussion with the supervisory team a decision was made to remove the responses with significant missing data from the data set. This left a total of 392 complete and eligible responses for data analysis.

Table 3.1 - Responses removed from data set

Number of responses removed	*Reasons*
1	Participant did not consent
26	Significant missing data. 15 did not answer any of the questions. 5 only answered 33% of the survey. 4 only answered 42% and 2 stopped the survey at 79%.
7	Participants not working within a clinical setting (‘Research’, ‘education’ and ‘Governance’).

3	Participants working in non-mental health clinical settings ('Student health visitor', 'physical health' and 'paediatric continence nurse').
2	Participants in senior roles overseeing many different clinical settings rather than front line staff working within a single clinical setting.
2	Participants working in more than one clinical setting, as I would not be able to tell which survey responses are related to which clinical setting.
3	Participants did not give enough information to identify what clinical setting they work within ('Bank nurse', 'adults and child role' and 'across adult services').

All Trusts met their individual recruitment target of 116 and together they overachieved the desired sample size of 347. Trust 1 sent the survey to approximately 613 nurses (all MHNs working within the Trust) and obtained 116 responses, this resulted in a 18.9% response rate. Trust 2 sent the survey to approximately 1284 nurses (all MHNs working within the Trust) and received 157 responses resulting in a 12.2% response rate. The number of MHNs on the distribution lists are greater than the numbers of MHNs in each Trust used to calculate the sample size. This is likely to be a result of new nurses joining the Trust and therefore the email distribution list since the original NHS digital data was downloaded in 2019 and nurses having left and not being removed creating a growing list. As there was no central mailing list for all of the nurses in Trust 3 it was not clear how many nurses received the survey, and therefore, a response rate could not be calculated. The table below (table 3.2) shows that Trust 2 had approximately 10% more respondents than the other two Trusts. However, the three Trusts differed in size and had unequal number of MHNs. Therefore, although Trust 2 had more respondents their response rate was lower than Trust 1. Low response rates can decrease the likelihood of a representative sample by increasing the possibility of non-response bias, which poses a threat to the generalisability of the results (Burkell, 2003). However, response rates alone do not always mean the sample is of low quality (Holtom *et al*, 2022), and should not render results as uninformative (Meterko *et al*, 2015).

Table 3.2 - Number of respondents per Trust

Trust	Frequency	Percent	Response Rate
Trust 1	116	29.6%	18.9%
Trust 2	157	40.1%	12.2%
Trust 3	119	30.4%	Unknown
Total	392	100%	

Descriptive statistics

Demographic information

Below is a table presenting the sample demographics (see table 3.3). Approximately three quarters of the sample were female (n=285, 72.7%). A larger proportion of the sample were aged between 41-65 (n=236, 60.2%) with the least participants in the 65+ age group. Most of the sample described themselves as heterosexual or straight (n=340, 86.7%). Just under half of the sample put their marital status as married (n=178, 45.4%). Approximately three quarters of the sample were White English/ Welsh/ Scottish/ Northern Irish/ British (n=296, 75.5%).

Table 3.3 - Demographic information

Demographics	Total Frequency (n)	Total percentage	Trust 1 (n)	Trust 2 (n)	Trust 3 (n)
Gender					
Female	285	72.7%	80	119	86
Male	97	24.7%	34	36	27
Prefer to self-describe	2	.5%	0	1	1
Prefer not to say	8	2%	2	1	5
Age					
21-30	61	15.6%	30	18	13
31-40	87	22.2%	35	24	28
41-50	105	26.8%	27	40	38
51-65	131	33.4%	24	70	37
65+	8	2%	0	5	3
Sexual orientation					
Heterosexual or straight	340	86.7%	98	136	106
Gay or Lesbian	15	3.8%	3	9	3
Bisexual	11	2.8%	5	4	2
Other	5	1.3%	1	2	2
Prefer not to say	21	5.4%	9	6	6
Marital status					
Single	73	18.6%	25	25	23
Co-habiting	83	21.2%	34	31	18
Married	178	45.4%	40	76	62
Civil partnership	7	1.8%	3	2	2
Divorced	31	7.9%	11	16	4
Separated	6	1.5%	0	3	3
Widowed	3	.8%	0	2	1
I would prefer not to say	11	2.8%	3	2	6
Religion					
No religion	195	49.7%	70	83	42
Christian	158	40.3%	37	60	61
Buddhist	5	1.3%	0	4	1
Hindu	3	.8%	0	2	1
Jewish	1	.3%	0	0	1
Muslim	4	1%	1	0	3
Other	11	2.8%	3	4	4
Prefer not to say	15	3.8%	5	4	6

Ethnic background			See table 3.4	See table 3.4	See table 3.4
White					
English/ Welsh/ Scottish/ Northern Irish/ British	296	75.5%			
Irish	8	2%			
Gypsy or Irish Traveller	4	1%			
Other White background	15	3.8%			
Asian/Asian British					
Indian	1	.3%			
Pakistani	1	.3%			
Chinese	1	.3%			
Other Asian background	3	.8%			
Black/African/Caribbean/Black British	42	10.7%			
African	6	1.5%			
Caribbean	4	1.0%			
Other Black/ African/ Caribbean background	3	.8%			
Mixed/Multiple ethnic background	3	.8%			
White and Black Caribbean	2	.5%			
White and Asian					
Other Mixed/ Multiple ethnic background	3	.8%			
Other ethnic group					

Ethnic background was broken down by Trust to compare the diversity of the study sample with the Trust data. The Workforce Race Equality Standard (WRES, 2020) report (available online but will not be referenced to maintain anonymity) for Trust 1 indicates that 76.2% of their staff identify as white and 14.6% as people from ethnic minority backgrounds which is comparable to the sample of nurses from Trust 1 in this study. The WRES report 2020 for Trust 2 states that 85.7% of their workforce identify as white and 12.7% as people from ethnic minority backgrounds, which is also comparable to the sample of nurses working within Trust 2 included in this study. Trust 3's WRES report 2020 states that 58.9% of their workforce identify as white and 39% as people from ethnic minority backgrounds, which again is commensurate with the sample of nurses from Trust 3 in this study. However, the WRES report is not specific to nurses and therefore these comparisons may not be accurate for nurses and should be treated with caution.

Table 3.4 – Ethnic background and Trust cross tabulation

Ethnic background		**Trust 1**	**Trust 2**	**Trust 3**
White	English/ Welsh/ Scottish/ Northern Irish/ British	98 (84.5%)	134 (85.4%)	64 (53.8%)
	Irish	2 (1.7%)	5 (3.2%)	1 (0.8%)
	Gypsy or Irish Traveller	0 (0%)	3 (1.9%)	1 (0.8%)
	Other white background	1 (0.9%)	9 (5.7%)	5 (4.2%)

Asian/Asian British	Indian	0 (0%)	1 (0.6%)	0 (0%)
	Pakistani	1 (0.9%)	0 (0%)	0 (0%)
	Chinese	0 (0%)	0 (0%)	1 (0.8%)
	Other Asian background	0 (0%)	0 (0%)	3 (2.5%)
Black/African/Caribbean/Black British	African	9 (7.8%)	0 (0%)	33 (27.7%)
	Caribbean	2 (1.7%)	0 (0%)	4 (3.4%)
	Other Black/ African/ Caribbean background	1 (0.9%)	1 (0.6%)	2 (1.7%)
Mixed/Multiple ethnic background	White and Black Caribbean	1 (0.9%)	1 (0.6%)	1 (0.8%)
	White and Asian	1 (0.9%)	2 (1.3%)	0 (0%)
	Other Mixed/ Multiple ethnic background	0 (0%)	0 (0%)	2 (1.7%)
Other ethnic group		0 (0%)	1 (0.6%)	2 (1.7%)

In summary, the study sample appeared to be largely female, from a white ethnic background and between the ages of 21 and 65 years old. The next section of this chapter will go on to describe and summarise participant's background information.

Background information

The total frequencies for individual services across all three Trusts show that the most responses were collected from people working within community-based mental health services for adults of working age (n=107, 27.3%) (table 3.5), followed by specialist community mental health services for children and young people (n=56, 14.3%), mental health crisis services and health-based places of safety (n=52, 13.3%), and acute wards for adults of working age and psychiatric intensive care units (n=51, 13%). The fewest responses came from community mental health services and wards for people with a learning disability or autism (1 and 2 responses). Respondents that selected 'other' specified that they worked in services that either did not fit accurately into one of the given categories or spanned multiple categories, such as eating disorder services that care for all ages. The written responses for the 'other' category for most of the variables will not be displayed in this thesis due to potentially exposing the participants and breaching confidentiality. However, if these generate any significant interesting results they will be anonymised and presented in more detail where possible. Please refer to table 3.5 for more information.

Table 3.5 - Number of respondents per service

Service	Frequency	Percent
Acute wards for adults of working age and psychiatric intensive care units	51	13%
Long stay or rehabilitation mental health wards for working age adults	16	4.1%
Child and adolescent mental health wards	9	2.3%
Wards for older people with mental health problems	26	6.6%
Wards for people with a learning disability or autism	2	.5%
Forensic inpatient or secure wards	11	2.8%
Mental health crisis services and health-based places of safety	52	13.3%
Community-based mental health services for adults of working age (including liaison and IAPT services)	107	27.3%
Community-based mental health services for older people (including liaison and IAPT services)	40	10.2%
Specialist community mental health services for children and young people (including liaison and IAPT services)	56	14.3%
Community mental health services for people with learning disabilities or autism	1	.3%
Substance misuse services	8	2%
Other	13	3.3%
Total	392	100%

The services were recoded into three broad categories for confidentiality and analysis purposes: Inpatient settings, Community settings and other clinical settings (see table 3.6). Nurses working within inpatient settings made up 29.3% (n=115) of the study sample compared with 67.3% (n=264) working within community settings. A very small proportion of the sample could not be placed into either the inpatient or community category as it was not clearly specified which type of clinical setting they worked in, or they worked across both type of settings or in neither inpatient nor community settings.

Table 3.6 – Number of respondents working in inpatient, community, and other clinical settings

Type of clinical setting	Frequency	Percentage
Inpatient	115	29.3%
Community	264	67.3%
Other	13	3.3%
Total	392	100%

Crosstabulation shown in table 3.7 shows how many nurses within the study sample worked in the three clinical settings across the three Trusts. More nurses who worked in Trust 1 indicated they worked in inpatient settings (n=48, 41.1%) than in Trusts 2 and 3. Whereas more nurses who worked in Trusts 2 and 3 indicated they worked in community settings than in Trust 1.

Table 3.7 - Cross tabulation of Trust and clinical setting

	Trust 1	Trust 2	Trust 3	Total

Inpatient setting	Frequency and % within NHS Trust	48 (41.1%)	38 (24.2%)	29 (24.4%)	115 (100%)
Community setting	Frequency and % within NHS Trust	64 (55.2%)	116 (73.9%)	84 (70.6%)	264 (67.3%)
Other clinical setting	Frequency and % within NHS Trust	4 (3.4%)	3 (1.9%)	6 (5%)	13 (3.3%)
	Total frequency	116	157	119	392

Just over half of the sample were band 6 nurses (n=203, 51.8%) with band 5 nurses currently in their preceptorship only making up 5.9% (n=23) of the overall sample (see table 3.8).

Table 3.8 - Number of respondents across different staff grades

Staff grade	Frequency	Percent
Band 5 (in preceptorship)	23	5.9%
Band 5 (not in preceptorship)	55	14%
Band 6	203	51.8%
Band 7	77	19.6%
Band 8	34	8.7%
Total	392	100%

A large proportion of the sample had over 10 years nursing experience (n=237, 60.5%). The cumulative total of participants with over 5 years nursing experience is 76.6% (n=300). Nurses with 4-5 years of nursing experience made up the smallest portion of the overall sample (n=12, 3.1%). Please see table 3.9.

Table 3.9 - Nursing experience

Years of experience	Frequency	Percent
Less than 1 year	19	4.8%
1-2 years	30	7.7%
2-3 years	13	3.3%
3-4 years	18	4.6%
4-5 years	12	3.1%
5+ years	63	16.1%
10+ years	237	60.5%
Total	392	100%

The largest group of respondents had been in their current job for less than one year making up 24.2% (n=95) of the overall sample. Followed by those who had been in their job for 1-2 years (n=79, 20.2%) and those who had been in their job for 10+ years (n=75, 19.1%). This could indicate that this study appealed more to these participants because of its relevance to them or

that nurses are now more likely to turnover after two years resulting in less nurses remaining in the same job for over two years. Please refer to table 3.10 for more details.

Table 3.10 - Time spent in current job

Time	Frequency	Percent
Less than 1 year	95	24.2%
1-2 years	79	20.2%
2-3 years	40	10.2%
3-4 years	21	5.4%
4-5 years	31	7.9%
5+ years	51	13%
10+ years	75	19.1%
Total	392	100%

The majority of the sample are worked 30 hours or more per week (n=339, 86.5%) with the remaining 13.5% (n=53) working part-time hours (see table 3.11).

Table 3.11 – Working hours

Hours	Frequency	Percent
Up to 29 hours	53	13.5%
30 or more hours	339	86.5%
Total	392	100%

The majority of the sample had either entered nursing with a diploma (n=147, 37.5%), or a bachelor's degree (n=157, 40.1%), which is the current main route into mental health nursing. The remainder of the sample had acquired a postgraduate qualification (see table 3.12). Some participants chose 'other' but did not specify in enough detail what qualification they hold so these could not be recoded into an existing category.

Table 3.12 - Nursing qualification

Qualification	Frequency	Percent
Batchelor's degree	157	40.1%
Post graduate qualification	63	16.1%
Diploma	147	37.5%
Other	25	6.4%
Total	392	100%

Just over a third of the sample have or regularly care for children up to the age of 17 years old (n=148, 37.8%). Some participants have other caring responsibilities that include supporting family members, friends, or neighbours because of a long term physical or mental ill health/

disability, or problems relating to old age (n=154, 39.3%). Please refer to table 3.13 for more information.

Table 3.13 - Caring responsibilities

		Frequency	Percent
Do you have or regular care for children up to the age of 17 years old?	Yes	148	37.8%
	No	243	62%
	Total	391	99.7%
Do you have other caring responsibilities that include supporting family members, friends, or neighbours?	Yes	154	39.3%
	No	237	60.5%
	Total	391	99.7%

In summary, the Trusts had similar numbers of respondents with a slightly higher number of respondents from Trust 2 and their response rates varied. The nurses worked across several services with the majority working within community settings. A large portion of the study sample were band 6 nurses with over 5 years of nursing experience. Most participants worked 30 hours or more and qualified with a bachelor's degree or diploma. The majority had been in their current job less than two years, with just over a third of the sample who have children or other caring responsibilities. The next section of this chapter will focus on participants mental wellbeing and work-related stress.

Mental wellbeing and work-related stress

Over half of the sample (n=242, 61.7%) stated that they have felt unwell as a result of work-related stress in the last 12 months (see table 3.14)

Table 3.14 - work related stress

Work-related stress	Frequency	Percent
Yes	242	61.7%
No	150	38.3%
Total	392	100%

Almost one-third of the sample indicated they had a physical or mental health condition or illness lasting or expected to last for 12 months or more (n=122, 31.1%). Of the proportion of the sample that does have a physical or mental health condition, 2.6% (n=10) stated that their employer had not made adequate adjustment(s) to enable them to carry out their work (see table 3.15).

Table 3.15 – Reasonable adjustments

		Frequency	Percent
Has your employer made adequate adjustment(s) to enable you to carry out your work?	Yes	68	17.3%
	No	10	2.6%
	No adjustment required	43	11%
	Total	121	30.9%

Below is a histogram demonstrating the distribution of the data for the SWEMWBS metric scores (see figure 3.1). The data is normally distributed shown by the symmetric bell-shaped curve with a mean score of 21.32 allowing for parametric analysis. The mean score is lower than the UK population norm (23.6 for women and 23.7 for men) from the health survey for England data 2010-2013 (Fat *et al*, 2017). The results of an unpaired t-test demonstrate a statistically significant difference between the mean SWEMWBS score for this study sample and the population norms for men (*p-value - 0.0001*) and women (*p-value – 0.0001*).

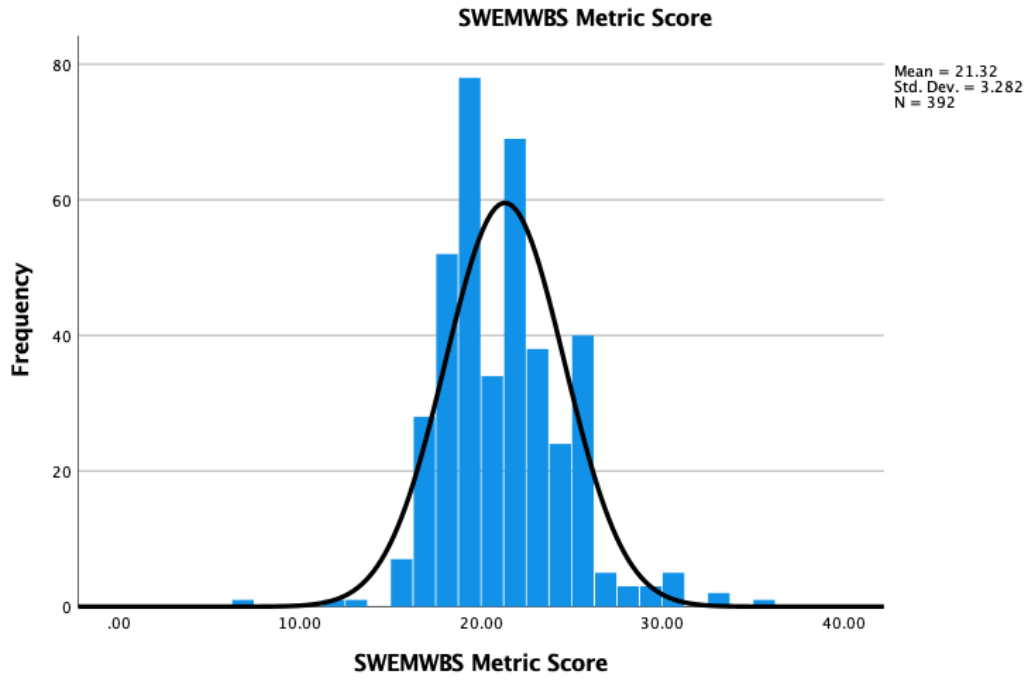

Figure 3.1 – Histogram SWEMWBS

Approximately half the sample had average mental wellbeing (n=210, 53.6%), however the rest of the sample had below average mental wellbeing except for 3.6% (n=14) of the sample that had high mental wellbeing (see table 3.16).

Table 3.16 - Mental wellbeing SWEMWBS

Mental wellbeing	Frequency	Percent
Probable depression or anxiety	38	9.7%
Possible depression or anxiety	130	33.2%
Average mental wellbeing	210	53.6%
High mental wellbeing	14	3.6%
Total	392	100%

In summary, over half of the sample reported feeling unwell with work-related stress. Almost one third reported that they had a physical or mental health condition or illness lasting or expected to last 12 months or more. The average wellbeing score for the study sample is significantly lower than that of the population norms. Approximately half of the sample's mental wellbeing was comparable with the population mean (average mental wellbeing), with a large portion being below the mean suggesting a large proportion of respondents to the survey may have been experiencing depression or anxiety. The final section in this chapter will go on to describe and summarise the data as it relates to nurses' intent to leave or stay in their current jobs, the NHS and the nursing profession.

Intention to leave

Just over one-third of the sample (n=146, 37.2%) indicated they are not considering leaving their current job, with almost two thirds (n=246, 62.8%) of the sample indicating that they are considering leaving current their job. A large proportion of those participants were at risk of turnover with 16.1% (n=63) considering moving to another job with the same organisation, and 14.8% (n=58) considering moving to a different NHS Trust or organisation. Only a small proportion (n=13, 3.3%) indicated that they would wish to move to a job outside the NHS. Almost one-third (n=112, 28.6%) indicated they were considering leaving nursing all together due to retirement, taking a career break, or moving to a job outside nursing (see table 3.17.

Table 3.17 - Most likely destination

Most likely destination	Frequency	Percent
I am not considering leaving my job	146	37.2%
I would want to move to another job within this organisation	63	16.1%
I would want to move to a job in a different NHS Trust/organisation	58	14.8%
I would want to move to a job in nursing, but outside the NHS	13	3.3%
I would want to move to a job outside nursing	58	14.8%
I would retire or take a career break	54	13.8%
Total	392	100%

The following three tables are more focused on whether participants were thinking about leaving their organisation and how close they were to doing so. Almost half of the sample (n=192, 49%) indicated that they often think about leaving their organisation (see table 3.18). However, this number reduces slightly to 31.9% (n=125) who indicated that they will probably look for a new job at a new organisation in the next 12 months (see table 3.19) and 22.7% (n=89) indicated that they will leave their organisation as soon as they can find another job (see table 3.20). The number of respondents that 'neither agree nor disagree' increases throughout the statements, which could suggest that although 49% (n=192) of nurses indicated that they often think about leaving their organisation, some of those were still ambivalent about their intentions.

Table 3.18 - number of participants who often think about leaving their organisation

I often think about leaving this organisation	Frequency	Percent
Strongly disagree	38	9.7%
Disagree	80	20.4%
Neither agree nor disagree	82	20.9%
Agree	123	31.4%
Strongly agree	69	17.6%
Total	392	100%

Table 3.19 - Number of participants who will probably look for a job in the next 12 months

I will probably look for a job at a new organisation in the next 12 months	Frequency	Percent
Strongly disagree	62	15.8%
Disagree	102	26%
Neither agree nor disagree	103	26.3%
Agree	73	18.6%
Strongly agree	52	13.3%
Total	392	100%

Table 3.20 - Number of participants who will leave their organisation as soon as they find a new job

As soon as I can find another job, I will leave this organisation	Frequency	Percent
Strongly disagree	76	19.4%
Disagree	115	29.3%
Neither agree nor disagree	112	28.6%
Agree	47	12%
Strongly agree	42	10.7%
Total	392	100%

To summarise, two thirds of the sample indicated that they are considering leaving their jobs, with almost a third considering leaving nursing all together. Approximately half of the nurses

in this study indicated that they often think about leaving the organisation in which they work, but the number of nurses who would probably act on these thoughts currently are slightly reduced. The next chapter will go on to present and summarise any relationships between nurses' intent to leave or stay and the other variables included in this study.

CHAPTER 4 – Phase 1 - Survey results – Inferential statistics - Intent to leave

This chapter will describe relationships between two categorical variables using a Chi Square test. I will identify and summarise any associations between intent to leave variables and clinical setting, Trust, background, mental wellbeing, and demographic variables. I will also go on to identify which categories are responsible for any significant associations using post-hoc tests.

Intent to leave and clinical setting and Trust

Clinical setting

When examining different clinical settings and nurses' intent to leave their organisation, cross-tabulation showed that 56.5% (n=65) of respondents working within inpatient settings indicated that they often think about leaving their organisation, compared with 46.6% (n=123) of respondents working within community settings and 30.8% (n=4) of respondents working in other clinical settings (table 4.1). Percentages of respondents who indicated they are intending on leaving their organisation across the clinical settings decreased over the next two statements. For respondents working within inpatient settings 44.3% (n=51) indicated that they are likely to look for a new job at a new organisation in the next 12 months, compared to 28% (n=74) of respondents working in community settings (table 4.2). A large proportion of the respondents working in other clinical settings indicated that they do not intend on looking for a new job at a new organisation in the next 12 months (n=11, 84.6%) and the rest appeared ambivalent. A smaller percentage, although still almost a third of the respondents working in inpatient settings, indicated that they will leave their organisation as soon as they find another job (n=36, 31.3%) compared with 20.1% (n=53) of respondents working in community settings (table 4.3). Community settings have the highest percentage of respondents who indicated that they will not leave their organisation as soon as they find another job (n=135, 51.1%), followed by other clinical settings (n=10, 48.7%) and then the inpatient services (n=46, 40%).

A Chi-Square test via Monte Carlo simulation reported a small but statistically significant association between respondents who often think of leaving their organisation and the type of clinical setting they work in ($p=.035$, V=.115), with a post-hoc z-test (Bonferroni Method) showing that a significantly higher proportion of respondents working in other clinical settings indicated that they do not often think of leaving their organisation than those working in

inpatient and community settings. This is shown in Table 4.1 by inpatient and community setting categories having the same subscript ($_a$) in the 'No' row, whereas the other clinical settings category has a different subscript ($_b$). There were no other significant differences between groups identified.

A Chi-Square test via Monte Carlo simulation found a small to medium highly significant association between different clinical settings and respondents who will probably look for a new job at a new organisation in the next 12 months (*p=<.001,* V=.168). A post-hoc z-test (Bonferroni Method) found that the proportion of respondents who indicated they will not probably look for a new job at a new organisation in the next 12 months differ significantly across all three types of clinical settings (table 4.2). The proportion of respondents working within inpatient settings who indicated that they are likely to look for a new job at a new organisation in the next 12 months was significantly larger than respondent working in community and other clinical settings, and the proportion working in community settings was significantly larger than the proportion working in other clinical settings.

A Chi-Square test via Monte Carlo simulation identified a small but significant association between nurses who indicated they will leave their organisation as soon as they can find another job and the type of clinical setting they work in (*p=.019,* V=.123). An additional z-test (Bonferroni Method) found that the proportion of respondents working in inpatient settings that indicated that they are likely to leave their organisation as soon as they find another job was significantly larger than respondents working in both community and other clinical settings (see table 4.3).

Table 4.1 – Intent to leave and clinical setting – I often think about leaving my organisation

			Inpatient	**Community**	**Other**	**Total**
I often think about leaving this organisation	**No**	Count and (% within NHS Trust)	26_a (22.6%)	84_a (31.8%)	8_b (61.5%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within NHS Trust)	24_a (20.9%)	57_a (21.6%)	1_a (7.7%)	82 (20.9%)
	Yes	Count and (% within NHS Trust)	65_a (56.5%)	123_a (46.6%)	4_a (30.8%)	192 (49%)
		Total count	115	264	13	392
Pearson Chi-Square value	10.3339					

p-value via Monte Carlo Simulation	.035*
Cramer's V	.115

Each subscript letter denotes a subset of type of clinical setting categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Table 4.2 – Intent to leave and clinical setting – I will probably look for a new job at a new organisation in the next 12 months

			Inpatient	Community	Other	Total
I will probably look for a new job at a new organisation in the next 12 months	**No**	Count and (% within NHS Trust)	34_a (29.6%)	119_b (45.1%)	11_c (84.6%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within NHS Trust)	30_a (26.1%)	71_a (26.9%)	2_a (15.4%)	103 (26.3%)
	Yes	Count and (% within NHS Trust)	51_a (44.3%)	74_b (28%)	0_c (0%)	125 (31.9%)
		Total count	115	264	13	392
Pearson Chi-Square value	22.091					
p-value via Monte Carlo Simulation	<.001*					
Cramer's V	.168					

Each subscript letter denotes a subset of type of clinical setting categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Table 4.3 – Intent to leave and clinical setting – As soon as I can find another job, I will leave this organisation

			Inpatient	Community	Other	Total
As soon as I can find another job, I will leave this organisation	**No**	Count and (% within NHS Trust)	46_a (40%)	135_b (51.1%)	10_b (48.7%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within NHS Trust)	33_a (28.7%)	76_a (28.8%)	3_a (23.1%)	112 (28.6%)
	Yes	Count and (% within NHS Trust)	36_a (31.3%)	53_b (20.1%)	0_b (0%)	89 (22.7%)
		Total count	115	264	13	392
Pearson Chi-Square value	11.877					
p-value via Monte Carlo Simulation	.019*					
Cramer's V	.123					

Each subscript letter denotes a subset of type of clinical setting categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Cross tabulation of respondent's most likely destination and different types of clinical settings (table 4.4) shows that a similar proportion of respondents indicated that they are not considering leaving their job across inpatient (n=37, 32.2%) and community settings (n=101,

38.3%). This number was approximately double for the respondents working in other clinical settings (n=8, 61.5%) such as eating disorder services. Of those respondents considering leaving their job, 20.9% (n=24) of inpatient nurses indicated that they would want to move to a different job but within the same organisation, compared with 12.9% (n=39) of community nurses suggesting they would want to leave their role, but stay within their Trust. Similar percentages can be seen for respondents who indicated that they would want to move to a job in a different Trust or organisation (inpatient – n=24, 20.9% and community – n=34, 12.9%). Very small numbers of nurses in both inpatient settings (n=6, 5.2%) and community settings (n=7, 1.8%) indicated that they were considering moving to another nursing job outside of the NHS. The same proportion of respondents from both inpatient and community settings indicated that they were considering moving to a job outside of nursing (14.8% - inpatient n=17 and community n=39), the percentage of respondents working in 'other' clinical settings was slightly higher (n=2, 15.4%). More respondents working in 'other' clinical settings (n=3, 23.1%) indicated that they would retire or take a career break than those working in community settings (n=44, 16.7%) and inpatient settings (n=7, 6.1%).

A Chi-Square test via Monte Carlo simulation suggests there was a small to medium significant association between different types of clinical settings and respondent's most likely destination (*p=.018,* V=.167). On investigation of the post-hoc z-test (Bonferroni Method), the proportion of respondents working in community settings that indicated they were likely to retire or take a career break was significantly larger than nurses working within inpatient settings. No significant differences were identified for different clinical and other most likely destinations (see table 4.4).

Table 4.4 – Intent to leave and clinical setting – Most likely destination

			Inpatient	**Community**	**Other**	**Total**
Most likely destination	**I am not considering leaving my current job.**	Count and (% within clinical setting)	37_a (32.2%)	101_a (38.3%)	8_a (61.5%)	146 (37.2%)
	I would want to move to another job within this organisation	Count and (% within clinical setting)	24_a (20.9%)	39_a (12.9%)	0_a (0%)	63 (16.1%)
	I would want to move to a job in a different NHS Trust/organisation	Count and (% within clinical setting)	24_a (20.9%)	34_a (12.9%)	0_a (0%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within clinical setting)	6_a (5.2%)	7_a (1.8%)	0_a (0%)	13 (3.3%)

	I would want to move to a job outside of nursing	Count and (% within clinical setting)	17_a (14.8%)	39_a (14.8%)	2_a (15.4%)	58 (14.8%)
	I would retire or take a career break	Count and (% within clinical setting)	7_a (6.1%)	44_b (16.7%)	$3_{a,\,b}$ (23.1%)	54 (13.8%)
		Total count	115	264	13	392
Chi -square value	21.779					
***p*-value via Monte Carlo method**	.018*					
Cramer's V	.167					

Each subscript letter denotes a subset of type of clinical setting categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Trust

Cross tabulation (see table 4.5) shows that across the three Trusts on average, 49% (n=192) of respondents indicated that they often think of leaving their organisation. Trust 1 had a much higher percentage (n=71, 61.2%) of respondents that indicated they often think about leaving their organisation than on average. The percentages of respondents intending to leave decreased for all Trusts for the following two statements relating to intent to leave their organisation. So, although 61.2% (n=71) of nurses in Trust 1 indicated they often think of leaving, 39.7% (n=46) of those indicated they will probably look for a new job at another organisation (see table 4.6), and 28.4% (n=33) indicated they will leave as soon as they find one (see table 4.7).

A Chi-square test of association demonstrated that there was a small, but statistically significant association between respondents that indicated that they often think about leaving their organisation and the Trust within which they worked (*p=.029*, V=.117). A post-hoc z-test (Bonferroni Method) demonstrated that the proportion of respondents from Trust 1 who indicated they often think about leaving their organisation was significantly higher than Trusts 2 and 3 (table 4.5). This is shown in Table 4.1 by Trusts 2 and 3 having the same subscript ($_b$) in the 'Yes' row, whereas Trust 1 has a different subscript ($_a$). A significant difference was also identified between the proportion of respondents who indicated they do not often think about leaving their organisation, with the proportion of respondents in Trust 2 (n=56, 35.7%) being significantly higher than Trust 1 (n=25, 21.6%).

A Chi-square test also showed a small to medium significant association between respondents who indicated that they will probably look for a job at a different organisation in the next 12 months and the Trust in which they work (*p=.002,* V=.148). A post-hoc z-test (Bonferroni Method) showed that the proportion of respondents from Trust 1 (n=46, 39.7%) who indicated that they will probably look for a new job at a new organisation in the next 12 months was significantly higher than the proportion of respondents from Trust 2 (see table 4.6). Also, the proportion of respondents from Trust 2 that indicated that they are not likely to look for a new job at a new organisation in the next 12 months (n=84, 53.5%) is significantly larger than the proportion of respondents from Trust 1 (n=34, 29.3%) and Trust 3 (n=46, 38.7%).

There was also a small significant association identified between the Trust respondents work for and those that indicated they will leave their organisation as soon as they find another job (*p=.038,* V=.114). A post-hoc z-test (Bonferroni Method) found that the proportion of respondents from Trust 1 (28.4%) that indicated that they would leave their organisation as soon as they could find another job in is significantly higher than Trust 2 (16.6%). Also, the proportion of respondents from Trust 2 (n=91, 58%) that indicated that they will not leave their organisation as soon as they could find another job is significantly higher than both Trust 1 (n=48, 41.4%) and Trust 3 (n=52, 43.7%) (see table 4.7).

Table 4.5 – Intent to leave and Trust - I often think about leaving this organisation

			Trust 1	**Trust 2**	**Trust 3**	**Total**
I often think about leaving this organisation	**No**	Count and (% within NHS Trust)	25_a (21.6%)	56_b (35.7%)	$37_{a,b}$ (31.1%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within NHS Trust)	20_a (17.2%)	35_a (22.3%)	27_a (22.7%)	82 (20.9%)
	Yes	Count and (% within NHS Trust)	71_a (61.2%)	66_b (42%)	55_b (46.2%)	192 (49%)
		Total count	116	157	119	392
Pearson Chi-Square value	10.813					
p-value	.029*					
Cramer's V	.117					

Each subscript letter denotes a subset of NHS Trust categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Table 4.6 - Intent to leave and Trust - I will probably look for a new job at a new organisation in the next 12 months

			Trust 1	**Trust 2**	**Trust 3**	**Total**
I will probably look for a new job at a new organisation in	**No**	Count and (% within NHS Trust)	34_a (29.3%)	84_b (53.5%)	46_a (38.7%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within NHS Trust)	36_a (31%)	32_b (20.4%)	$35_{a,b}$ (29.4%)	103 (26.3%)

the next 12 months	**Yes**	Count and (% within NHS Trust)	46_a (39.7%)	41_b (26.1%)	$38_{a,b}$ (31.9%)	125 (31.9%)
		Total count	116	157	119	392
Pearson Chi-Square value	17.102					
p-value	.002*					
Cramer's V	.148					
Each subscript letter denotes a subset of NHS Trust categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.						

Table 4.7 - Intent to leave and Trust – As soon as I can find another job, I will leave this organisation

			Trust 1	**Trust 2**	**Trust 3**	**Total**
As soon as I can find another job, I will leave this organisation	**No**	Count and (% within NHS Trust)	48_a (41.4%)	91_b (58%)	52_a (43.7%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within NHS Trust)	35_a (30.2%)	40_a (25.5%)	37_a (31.3%)	112 (28.6%)
	Yes	Count and (% within NHS Trust)	33_a (28.4%)	26_b (16.6%)	$30_{a,b}$ (25.2%)	89 (22.7%)
		Total count	116	157	119	392
Pearson Chi-Square value	10.171					
p-value	.038*					
Cramer's V	.114					
Each subscript letter denotes a subset of NHS Trust categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.						

Cross tabulation (table 4.8) shows that less than half of the respondents in all three Trusts were not considering leaving their current job. Of the respondents that indicated they were considering leaving their current job in Trust 1, only 8.6% (n=10) would want to move to another job within their current organisation and 19.8% (n=23) would want to move to a job in a different NHS Trust/Organisation, indicating a retention issue at a Trust level. A reverse trajectory can be seen for Trust 2, 19.1% (n=30) of the respondents stated that they would want to move to another job with their current Trust and only 8.3% (n=13) stated they would want to move to a job in a different organisation. This could indicate that a problem with retention at clinical setting level as opposed to Trust level for this Trust. For Trust 3 there were similar percentages of respondents who would want to move to a different job within their current Trust (n=23, 19.3%), and who would want to move to another Trust (n=22, 18.5%). This could suggest potential retention issues at both Trust and clinical setting level. Very small numbers of respondents across all Trusts indicated that they would want another job in nursing outside the NHS (Trust 1 – n=5, 4.3%, Trust 2 – n=3, 1.9% and Trust 3 – n=5, 4.2%). Trust 1 had the highest percentage of respondents who would want to leave the profession altogether (n=28, 24.1%). Whereas Trust 2 had the largest percentage who would retire or take a career break (n=28, 17.8%).

A Chi-square test of association demonstrated a small to medium significant association between Trust and most likely destination (V=.194, *p=.001*). An additional z-test (Bonferroni Method) shown in table 4.8 found that the proportion of respondents from Trust 2 that indicated that they would want to move to another job within the same Trust was significantly larger than the proportion in Trust 1. Significantly more respondents in Trust 1 and 3 indicated that they would like to move to a job outside of their current Trust than Trust 2. The proportion of respondents in Trust 1 that indicated that they are likely to move to a job outside of nursing was significantly larger than the other two Trusts. No other significant differences were found between respondents working in different Trusts and most likely destination.

Table 4.8 – Intent to leave and Trust – Most likely destination

			Trust 1	**Trust 2**	**Trust 3**	**Total**
Most likely destination	**I am not considering leaving my current job.**	Count and (% within NHS Trust)	39_a (33.6%)	64_a (40.8%)	43_a (36.1%)	146 (37.2%)
	I would want to move to a job within this organisation	Count and (% within NHS Trust)	10_a (8.6%)	30_b (19.1%)	$23_{a,\,b}$ (19.3%)	63 (16.1%)
	I would want to move to a job in a different NHS Trust/organisation	Count and (% within NHS Trust)	23_a (19.8%)	13_b (8.3%)	22_a (18.5%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within NHS Trust)	5_a (4.3%)	3_a (1.9%)	5_a (4.2%)	13 (3.3%)
	I would want to move to a job outside of nursing	Count and (% within NHS Trust)	28_a (24.1%)	19_b (12.1%)	11_b (9.2%)	58 (14.8%)
	I would retire or take a career break	Count and (% within NHS Trust)	11_a (9.5%)	28_a (17.8%)	15_a (12.6%)	54 (13.8%)
		Total count	116	157	119	392
Pearson Chi-Square value	29.451					
p-value	.001*					
Cramer's V	.194					

Each subscript letter denotes a subset of NHS Trust categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Summary

Clinical settings appeared to be linked to respondents' intent to leave their organisation/Trust and the profession altogether by means of retiring or taking a career break. Respondents working in other clinical settings indicated they were significantly more likely to remain in their organisation than those working in community and inpatient settings. Respondents working within inpatient settings were significantly more likely to probably look for a new job at a new organisation within the next 12 months and leave as soon as they find one than those

working in community and other clinical settings. Respondents working within community settings were more likely to leave their organisation as soon as they find another job than respondents working in other clinical settings. Different types of clinical settings also appeared to be associated with respondent's most likely destination after they leave, with respondents working in community settings indicating they were significantly more likely to retire or take a career break than the other two settings.

These results also suggest that respondent's intent to leave their job, organisation/NHS Trust and the nursing profession was associated with the Trust they work in. Respondents working in Trust 1 indicated they often think of leaving their organisation significantly more than nurses in the other two Trusts. Respondents in Trust 1 indicated they were also significantly more likely to take action and look for a new job at a new organisation in the next 12 months and leave as soon as they find one than Trust 2. Whereas respondents in Trust 2 indicated they were significantly more likely to remain in their organisation than the other two Trusts.

Although respondents in Trust 2 were significantly more likely to remain in their organisation, they indicated that they were significantly more likely to turnover within their organisation than the other two Trusts. This may be indicative of better overall Trust retention in Trust 2 but could point towards retention issues within the individual clinical settings. Respondents in Trusts 1 and 3 had significantly higher proportions of nurses that would want to move to a new job at a new organisation than Trust 2 suggesting a problem with overall retention at Trust level. Most worryingly, significantly more respondents in Trust 1 indicated they are more likely to move to a job outside of nursing than nurses in the other two Trusts, suggesting that Trusts in which nurses work in can impact on their decisions to leave the profession.

The next section will go on to examine any significant relationships between nurses' background variables and intent to leave.

Intent to leave and background variables

Staff grade

Tables 4.9, 4.10 and 4.11 show cross tabulation of respondent's staff grade and intent to leave or stay in their organisation. Table 4.9 shows that band 5 nurses (still in preceptorship) had the lowest percentage of respondents who indicated that they often think of leaving their

organisation (n=4, 17.4%), and band 5 nurses (not in preceptorship) had the highest percentage of respondents that indicated they often thinking of leaving their organisation (n=38, 69.1%). It appears that as respondent's staff grade increased beyond band 5 intent to leave their organisation decreased with just over half of the band 6 nurses (n=107, 52.7%), 41.6% (n=32) of band 7 nurses and 32.4% (n=11) of band 8 nurses indicating that they often thinking of leaving their organisation. Band 8 nurses had the highest percentage of respondents who indicated that they do not often think of leaving their organisation (n=17, 50%).

Table 4.10 shows that although band 5 nurses (still in their preceptorship) had the smallest proportion of respondents who indicated they often think of leaving their organisation, this number increased for those who indicated that they will probably look for another job at a new organisation in the next 12 months (n=9, 39.1%). Band 5 nurses (not in preceptorship) had the highest percentage of respondents that indicated that they will probably look for a new job at a new organisation in the next 12 months (n=25, 45.5%), and band 8 nurses had the highest percentage of respondents that indicated that they will probably not look for another job and were likely to remain in their organisation for now (n=18, 52.9%).

Table 4.11 shows that band 5 nurses had the highest numbers of respondents who indicated that as soon as they can find another job, they will leave their organisation (band 5 in preceptorship – n=7, 30.4% and band 5 not in preceptorship – n=17, 30.9%). However, band 5 nurses (still in preceptorship) along with band 8 nurses had the highest number of respondents who indicated they will not leave their organisation as soon as they find another job (n=23, 67.6%).

A small to medium highly significant association was found between respondent's staff grade and respondents who indicated that they often think of leaving their organisation ($p=<.001$, V=.198). A post-hoc z-test (Bonferroni Method) demonstrated that the proportion of band 5 nurses (not in preceptorship) that indicated that they often think of leaving their organisation was significantly higher than the proportion of respondents in every other band. This is shown in Table 4.9 by band 5 nurses (not in preceptorship) not sharing the same subscript letter with any other band in the 'Yes' row. The proportion of band 6 nurses that indicated that they often think of leaving their organisation was significantly higher than the proportion of band 5 nurses (still in preceptorship) and Band 8 nurses. The proportion of band 5 nurses (still in preceptorship), band 6, 7 and 8 nurses who indicated they do not often think of leaving their

organisation were all significantly higher than band 5 nurses (not in preceptorship). Although band 5 nurses (still in preceptorship) indicated that they were significantly less likely to often think of leaving, they had a significantly higher proportion of respondents that indicated that they are ambivalent about leaving or staying (neither agree nor disagree) than band 6 nurses.

A small to medium significant association was also found between respondent's staff grade and those who indicated that they will probably look for a new job at a new organisation in the next 12 months (*p=.003*, V=.173). An additional z-test (Bonferroni Method) shown in table 4.10 indicates that the proportion of band 5 nurses (not in preceptorship) that indicated that they will probably look for a new job at a new organisation in the next 12 months was significantly larger than the proportion of band 7 and 8 nurses. It also showed that the proportion of nurses who indicated they will probably not look for a new job in the next 12 months was significantly lower for band 6 nurses compared with nurses in every other band.

Another small to medium highly significant association was found between respondent's staff grade and respondents who indicated that as soon as they can find another job, they will leave their organisation (*p=<.001*, V=.186). A post-hoc z-test (Bonferroni Method) shown in table 4.11 demonstrated that band 5 and 6 nurses were significantly more likely to leave their organisation as soon as they could find another job than band 7 nurses. Band 5 nurses (not in preceptorship) were also significantly more likely to leave their organisation as soon as they could find another job than band 8 nurses. Band 8 nurses were significantly less likely to leave their organisation as soon as they could find another job than band 6 nurses and band 5 nurses (not in preceptorship), whilst band 6 nurses were significantly less likely to leave as soon as they could find another job than band 5 nurses (not in preceptorship).

Table 4.9 - Intent to leave and staff grade – I often think about leaving this organisation

			Band 5 (in preceptorship)	**Band 5 (not in preceptorship)**	**Band 6**	**Band 7**	**Band 8**	**Total**
I often think about leaving this organisation	**No**	Count and (% within staff grade)	$10_{a, b}$ (43.5%)	6_{c} (10.9%)	57_{b} (28.1%)	$28_{a, b}$ (36.4%)	17_{a} (50%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within staff grade)	9_{a} (39.1%)	$11_{a, b}$ (20%)	39_{b} (19.2%)	$17_{a, b}$ (22.1%)	$6_{a, b}$ (17.6%)	82 (20.9%)
	Yes	Count and (% within staff grade)	4_{a} (17.4%)	38_{b} (69.1%)	107_{c} (52.7%)	$32_{c, d}$ (41.6%)	$11_{a, d}$ (32.4%)	192 (49%)
		Total count	23	55	203	77	34	392

Pearson Chi-Square value	30.612
p-value	<.001*
Cramer's V	.198

Each subscript letter denotes a subset of staff grade categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Table 4.10 - Intent to leave and staff grade – I will probably look for a new job at a new organisation in the next 12 months

			Band 5 (in preceptorship)	**Band 5 (not in preceptorship)**	**Band 6**	**Band 7**	**Band 8**	**Total**
I will probably look for a new job at a new organisation in the next 12 months	**No**	Count and (% within staff grade)	11_{a} (47.8%)	9_{b} (16.4%)	89_{a} (43.8%)	37_{a} (48.1%)	18_{a} (52.9%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within staff grade)	3_{a} (13%)	21_{b} (38.2%)	47_{a} (23.2%)	$23_{a, b}$ (29.9%)	$9_{a, b}$ (26.5%)	103 (26.3%)
	Yes	Count and (% within staff grade)	$9_{a, b}$ (39.1%)	25_{b} (45.5%)	$67_{a, b}$ (33%)	17_{a} (22.1%)	7_{a} (20.6%)	125 (31.9%)
		Total count	23	55	203	77	34	392
Pearson Chi-Square value	23.586							
p-value	.003*							
Cramer's V	.173							

Each subscript letter denotes a subset of type of staff grade categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Table 4.11 - Intent to leave and staff grade – As soon as I find another job, I will leave this organisation

			Band 5 (in preceptorship)	**Band 5 (not in preceptorship)**	**Band 6**	**Band 7**	**Band 8**	**Total**
As soon as I find another job, I will leave this organisation	**No**	Count and (% within staff grade)	$14_{a, b}$ (60.9%)	15_{c} (27.3%)	99_{b} (48.8%)	$40_{a, b}$ (51.9%)	23_{a} (67.6%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within staff grade)	2_{a} (8.7%)	23_{b} (41.8%)	$52_{a, c}$ (25.6%)	$28_{b, c}$ (36.4%)	$7_{a, c}$ (20.6%)	112 (28.6%)
	Yes	Count and (% within staff grade)	$7_{a, b}$ (30.4%)	17_{b} (30.9%)	$52_{a, b}$ (25.6%)	9_{c} (11.7%)	$4_{a, c}$ (11.8%)	89 (22.7%)
		Total count	23	55	203	77	34	392
Pearson Chi-Square value	27.029							
p-value	<.001*							
Cramer's V	.186							

Each subscript letter denotes a subset of type of staff grade categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Cross tabulation for respondent's staff grade and most likely destination (table 4.12) showed that over half of the band 5 nurses (in preceptorship) and band 8 nurses indicated that they are not considering leaving their current job, with band 5 nurses (not in preceptorship) making up

the smallest proportion of respondents who indicated that they are not considering leaving their current job (n=12, 21.8%). Of those who indicated that they are considering leaving their current job, band 7 nurses have the highest percentage of respondents that indicated they would want to move to another job in the same organisation (n=17, 22.1%), whereas band 5 nurses have the highest percentage of nurses who indicated they would want to move to a different Trust/organisation (band 5 in preceptorship – n=6, 26.1% and Band 5 not in preceptorship – n=14, 25.5%). Similarly small proportions of respondents in all bands indicated that they would want to move outside the NHS across all staff grades. Band 5 nurses (not in preceptorship) had the highest proportion of respondents who indicated that they would want to move to a job outside of nursing (n=16, 29.1%), with band 6 nurses having the highest number of respondents who indicated they would want to retire or take a career break (n=32, 15.8%).

A Chi-Square test via Monte Carlo simulation demonstrated a medium significant association between nurses' staff grade and most likely destination (*p=.005*, V=.161). An additional z-test (Bonferroni Method) shown in table 4.12 indicates that the proportion of band 5 nurses (in preceptorship) and band 8 nurses who indicated that they are not considering leaving their current job was significantly higher than the proportion of band 5 nurses (not in preceptorship). Band 5 nurses (not in preceptorship) had a significantly higher proportion of respondents that indicated they would want to move to a job outside nursing than band 5 nurses (in preceptorship).

Table 4.12 – Intent to leave and staff grade – Most likely destination

			Band 5 (in preceptorship)	**Band 5 (not in preceptorship)**	**Band 6**	**Band 7**	**Band 8**	**Total**
Most likely destination	**I am not considering leaving my current job.**	Count and (% within clinical setting)	13_{a} (56.5%)	12_{b} (21.8%)	$71_{a, b}$ (35%)	$31_{a, b}$ (40.3%)	19_{a} (55.9%)	146 (37.2%)
	I would want to move to another job within this organisation	Count and (% within clinical setting)	3_{a} (13%)	5_{a} (9.1%)	34_{a} (16.7%)	17_{a} (22.1%)	4_{a} (11.8%)	63 (16.1%)
	I would want to move to a job in a different NHS Trust/organisation	Count and (% within clinical setting)	6_{a} (26.1%)	14_{a} (25.5%)	28_{a} (13.8%)	7_{a} (9.1%)	3_{a} (8.8%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within clinical setting)	1_{a} (4.3%)	2_{a} (3.6%)	7_{a} (3.4%)	3_{a} (3.9%)	0_{a} (0%)	13 (3.3%)
	I would want to move to a job outside of nursing	Count and (% within clinical setting)	0_{a} (0%)	16_{b} (29.1%)	$31_{a, b}$ (15.3%)	$8_{a, b}$ (10.4%)	$3_{a, b}$ (8.8%)	58 (14.8%)

	I would retire or take a career break	Count and (% within clinical setting)	0_a (0%)	6_a (10.9%)	32_a (15.8%)	11_a (14.3%)	5_a (14.7%)	54 (13.8%)
		Total count	23	55	203	77	34	392
Chi -square value	40.564							
***p*-value via Monte Carlo method**	.005							
Cramer's V	.161							

Each subscript letter denotes a subset of staff grade categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Nursing experience

There was no significant association identified between years of nursing experience and respondent's intent to leave their organisation (see tables 4.13, 4.14 and 4.15). However, A Chi-Square test via Monte Carlo simulation showed a medium to large highly significant association between nursing experience and respondent's most likely destination (*p=<.001,* V=.197). A post-hoc z-test (Bonferroni Method) shown in table 4.16 indicates that the percentage of respondents who indicated that they would want to move to a job in a different Trust/organisation was significantly higher for nurses with 1-2 years' experience (n=12, 40%) than those with 10+ years' experience (n=24, 10.1%). Also, the proportion of respondents that indicated they would want to retire or take a career break was significantly higher for those with 10+ years' experience (n=51, 21.5%) than 5+ years' experience (n=2, 3.2%).

Table 4.13 – Intent to leave and nursing experience – I often think about leaving this organisation

			Less than 1 year	**1-2 years**	**2-3 years**	**3-4 years**	**4-5 years**	**5+ years**	**10+ years**	**Total**
I often think about leaving this organisation	**No**	Count and (% within nursing experience)	8 (42.2%)	7 (23.3%)	5 (38.5%)	3 (16.7%)	2 (16.7%)	14 (22.2%)	79 (33.3%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within nursing experience)	7 (36.8%)	5 (16.7%)	2 (15.4%)	7 (38.9%)	2 (16.7%)	13 (20.6%)	46 (19.4%)	82 (20.9%)
	Yes	Count and (% within nursing experience)	4 (21.2%)	18 (60%)	6 (46.2%)	8 (44.4%)	8 (66.7%)	36 (57.1%)	112 (47.3%)	192 (49%)
		Total count	19	30	13	18	12	63	237	392
Pearson Chi-Square value	17.117									
***p-value* via Monte Carlo method**	.141									

Table 4.14 – Intent to leave and nursing experience – I will probably look for a new job at a new organisation in the next 12 months

			Less than 1 year	1-2 years	2-3 years	3-4 years	4-5 years	5+ years	10+ years	Total
I will probably look for a new job at a new organisation in the next 12 months	**No**	Count and (% within nursing experience)	10 (52.6%)	7 (23.3%)	7 (53.8%)	3 (16.7%)	4 (33.3%)	24 (38.1%)	109 (46%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within nursing experience)	2 (10.5%)	9 (30%)	3 (23.1%)	8 (44.4%)	1 (8.3%)	17 (27%)	63 (26.6%)	103 (26.3%)
	Yes	Count and (% within nursing experience)	7 (36.8%)	14 (46.7%)	3 (23.1%)	7 (38.9%)	7 (58.3%)	22 (34.9%)	65 (27.4%)	125 (31.9%)
		Total count	19	30	13	18	12	63	237	392
Pearson Chi-Square value	20.396									
***p-value* via Monte Carlo method**	.056									

Table 4.15 – Intent to leave and nursing experience – As soon as I find another job, I will leave this organisation

			Less than 1 year	1-2 years	2-3 years	3-4 years	4-5 years	5+ years	10+ years	Total
As soon as I find another job, I will leave this organisation	**No**	Count and (% within nursing experience)	12 (63.2%)	13 (43.3%)	7 (53.8%)	8 (44.4%)	3 (25%)	27 (42.9%)	121 (51.1%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within nursing experience)	2 (10.5%)	9 (30%)	4 (30.8%)	6 (33.3%)	6 (50%)	18 (28.6%)	67 (28.3%)	112 (28.6%)
	Yes	Count and (% within nursing experience)	5 (26.3%)	8 (26.7%)	2 (15.4%)	4 (22.2%)	3 (25%)	18 (28.6%)	49 (20.7%)	89 (22.7%)
		Total count	19	30	13	18	12	63	237	392
Pearson Chi-Square value	9.550									
***p-value* via Monte Carlo method**	.662									

Table 4.16 – Intent to leave and nursing experience – Most likely destination

			Less than 1 year	1-2 years	2-3 years	3-4 years	4-5 years	5+ years	10+ years	Total
Most likely destination	**I am not considering leaving my current job.**	Count and (% within nursing experience)	11*a* (57.9%)	10*a* (33.3%)	8*a* (61.5%)	5*a* (27.8%)	3*a* (25%)	23*a* (36.5%)	86*a* (36.3%)	146 (37.2%)
	I would want to move to another job within this organisation	Count and (% within nursing experience)	2*a* (10.5%)	3*a* (10%)	2*a* (15.4%)	6*a* (33.3%)	4*a* (33.3%)	10*a* (15.9%)	36*a* (15.2%)	63 (16.1%)

	I would want to move to a job in a different NHS Trust/organisation	Count and (% within nursing experience)	5*a, b* (26.3%)	12*b* (40%)	2*a, b* (15.4%)	5*a, b* (27.8%)	1*a, b* (8.3%)	9*a, b* (14.3%)	24*a* (10.1%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within nursing experience)	1*a* (5.3%)	2*a* (6.7%)	1*a* (7.7%)	0*a* (0%)	1*a* (8.3%)	2*a* (3.2%)	6*a* (2.5%)	13 (3.3%)
	I would want to move to a job outside of nursing	Count and (% within nursing experience)	0*a* (0%)	2*a* (6.7%)	0*a* (0%)	2*a* (11.1%)	3*a* (25%)	17*a* (27%)	34*a* (14.3%)	58 (14.8%)
	I would retire or take a career break	Count and (% within nursing experience)	0*a, b* (0%)	1*a, b* (3.3%)	0*a, b* (0%)	0*a, b* (0%)	0*a, b* (0%)	2*b* (3.2%)	51*a* (21.5%)	54 (13.8%)
		Total count	19	30	13	18	12	63	237	392
Chi -square value	76.303									
***p*-value via Monte Carlo method**	<.001*									
Cramer's V	.197									
Each subscript letter denotes a subset of nursing experience categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.										

Summary

Staff grade was the only background variable significantly associated with respondent's intent to leave their organisation. Band 5 nurses (not in preceptorship) indicated that they often think about leaving their organisation significantly more than respondents in every other band, and they were significantly more likely to look for another job at a new organisation in the next 12 months than band 7 and 8 nurses. Both band 5 and 6 nurses were significantly more likely to leave their organisation as soon as they find another job than band 7 nurses, with band 5 nurses (not in preceptorship) also being significantly more likely than band 8 nurses.

Staff grade and nursing experience were significantly associated with respondent's most likely destination. The results found that band 5 nurses (in preceptorship) and band 8 nurses were significantly less likely to consider leaving their current job than band 5 nurses (not in preceptorship). For respondents that were considering leaving their job, nurses with 1-2 years nursing experience were significantly more likely to want to move to a job at a new organisation than respondents with 10+ years nursing experience. Whereas respondents with 10+ years' experience indicated that they are significantly more likely to retire or take a career break than respondents with 5+ years' experience. Band 5 nurses (not in preceptorship) were

significantly more likely to move to a job outside of nursing than band 5 nurses sill in their preceptorship.

The next section will go on to examine any significant relationships between respondent's work-related stress and wellbeing and intent to leave.

Intent to leave and work-related stress and wellbeing

Work-related stress

Cross tabulation showed that 62.8% (n=152) of respondents who indicated that they had felt unwell because of work-related stress during the last 12 months stated they often think about leaving their organisation, compared with 26.7% (n=40) of respondents who indicated that they had not (table 4.17). A smaller but still large number of respondents who indicated they had felt unwell with work-related stress during the last 12 months stated that they will probably look for a new job at a new organisation in the next 12 months (n=100, 41.3%), compared with 16.7% (n=25) who had not (table 4.18). There were more respondents who had felt unwell with work-related stress during the last 12 months and indicated they will leave their organisation as soon as they find a new job (n=73, 30.2%) than on average (22.7%), and in comparison, to respondents who had not felt unwell with work-related stress (n=16, 10.7%) (see table 4.19).

A Chi-Square test found a medium and highly significant association between work-related stress and respondents who indicated that they often think about leaving their organisation (*p=<.001,* V=.354). A post-hoc z-test (Bonferroni Method) shown in table 4.17 demonstrated that respondents who indicated that they had felt unwell with work-related stress during the last 12 months were significantly more likely to often think about leaving their organisation than those who indicated they had not. Conversely, respondents who indicated they had not felt unwell because of work-related stress were significantly more likely to not often think about leaving their organisation than those who had.

A Chi-Square test identified a medium and highly significant association between work-related stress and respondents who will probably look for a new job at a new organisation in the next 12 months (*p=<.001,* V=.325). A post-hoc z-test (Bonferroni Method) shows that the proportion of respondents who had not felt unwell with work-related stress during the last 12 months who indicated they will probably not look for a new job at a new organisation in the

next 12 months was significantly higher than respondents who indicated that they had. Respondents who indicated that they had felt unwell with work-related stress during the last 12 months were significantly more likely to probably look for a new job at a new organisation in the next 12 months than those who indicated they had not (see table 4.18).

A Chi-Square test identified a medium highly significant association between work-related stress and respondents, who as soon as they find another job, will leave their organisation (*p=<.001*, V=.305). An additional z-test (Bonferroni Method) showed that the proportion of respondents who indicated that they had felt unwell with work-related stress that stated they will leave their organisation as soon as they find another job was significantly higher than those who indicated that they had not. Conversely, the proportion of respondents who indicated that they had not felt unwell with work-related stress that stated they will not leave their organisation as soon as they find another job is significantly higher than those who indicated that they had (table 4.19).

Table 4.17 – Intent to leave and Work-related stress – I often think about leaving this organisation

			Work-related stress		
			Yes	**No**	**Total**
I often think about leaving this organisation	**No**	Count and (% within work-related stress)	50_a (20.7%)	68_b (45.3%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within work-related stress)	40_a (16.5%)	42_b (28%)	82 (20.9%)
	Yes	Count and (% within work-related stress)	152_a (62.8%)	40_b (26.7%)	192 (49%)
		Total count	242	150	392
Pearson Chi-Square value	49.249				
p-value	<.001*				
Cramer's V	.354				
Each subscript letter denotes a subset of work-related stress categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.					

Table 4.18 – Intent to leave and Work-related stress – I will probably look for a new job at a new organisation in the next 12 months

			Work-related stress		
			Yes	**No**	**Total**
I will probably look for a new job at a new organisation in the next 12 months	**No**	Count and (% within work-related stress)	72_a (29.8%)	92_b (61.3%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within work-related stress)	70_a (28.9%)	33_a (22%)	103 (26.3%)
	Yes	Count and (% within work-related stress)	100_a (41.3%)	25_b (16.7%)	125 (31.9%)
		Total count	242	150	392
Pearson Chi-Square value	41.420				
p-value	<.001*				

Cramer's V	.325

Each subscript letter denotes a subset of work-related stress categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Table 4.19 - Intent to leave and Work-related stress – As soon as I can find another job, I will leave this organisation

			Work-related stress		
			Yes	**No**	**Total**
As soon as I can find another job, I will leave this organisation	**No**	Count and (% within work-related stress)	90_a (37.2%)	101_b (67.3%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within work-related stress)	79_a (32.6%)	33_b (22%)	112 (28.6%)
	Yes	Count and (% within work-related stress)	73_a (30.2%)	16_b (10.7%)	89 (22.7%)
		Total count	242	150	392
Pearson Chi-Square value	36.448				
p-value	<.001*				
Cramer's V	.305				

Each subscript letter denotes a subset of work-related stress categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Cross tabulation in table 4.20 shows that over half of the respondents who had not felt unwell with work related stress during the last 12 months are not considering leaving their job. For those that are considering leaving their job, respondents who had felt unwell with work-related stress had a higher percentage of respondents for every most likely destination apart from retiring or taking a career break.

A Chi-square test identified a large and highly significant association between work-related stress and most likely destination ($p=<.001$, V=.372). A post-hoc z-test (Bonferroni Method) shown in table 4.20 demonstrated that the proportion of respondents who had not felt unwell with work related stress during the last 12 months and indicated that they are not considering leaving their job was significantly higher than those who had. For those that were considering leaving, the proportion of respondents who had felt unwell with work-related stress in the last 12 months and indicated they would want to move to another job in the same organisation, to a job in nursing at a different organisation, to a job in nursing but outside the NHS, and to a job outside nursing, was significantly higher than the proportion of respondents who had not felt unwell with work-related stress in the last 12 months.

Table 4.20 – Intent to leave and work-related stress – Most likely destination

			Work-related stress		
			Yes	No	Total
Most likely destination	**I am not considering leaving my current job.**	Count and (% within work-related stress)	61_a (25.2%)	85_b (56.7%)	146 (37.2%)

	I would want to move to a job within this organisation	Count and (% within work-related stress)	47_a (19.4%)	16_b (10.7%)	63 (16.1%)
	I would want to move to a job in a different NHS Trust/organisation	Count and (% within work-related stress)	43_a (17.8%)	15_b (10%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within work-related stress)	12_a (5%)	1_b (0.7%)	13 (3.3%)
	I would want to move to a job outside of nursing	Count and (% within work-related stress)	50_a (20.7%)	8_b (5.3%)	58 (14.8%)
	I would retire or take a career break	Count and (% within work-related stress)	29_a (12%)	25_a (16.7%)	54 (13.8%)
		Total count	242	150	392
Chi -Square value	54.124				
***p*-value**	<.001*				
Cramer's V	.372				

Each subscript letter denotes a subset of work-related stress categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Mental wellbeing (SWEMWBS)

Cross tabulation in table 4.21 shows that the better the wellbeing the less respondents often thought of leaving their organisation and vice versa, with 86.8% (n=33) of respondents with probable depression or anxiety indicating that they often think of leaving their organisation. The same trend can be seen for those who indicated that they will probably look for a new job at a new organisation in the next 12 months, with 71.1% (n=27) of respondents with probable depression or anxiety indicating they will probably look for a new job at a new organisation in the next 12 months (see table 4.22). Again, as mental wellbeing increased the percentage of respondents who indicated that they would leave their organisation as soon as they find another job reduced and vice versa, with 60.5% (n=23) of respondents with probable anxiety or depression indicating that they will leave their organisation as soon as they find another job (see table 4.23).

A Chi-square test of association identified a medium highly significant association between mental wellbeing and respondents who indicated that they often think about leaving their organisation (*p=<.001,* V=.234). A post-hoc z-test (Bonferroni Method) shown in table 4.21 demonstrated that respondents with above average mental wellbeing were significantly more likely to not often think about leaving their organisation. The proportion of respondents with probable anxiety or depression were significantly more likely to often think about leaving their organisation than respondents with possible depression or anxiety, and average and high mental wellbeing. The proportion of respondents with possible depression and anxiety who indicated

they often think about leaving their organisation was significantly higher than those with average or high mental wellbeing.

A Chi-square test identified a medium highly significant association between mental wellbeing and respondents who indicated that they will probably look for a new job at a new organisation in the next 12 months (*p=<.001,* V=.234). An additional z-test (Bonferroni Method) shown in table 4.22 found that the proportion respondents with average or high mental wellbeing who indicated that they will not probably look for a new job at a new organisation in the next 12 months was significantly higher than both respondents with possible and probable depression or anxiety. The proportion of respondents with possible depression or anxiety who indicated that they will probably not look for a new job at a new organisation in the next 12 months was significantly higher than respondents who have probable depression or anxiety. The proportion of respondents with probable depression or anxiety who indicated that they will probably look for a new job at a new organisation in the next 12 months was significantly higher than respondents with higher mental wellbeing.

A Chi-square test identified a medium highly significant association between mental wellbeing and respondents who indicated that as soon as they can find another job, they will leave their organisation (*p=<.001,* V=.261). A post-hoc z-test (Bonferroni Method) shown in table 4.23 demonstrated that the proportion of respondents with average or high mental wellbeing who indicated they will not leave their organisation that as soon as they can find another, was significantly higher than both respondents with possible and probable depression or anxiety. The proportion of respondents with probable depression or anxiety who indicated that as soon as they can find another job, they will leave their organisation, was significantly higher than respondents with better mental wellbeing.

Table 4.21 – Intent to leave and mental wellbeing – I often think about leaving this organisation

			Mental wellbeing				
			Probable depression or anxiety	**Possible depression or anxiety**	**Average mental wellbeing**	**High mental wellbeing**	**Total**
I often think about leaving this organisation	**No**	Count and (% within mental wellbeing)	3_a (7.9%)	27_a (20.8%)	80_b (38.1%)	8_b (57.1%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within mental wellbeing)	2_a (5.3%)	28_b (21.5%)	49_b (23.3%)	$3_{a,\ b}$ (21.4%)	82 (20.9%)

	Yes	Count and (% within mental wellbeing)	33_a (86.8%)	75_b (57.7%)	81_c (38.6%)	3_c (21.4%)	192 (49%)
		Total count	38	130	210	14	392
Pearson Chi-Square value	42.860						
p-value	<.001*						
Cramer's V	.234						
Each subscript letter denotes a subset of mental wellbeing categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.							

Table 4.22 – Intent to leave and mental wellbeing – I will probably look for a new job at a new organisation in the next 12 months

			Mental wellbeing				
			Probable depression or anxiety	**Possible depression or anxiety**	**Average mental wellbeing**	**High mental wellbeing**	**Total**
I will probably look for a new job at a new organisation in the next 12 months	**No**	Count and (% within mental wellbeing)	4_a (10.5%)	45_b (34.6%)	106_c (50.5%)	9_c (64.3%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within mental wellbeing)	$7_{a, b}$ (18.4%)	43_b (33.1%)	49_a (23.3%)	$4_{a, b}$ (28.6%)	103 (26.3%)
	Yes	Count and (% within mental wellbeing)	27_a (71.7%)	42_b (32.3%)	55_b (26.2%)	1_b (7.1%)	125 (31.9%)
		Total count	38	130	210	14	392
Pearson Chi-Square value	42.971						
p-value	<.001*						
Cramer's V	.234						
Each subscript letter denotes a subset of mental wellbeing categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.							

Table 4.23 – Intent to leave and mental wellbeing – As soon as I can find another job, I will leave this organisation

			Mental wellbeing				
			Probable depression or anxiety	**Possible depression or anxiety**	**Average mental wellbeing**	**High mental wellbeing**	**Total**
As soon as I can find another job, I will leave this organisation	**No**	Count and (% within mental wellbeing)	4_a (10.5%)	53_b (40.8%)	123_c (58.6%)	11_c (78.6%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within mental wellbeing)	$11_{a, b}$ (28.9%)	47_b (36.2%)	52_a (24.8%)	$2_{a, b}$ (14.3%)	112 (28.6%)
	Yes	Count and (% within mental wellbeing)	23_a (60.5%)	30_b (23.1%)	35_b (16.7%)	1_b (7.1%)	89 (22.7%)
		Total count	38	130	210	14	392
Pearson Chi-Square value	53.306						
p-value	<.001*						
Cramer's V	.261						

Each subscript letter denotes a subset of mental wellbeing categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Cross tabulation of respondent's mental wellbeing and most likely destination showed that the better the mental wellbeing the more respondents were not considering leaving their job (see table 4.24). For those that were considering leaving, the poorer the mental wellbeing the more nurses indicated they would want to move to another job within their organisation. No respondents with high mental wellbeing indicated that they would want to move to a new job in a different Trust/organisation, in comparison to 18.4% (n=7) of respondents with probable depression or anxiety. Respondents with probable depression and anxiety had the highest proportion of respondents who indicated that they would want to move to a job outside of nursing (n=16, 42.1%), followed by respondents who had possible depression or anxiety (n=27, 20.8%). Respondents with high mental wellbeing have the highest proportion of nurses who indicated that they would retire or take a career break (n=3, 21.4%) with the percentages decreasing as mental wellbeing decreased.

A Chi-square test via the Monte Carlo method found a medium highly significant association between respondent's mental wellbeing and most likely destination (*p=<.001,* V=.226). A post-hoc z-test (Bonferroni Method) shown in table 4.24 demonstrated that the proportion of respondents with average and high mental wellbeing who indicated they are not considering leaving their current job was significantly higher than respondents with probable or possible depression or anxiety, and the proportion of respondents with possible depression or anxiety was significantly larger than respondents with probable depression or anxiety. The proportion of respondents with probable depression or anxiety who indicated that they would want to move to a job outside nursing was significantly higher than nurses with better mental wellbeing. The proportion of respondents with possible depression or anxiety who indicated that they would want to move to a job outside of nursing was significantly higher than respondents with average mental wellbeing.

Table 4.24 – Intent to leave and mental wellbeing – Most likely destination

			Mental wellbeing				
			Probable depression or anxiety	Possible depression or anxiety	Average mental wellbeing	High mental wellbeing	Total
Most likely destination	**I am not considering leaving my current job.**	Count and (% within mental wellbeing)	2_a (5.3%)	42_b (32.3%)	93_c (44.3%)	9_c (64.3%)	146 (37.2%)

	I would want to move to a job within this organisation	Count and (% within mental wellbeing)	8_a (21.1%)	22_a (16.9%)	32_a (15.2%)	1_a (7.1%)	63 (16.1%)
	I would want to move to a job in a different NHS Trust/organisation	Count and (% within mental wellbeing)	7_a (18.4%)	16_a (12.3%)	35_a (16.7%)	0_a (0%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within mental wellbeing)	3_a (7.9%)	5_a (3.8%)	5_a (2.4%)	0_a (0%)	13 (3.3%)
	I would want to move to a job outside of nursing	Count and (% within mental wellbeing)	16_a (42.1%)	27_b (20.8%)	14_c (6.7%)	$1_{b, c}$ (7.1%)	58 (14.8%)
	I would retire or take a career break	Count and (% within mental wellbeing)	2_a (5.3%)	18_a (13.8%)	31_a (14.8%)	3_a (21.4%)	54 (13.8%)
		Total count	38	130	210	14	392
Chi -Square value	60.206						
***p*-value via Monte Carlo method**	<.001*						
Cramer's V	.226						

Each subscript letter denotes a subset of mental wellbeing categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.

Summary

Work-related stress and mental wellbeing were significantly associated with respondent's intent to leave their organisation. Respondents who had felt unwell with work-related stress and those with lower mental wellbeing were significantly more likely to leave their organisation.

Work-related stress and mental wellbeing were also significantly associated with respondent's most likely destination. Respondents who had felt unwell with work-related stress were significantly more likely to move to a job in another organisation, outside the NHS, and outside of the nursing profession. Respondents with lower-than-average mental wellbeing were also more likely to move to a job outside of nursing.

The next section will go on to examine any significant relationships between respondent's demographic variables and intent to leave.

Intent to leave and demographic variables

Age

Cross tabulation of respondent's age and intent to leave their organisation shows that respondents in the 21-30 age group had the highest percentage of respondents who indicated that they often think about leaving their organisation (n=37, 60.7%). Whereas respondents in the 65+ age group had the smallest percentage of respondents who indicated that they often think about leaving their organisation (n=3, 37.5%) (table 4.25). There were similar proportions of respondents who indicated that they do not often think about leaving their organisation across the age groups (see table 4.25). Respondents in the 21-30 age group also had the highest percentage of respondents who indicated they will probably look for a new job at a new organisation in the next 12 months (n=25, 41%), whilst respondents in the 65+ age group had the smallest (n=1, 12.5%) (table 4.26). Respondents in the 51-65 age group had the highest proportion of respondents who indicated that they will probably not look for a new job at a new organisation in the next 12 months (n=67, 51.1%) (table 4.26). Table 4.47 shows that respondents between the ages of 21 and 50 had higher proportions of respondents that indicated that as soon as they find another job, they will leave their organisations than on average.

There was no statistically significant association identified between age and respondents that indicated that they often think about leaving their organisation (*p=.060*) (table 4.25). However, a Chi-Square test did identify a small but statistically significant association between age and respondents who indicated that they will probably look for a new job at a new organisation in the next 12 months (*p=.043,* V=.143). A post-hoc z-test (Bonferroni Method) shown in table 4.26 identified that respondents between the ages of 21 and 50 had significantly higher proportions of respondents who indicated that they will probably look for a job at a new organisation in the next 12 months than respondents in the 51-65 age group. Conversely, respondents in the 51-65 age group had a significantly higher proportion of respondents that indicated they would probably not look for a new job at a new organisation in the next 12 months than respondents in the 21-30 and 41-50 age groups. There was no statistically significant association identified between age and respondents who indicated that they would leave their organisation as soon as they find another job (*p=.113*) (table 4.27).

Table 4.25 – Intent to leave and age – I often think about leaving this organisation

	21-30	**31-40**	**41-50**	**51-65**	**65+**	**Total**

I often think about leaving this organisation	**No**	Count and (% within age)	17 (27.9%)	30 (34.5%)	31 (29.5%)	38 (29%)	2 (25%)	118 (30.1%)
	Neither agree nor disagree	Count and (% within age)	7 (11.5%)	10 (11.5%)	29 (27.6%)	33 (25.2%)	3 (37.5%)	82 (20.9%)
	Yes	Count and (% within age)	37 (60.7%)	47 (54%)	45 (42.9%)	60 (45.8%)	3 (37.5%)	192 (49%)
		Total count	61	87	105	131	8	392
Pearson Chi-Square value	14.970							
***p-value* via Monte Carlo method**	.060							

Table 4.26 – Intent to leave and age – I will probably look for a new job at a new organisation in the next 12 months

			21-30	**31-40**	**41-50**	**51-65**	**65+**	**Total**
I will probably look for a new job at a new organisation in the next 12 months	**No**	Count and (% within age)	21_{a} (34.4%)	$38_{a, b}$ (43.7%)	35_{a} (33.3%)	67_{b} (51.1%)	$3_{a, b}$ (37.5%)	164 (41.8%)
	Neither agree nor disagree	Count and (% within age)	15_{a} (24.6%)	19_{a} (21.8%)	30_{a} (28.6%)	35_{a} (26.7%)	4_{a} (50%)	103 (26.3%)
	Yes	Count and (% within age)	25_{a} (41%)	30_{a} (34.5%)	40_{a} (38.1%)	29_{b} (22.1%)	$1_{a, b}$ (12.5%)	125 (31.9%)
		Total count	61	87	105	131	8	392
Pearson Chi-Square value	15.970							
***p-value* via Monte Carlo method**	.043*							
Cramer's V	.143							
Each subscript letter denotes a subset of age categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.								

Table 4.27 – Intent to leave and age – As soon as I can find another job, I will leave this organisation

			21-30	**31-40**	**41-50**	**51-65**	**65+**	**Total**
As soon as I can find another job, I will leave this organisation	**No**	Count and (% within age)	29 (47.5%)	45 (51.7%)	39 (37.1%)	73 (55.7%)	5 (62.5%)	191 (48.7%)
	Neither agree nor disagree	Count and (% within age)	18 (29.5%)	19 (21.8%)	38 (36.2%)	34 (26%)	3 (37.5%)	112 (28.6%)
	Yes	Count and (% within age)	14 (23%)	23 (26.4%)	28 (26.7%)	24 (18.3%)	0 (0%)	89 (22.7%)
		Total count	61	87	105	131	8	392
Pearson Chi-Square value	12.954							
***p-value* via Monte Carlo method**	.113							

Cross tabulation of respondent's age and most likely destination displayed in table 4.28 shows that there were similar percentages of nurses who indicated that they are not considering leaving their current job across all the age groups. Respondents in the 41-50 age group had the highest percentage of respondents who indicated that they would want to move to another job within the same organisation (n=23, 21.9%), whilst respondents in the 21-30 age group had the highest percentage of nurses who indicated that they would want to move to a job in a different NHS Trust/organisation (n=16, 26.2%). Respondents in the 31-40 age group had the highest percentage of respondents who indicated that they would want to move to a job in nursing, but outside the NHS (n=8, 9.2%). Respondents in the 41-50 age group had the highest percentage of respondents that indicated that they would want to move to a job outside of nursing (n=24, 22.9%), and respondents in the 65+ age group had the highest number of respondents who indicated that they would want to retire or take a career break (n=3, 37.5%).

A Chi-Square test via Monte Carlo simulation identified a large highly significant association between respondent's age and most likely destination (*p=<.001,* V=.280). A post-hoc z-test (Bonferroni Method) shown in table 4.28 demonstrated that respondents in the 21-30 and 41-50 age groups were significantly more likely to want to move to another job within the same organisation than the 51-65 age group. The proportion of respondents in the 21-30 age group that indicated they would want to move to a job in a different Trust/organisation was significantly larger than those in the 51-65 age group. The proportion of respondents in the 31-40 age group that indicated they would want to move to a nursing job, but outside the NHS, was significantly larger than those in all other age groups except from the 65+ age group. The proportion of respondents in the 51-65 age group that indicated that they would want to move to a job outside of nursing was significantly smaller than the younger age groups. The proportion of respondents in the 51-65 and 65+ age groups who indicated that they would want to retire or take a career break was significantly larger than all the other age groups.

Table 4.28 – Intent to leave and age – Most likely destination

			21-30	**31-40**	**41-50**	**51-65**	**65+**	**Total**
Most likely destination	**I am not considering leaving my current job.**	Count and (% within age)	23_{a} (37.7%)	33_{a} (37.9%)	37_{a} (35.2%)	50_{a} (38.2%)	3_{a} (37.5%)	146 (37.2%)
	I would want to move to another job within this organisation	Count and (% within age)	13_{a} (21.3%)	$13_{a, b}$ (14.9%)	23_{a} (21.9%)	13_{b} (9.9%)	$1_{a, b}$ (12.5%)	63 (16.1%)

	I would want to move to a job in a different NHS Trust/organisation	Count and (% within age)	16_{a} (26.2%)	$12_{a, b}$ (13.8%)	$18_{a, b}$ (17.1%)	12_{b} (9.2%)	$0_{a, b}$ (0%)	58 (14.8%)
	I would want to move to a job in nursing, but outside the NHS	Count and (% within age)	0_{a} (0%)	8_{b} (9.2%)	2_{a} (1.9%)	3_{a} (2.3%)	$0_{a, b}$ (0%)	13 (3.3%)
	I would want to move to a job outside of nursing	Count and (% within age)	8_{a} (13.1%)	19_{a} (21.8%)	24_{a} (22.9%)	6_{b} (4.6%)	$1_{a, b}$ (12.5%)	58 (14.8%)
	I would retire or take a career break	Count and (% within age)	1_{a} (1.6%)	2_{a} (3.2%)	1_{a} (1%)	47_{b} (35.9%)	3_{b} (37.5%)	54 (13.8%)
		Total count	61	87	105	131	8	392
Chi -square value	122.886							
***p*-value via Monte Carlo method**	<.001*							
Cramer's V	.280							
Each subscript letter denotes a subset of age categories whose column proportions do not differ significantly from each other at the .05 level. * Represents a statistically significant result.								

Summary

These results indicate that age was significantly associated with respondent's intent to leave their job and organisation to some extent. Respondents in the 21-30 and 41-50 age groups were significantly more likely to move to another job within the same organisation than respondents in the 51-65 age group. Respondents in the 21-30 age group were also significantly more likely to move to a job in a different NHS Trust/organisation than respondents in the 51-65 age group. Respondents who were in the 31-40 age group were significantly more likely to move to a job in nursing but outside the NHS than all the other age groups except 65+. Respondents in the 51-65 were significantly less likely to move to a job outside of nursing than all the other age groups except 65+. Respondents in the 51-65 and 65+ age groups were significantly more likely to retire or take a career break.

Chapter 5 – Phase 2 (interviews) findings – Thematic analysis

The previous chapter identified that different clinical settings, NHS Trusts, staff grade, nursing experience, work-related stress, mental wellbeing, and age may be significantly associated with MHNs' intent to leave or stay to some extent. This chapter will set out to identify the contextual factors influencing MHNs' intention to leave or stay in both inpatient and community settings.

Sample

Out of the 306 of participants that consented to be contacted, 107 were purposefully selected based on survey responses indicating high or low intent to leave their current clinical setting, and their organisation, the NHS, or nursing profession altogether. All 107 potential participants were then invited to interview via email and 30 responded to the email invitation and completed the interview. The rest did not respond or were non-contactable using the email address they provided. Twelve were from inpatient settings, 15 were from community settings and three were from clinical settings that fell into the 'other' category. A thorough investigation of the three interviews within the 'other' clinical settings found that although they were not traditional community settings, such as Community Mental Health Teams (CMHTs), they were still clinical settings based in the community. Therefore, the data from these interviews were analysed alongside those data collected from participants in the community settings, bringing the total number of interviews from participants working in community settings to 18.

A total of 14 senior leaders who met the eligibility criteria were invited to interview and 10 senior leaders completed the interview. Those who did not complete the interview either did not respond to the email invitation or we were unable to arrange a date and time due to their busy schedules.

A total of 26 MHNs opted for a remote interview conducted by telephone. Two MHNs selected virtual interviews and two selected face-to-face. All the senior leaders opted for virtual interviews conducted on either Microsoft Teams or Google Meet. All interviews were audio recorded and transcribed verbatim and anonymised ready for data analysis. I initially began transcription, but due to the number of interviews and amount of data gathered a minor amendment was submitted for ethical review to use a transcription service.

Thematic Analysis

From the analytic process five themes were generated from the data: *Disillusionment with Mental Health Nursing, The Impact of Leadership and Management, The Impact of the Work Environment, The Impact of Training and Development,* and *The Impact of Staffing.* Each theme highlights aspects of nurses' experiences relevant to retention or intention to leave. As such, the themes illustrate the conditions that make wanting to leave their clinical settings, Trusts, the NHS, or indeed the profession, more or less likely. Each theme is representative of a distinct area of professional working experience, although these are not mutually exclusive and at times are inter-dependent. The themes highlight both positive and negative experiences and it will be clear which aspects of nurses' experiences inhibit or facilitate retention for nurses in both settings. Although there are significant commonalities in most areas, I will draw attention to the parts of the themes that are more pertinent to community or inpatients settings. I used a weaving approach to present the two sets of qualitative findings, which involved combining the qualitative data from the MHNs and senior leaders on a theme-by-theme basis (Fetters *et al,* 2013).To illustrate the findings, I have used quotations and labelled them with the type of setting the participants work in, their staff grade, and whether or not at the time of interview they were still in the same post as when they completed the survey.

Disillusionment with Mental Health Nursing

This theme describes a range of experiences that influences MHNs to become disillusioned with their role and the profession or not, which then influences intention to leave. This theme is made up two subthemes: *'The Responsibility of Managing Risk',* and *'The Merry-Go-Round.*

The Responsibility of Managing Risk

Nurses in both settings described bearing enormous responsibility for the safety of service users and colleagues. Nurses in both settings reported being able to keep safe, service users, staff teams, and themselves, as an important factor in preventing burnout and promoting workplace wellbeing. Nurses in both settings reported feeling safer in settings where risk is more easily managed, and they can share or handover risk management decisions.

> *"To know that they are looked after, or they are safe, it's a massive advantage. For me, that's why I don't think I will ever leave inpatient [setting]" (P15, inpatient nurse, band 7, Trust 2, still in post)*

Whilst on shift, inpatient nurses reported being responsible for the care and safety of up to 21 acutely unwell service users and large staff teams on their shifts. Their responsibilities extend to the management of frequent emergency interventions and complex dynamics on the ward to maintain safety and deliver effective care. Emergency interventions are often manifested in violence and aggression, serious self-harm, and in some cases the death of a service user.

> *"It's a lot of responsibility, potentially someone could die as a result of any sort of errors that you make so it is quite hard". (P25, inpatient nurse, band 6, Trust 1, still in post)*

Despite working within multidisciplinary teams (MDTs), many community nurses described feeling solely responsible for safety of large numbers of people (up to 100), due to ever increasing demand for their services. In some cases, MHNs have had to involve their Trade Unions and have had their caseloads capped to help them manage their caseloads safely and effectively. In comparison to inpatient nurses, community nurses described that they were unable, at times, to engage the support of out of hours crisis teams to support them with risk management outside of their working hours. This left them feeling anxious and unable to fulfil their responsibility as a MHN to keep people safe.

> *"I'd leave on a Friday worried that some of my patients wouldn't make it until Monday and there is nothing I can do about it" (P7, community nurse, band 6, Trust 3, has since left their post).*

Raised acuity associated with the current bed pressures increasing the threshold to secure an inpatient bed has increased the level of risk nurses are managing in both settings. Inpatient nurses described the increase in service users with intense care needs and high level of risk has caused unpredictable ward environments filled with complex and dangerous clinical situations. They reported how this has significantly increased their workload forcing them to manage multiple priorities, make rushed clinical decisions, and has increased the pressure on documentation to try and maintain safety. They described relentless, intense, chaotic and risk posing shifts, leaving them with a sense of dread and prior to going to work.

> *"There were a few times where before my shift started, I would sit in the car and cry….and that's not like me at all and that's a very powerful thing to, kind of, reflect*

on and think, okay, this isn't normal". (P22, inpatient nurse, band 5 in preceptorship, Trust 2, has since left their post)

For community nurses, raised acuity has increased the number of service users on their caseloads presenting with acute care needs and high risk. They explained that holding large caseloads with too many high-risk service users, on top of huge workloads generated through the duty care responsibilities, caused unbearable work-related stress.

"I felt like not only was my mental health at risk, my pin was at risk, it was really exhausting (…) there were just so many times when there were days when it was just so horrible and so difficult to manage that I just thought I can't do this long-term, I need to get out, like this is affecting my health". (P10, community nurse, band 6, Trust 1, has since left their post)

Despite experiencing work-related stress, community nurses also described finding it difficult to go on leave or take time off when sick, even when they were too unwell to work, due to the risk involved causing them to consider leaving their clinical settings and the profession altogether:

"It was very difficult for us as nurses to go on leave because no one would see your patients. And if something happened to them, it would still be on you, despite you not being there, which was something I found very difficult". (P7, community nurse, band 6, Trust 3, has since left their post).

Some senior leaders acknowledged the increasing size and complexity of caseloads as a factor impacting community nurses' mental wellbeing and influencing their decision to leave their clinical settings. They acknowledged the burden of responsibility and risk community nurses are holding and perceived this to be partly due to inadequate crisis pathways and the paucity of inpatient beds, causing them to hold more risk with lacking infrastructure.

"The level of risk that they're holding, I think, is one of the main issues that leads to community staff feeling like they can't continue at that pace in mental health". (Senior Leader 6, Trust 2).

They described a need to increase support around caseload management and associated clinical decision making. Some described large financial investments into transforming community mental health services to support more service users being treated in primary care. The aim being to reduce nurses' feeling of sole responsibility by having the support of primary care services and reduce the demand for secondary services. Some described continuous internal review processes and regular complex case discussions to support nurses to manage their caseloads.

Some senior leaders reported they were in the process of implementing caseload management tools to help monitor and manage the size and intensity of nurses' caseloads and the associated risks. Others have implemented safety huddles, which are protected times for discussing risk management issues, particularly for those working from home alone. Others explained hypothetically that support to manage caseloads could be done through training, managerial support, and by nurses increasing their professional network to seek advice from to improve their skills and confidence around risk management.

Violence and aggression were factors cited by nurses in both settings that directly impacts wellbeing eventuating in burnout, causing them to consider leaving their clinical settings and the profession.

> *"I've had patients attack me and stuff and you think like why am I here? I got pushed and punched in the face by a patient, and I ended up concussed for three days which I was off sick (…) it's those scenarios I think why?" (P7, community nurse, band 6, Trust 3, has since left their post)*

Inpatient nurses described having to manage people with extreme levels of violence and aggression, often fuelled by newly manufactured illicit substances. They reported that they are inadequately equipped to manage extreme violence and aggression within their ward environments, which results in unmanageable risk scenarios with a reliance on emergency services to support them. They explained how they did not feel that senior leaders, who can influence policy or training, understand the level of violence and aggression they are faced with due to their lack of current clinical experience.

"The level of violence and aggression that is faced, particularly in acute wards, particularly in PICUs, particularly in 136 suites. So often we are at the complete mercy of a patient who was heavily under the influence of like narcotics and their physical responses matched that, were so extreme (…) I don't believe a lot of the seniors would actually recognise the degree and intensity of that psychosis and subsequent aggression" (P17, inpatient nurse, band 7, Trust 2, has since left their post)

Inpatient nurses who described having the time to develop therapeutic relationships with their service users, which helps to build up relational security, felt better equipped to manage violent and aggressive incidents and often achieved more positive risk management outcomes.

"If somebody's unwell and irate and faced with somebody they don't know very well, then there's a lot higher chance that they could respond aggressively towards them I suppose. If they're faced with somebody they know quite well and they've actually got a history of getting on really quite famously with, then it's a lot easier to de-escalate"(P12, inpatient nurse, band 5, Trust 1, still in post).

Some senior leaders perceived that inpatient nurses are more exposed to violence and aggression, and therefore, suggested this is a more prominent factor affecting the retention of inpatient nurses. Senior leaders acknowledged that violence and aggression cannot be eradicated altogether, but they described making huge strides in reducing some of the causes of violence and aggression. They described focussing on reducing restrictive practices, by allowing service users to have their phones, introducing e-cigarettes, and using less restrictive restraint techniques. They have increased the number of ward-based activities to minimise boredom and are working on improving relational security. They have also increased the rate at which they optimise service users' treatment and are trying to reduce delayed discharges.

Nurses in both settings perceived inappropriate admissions and cases as a frustrating factor causing more complex and unnecessary risk management decisions. Inpatient nurses reported how people with a high risk of violence and aggression are inappropriately admitted to their ward that is unequipped to safely manage them, due to fewer ward restrictions and lower staffing levels. Moreover, nurses reported being obstructed from moving people to the more suitable environments to mitigate or minimise the risk of someone getting hurt. They saw this as a result of least restrictive practices, which dictate that staff must act reactively rather than

proactively when trying to maintain safety. This left nurses in a constant state of worry, whereby they feel unable to manage the level of risk during their shifts.

> *"They're just going to wait for something to go wrong before they move them (…) so they can go to the most appropriate service (…) we're then fearful we're going to get hurt at that point" (P25, inpatient nurse, band 6, Trust 1, still in post)*

Inpatient nurses reported having to inappropriately admit people who have experienced significant trauma whose risk of self-harm escalates in an inpatient environment creating a more dangerous and unsafe situation often leading to re-traumatisation. This leaves nurses trying to discharge people with heightened risks to inappropriate and overwhelmed services in the community, increasing readmission rates. Nurses reported feeling helpless and drained by these negative cycles involving a numerous amount of risk incidents requiring lots of emergency interventions. These risk scenarios often eventuated in emotional exhaustion, moral injury, and accelerate burnout.

Community nurses also described having people with high risks on their caseload who are unsuitable for their services. This creates a feeling that nurses are only being used to be held accountable if something goes wrong rather than for what care they and their service can provide.

> *"It's almost like if he kills himself then it has to be on one of us but why? Why does it have to be on one of us?" (P26, community nurse, band 6, Trust 1, still in post)*

The Merry-Go-Round

Nurses in both settings reported working with people with mental health problems and supporting them to make meaningful improvements to their lives as rewarding, interesting, inspiring, and a privilege. Nurses in both settings who felt able make meaningful differences to people's lives (often confirmed by good clinical outcomes, meaningful appreciation from service users or acknowledgement from management) feel that their role as a mental health nurse has purpose and value, which significantly contributed to their intention to stay in their clinical setting and the profession. Senior leaders acknowledged this, and some described introducing 'Make a Difference' awards as a mechanism for providing meaningful recognition

and positive feedback, via nominations for nurses who go above and beyond for their service users.

> *"I feel like I have real job satisfaction and I have a purpose within my role. And I know that from kind of patient feedback that we get sometimes that actually we do make a difference" (P24, inpatient nurse, band 6, Trust 3, still in post).*

However, many participants reported a lack of positive feedback, meaningful recognition, or appreciation from management or senior leaders has led them to feel doubtful of their contribution and demotivated. Community nurses described finding it difficult to be solely responsible for the care of large numbers of people. This carries high expectations that nurses will completely resolve service user's mental health problems, which often manifests in job dissatisfaction and moral distress. Trying to manage these expectations with increasing demand on their services, with what they saw as insufficient resources, has left community nurses feeling exhausted, and compassion fatigued.

> *"There's something about community where it just feels like it's on your shoulders (…) I think on a weekly basis I say, I just can't do this anymore, I can't keep up with the demand." (P3, community nurse, band 7, Trust 3, still in post).*

Some nurses working in both settings had reset their expectations of care and treatment outcomes, and now appreciate smaller achievements, to maintain motivation and remain in their clinical setting and the profession. However, community nurses explained how refocusing their view on the care and treatment outcomes came at the cost of losing some of their passion. Despite some community nurses reporting their passion for caring for people with mental health problems is a reason for staying in the profession, others reported that losing some of their passion has prevented burnout and enabled them to remain in their clinical settings and the profession for longer.

> *"Unfortunately, I think that's almost the way it ends up being in this field. That the more passionate you are, the more stressed you get about it" (P2, community nurse, band 6, Trust 2, has since left their post).*

Nurses working in both settings described the challenging, unpredictable, and varied nature of their role as a reason for staying in their current clinical settings and the nursing profession. However, many inpatient nurses expressed dissatisfaction with constantly having to provide high intensity care due to increasing acuity accelerating burnout and intention to leave their clinical setting. They discussed how they are constantly caring for people in distressing conditions without seeing adequate improvements in people's presentations before discharging them prematurely.

> *"I was thinking about branching out and doing some more psychological focussed therapies, because to be honest at one point you want to see people getting better" (P19, inpatient nurse, band 5, Trust 2, has since left their post)*

Senior leaders demonstrated some insight into the effect increased acuity has had on the intensity of care inpatient nurses are providing:

> *"There's a pressure to get people out again really quickly. What we know is if you have more people who are unwell on a ward, it makes the whole ward feel much worse. So, (…) before the beds were closed, you had a certain proportion of patients who were quite well, it kind of counterbalanced. Whereas that's the not the case anymore. Everybody's unwell." (Senior Leader 9, Trust 1).*

Although some senior leaders acknowledged they cannot change the acuity on inpatient wards, they did not see this as a factor only causing people to leave. They reported that the challenges and fast pace that comes with high acuity and turnover are suited to some nurses and not others. Those who enjoy the challenges and faster pace will stay in inpatient wards with higher acuity, whereas those who do not will often feel more anxious, demoralised, and demotivated causing them to become disillusioned and leave for settings more suited to them. So, some believe it is about allowing and supporting nurses to find the right setting that provides them with job satisfaction.

Nurses from both settings illustrated that spending meaningful time with their service users is the most enjoyable part of being a nurse; and underpins positive recovery prospects and service users' satisfaction with their care. Community nurses who described having more time, fewer restrictions, and appropriate care models in place that allow them to spend adequate meaningful

time with service users, enables them to develop therapeutic relationships essential for quality care and treatment. It is the view of both senior leaders and community nurses that if nurses are trusted to work autonomously and possess collective leadership over the care they provide they are more likely to remain.

> *"I'm looking forward to being able to still get a lot of face-to-face contact with people (…) because that's the best part of the job, (…) it's going into people's homes sitting with them in the darkest days of their lives, getting to know their family and being part of their lives and building up that therapeutic relationship". (P10, community nurse, band 6, Trust 1, has since left their post).*

Nurses from both settings who described being unable to spend meaningful nursing time with their service users, due to high workloads consisting of excessive, lengthy, and often duplicated paperwork, had difficulty building therapeutic relationships and relational security with service users.

Inpatient nurses who were less able to engage in meaningful interactions with service users felt that their roles were limited to the administration of medication, writing reports and the management of restrictions, which negatively impacted their job satisfaction and increased intention to leave. They reported that they are now having to work in a more task orientated way focussed almost entirely on maintaining safety in the present, rather than working with people to create a more meaningful future defined by themselves, which will influence more positive and sustained longer-term outcomes.

> *"So, I was aware of it [decreasing job satisfaction] and still trying to get that meaningful bit of work going. It wasn't easy, it became harder, and I think that was probably another reason why I wanted to leave" (P5, inpatient nurse, band 5, Trust 2, has since left their post)*

Senior leaders acknowledged the excessive workloads for inpatient nurses beyond direct clinical contact with service users. Thus, some senior leaders are looking at how they can support nurses to outsource some of the non-clinical tasks related to people's care, so that nurses can provide clinical therapeutic interventions, including collaborative care planning they have been trained to provide.

"I think the workload on those inpatient [nurses] is so, so, so high that at some point people just say, actually I want something different." (Senior Leader 10, Trust 3).

Community nurses providing care and treatment for service users in new, innovative, and unique settings, especially those focussed on early intervention or specialist areas, were planning on remaining in their clinical settings and Trusts. They explained how they experience less demand and more support from management and leadership due to the infancy of their setting or the tight threshold criteria due to the specialist nature of their service. Consequently, their service users often receive better quality care tailored to their needs, which improves job satisfaction and the experience of being a mental health nurse. Senior leaders added how the development of new services in the community, such as Assertive Outreach Teams, meant that the wards no longer held as much excitement causing inpatient nurses to leave for community settings, where they could still care for acutely unwell service users.

Many community nurses described working in services that lack specific threshold criteria and poorly nurtured relationships with other services. They explained how this prevents knowledge and understanding of their service's remit, which prompts inappropriate referrals and disjointed transitions for service users and increases workloads. They described how inappropriate referrals are constantly re-referred until enough pressure is put on the service to accept them, despite the service being unsuitable for them often resulting in moral injury for the nurses responsible for their care.

"People often describe it as a bit of a dumping ground where patients don't fit in any other service, and I think people find that quite hard". (P13, community nurse, band 8a, Trust 1, still in post).

Nurses working in both settings that promote and encourage good practice that allows them to provide a high standard of care and treatment felt proud of their role in their current clinical setting. Inpatient nurses reported that the introduction of trauma-informed care involving psychological input on their wards is a significant reason for staying in their current clinical setting. Comparatively, those who felt they were engaged in a never-ending battle to provide quality care and worked in services that promote bad practice, described how they quickly

became exhausted and experienced moral distress contributing to their intention to leave the profession altogether.

> *"It got to the point where I was almost embarrassed to tell people that I worked there, which is quite a powerful thing, yes, to sit back and not want to tell someone that I work in this particular place because I don't want to be associated with how they practice and what they do" (P22, inpatient nurse, band 5 in preceptorship, Trust 2, has since left their post)*

Some senior leaders reported that their Trusts have introduced a Clinical Decisions Unit (CDU) to receive all the admissions relieving the pressure and reducing the acuity from the assessment and treatment wards. This minimises the risk of inappropriate admissions, over-occupying wards, premature discharges, and admission paperwork for the wards providing more longitudinal assessments, care, and treatment. Some senior leaders explained how investment into transforming community mental health services will reduce preventable admissions and their associated administrative workloads and support the flow of service users from inpatient wards back into the community.

> *"So, what we've done really is to invest more in the community, invest more in our community teams, to really work on avoiding admission, that's our push. We believe that we should do everything possible where risk allows us to support people in their own homes." (Senior Leader 10, Trust 3).*

Nurses in both settings described difficulty working in services focussed solely on what they saw as the medical model, where the role neglects the psychological and psychosocial aspects of care. They reported that this did not align with their understanding of the aetiology of mental health problems and how to best address them.

> *"All you see is patients who are having their symptoms supressed by chemical medications, going out, becoming more unwell, coming back to us. Just a merry-go-round (…) If the care was really effective, we wouldn't see patients keep on coming back to year after year. Medications never get to the root of the issue; medications only dampen down the symptoms caused by the issue" (P12, inpatient nurse, band 5, Trust 1, still in post)*

Some senior leaders reported they have worked to develop a care model less focused on the medical model for inpatient environments, whereby nurses can provide therapeutic interventions to contribute to more purposeful admissions for services users. They explained how this ensures nurses are playing a meaningful part in people's recovery like those working in community settings.

The Impact of Leadership and Management

This theme incorporates factors related to leadership and management that affects the experience of being a mental health nurse and influences intent to leave. This theme is broken down into three subthemes: *'Visible and Approachable Leadership', 'Are you ok? Supportive Leadership and Management',* and *'Poorly Managed Services'.*

Visible and Approachable Leadership

Community nurses who reported that they have a well-defined senior leadership and management structure, which means they can easily escalate concerns and access support, described favourable working conditions. They described an inclusive senior leadership and management team that emulate their Trust values, which align with their own values and creates a positive organisational culture. Senior leaders' perceptions acknowledged that working within an organisational culture that feels safe, will encourage nurses to remain.

> *"I think, ultimately, in my experience, what relates to success is the reputation as an employer, do people know the culture is safe" (Senior Leader 3, Trust 1)*

However, many nurses in both settings reported that their Trusts' leadership and management structure lacks clarity, with many nurses not knowing who their managers or senior leaders are.

> *"Even though I've got a great manager, I don't really know who her manager is, I don't really know who that manager's manager is" (P5, inpatient nurse, band 5, Trust 2, has since left their post)*

An absence of clarity about the roles and responsibilities of senior leadership and management in their Trust was noted by some participants. Changes in management and senior leadership teams in a short space of time was perceived to cause a lack of continuity and further lack of

clarity. They described how this often led to conflicting advice causing inconsistencies in the delivery of care and treatment, which is negatively impacting on the experience of being a mental health nurse causing them to contemplate leaving their clinical settings and Trusts.

> *"When you've got four modern matrons who I don't even know what half of them are supposed to be responsible for, when they are giving conflicting advice and information (…) That's not putting you in a great position, and that's not fair on you, it's not fair on patients, it's not fair on the team". (P28, inpatient nurse, band 5, Trust 1, still in post)*

Senior leaders from two Trusts described how their leadership teams have just gone through, or are amid, a huge transition, with many of the participating senior leaders included being new to their post and Trust. They explained how this transition limits their knowledge of the experiences of the mental health nurses in their new Trusts.

The narratives of nurses in both settings, and senior leaders, reflected the importance of visible leadership for the retention of nurses. Community nurses explained how visible leadership has enabled their managers and senior leaders to become aware of the issues that need addressing through inclusive and open dialogues between leadership and management and frontline nurses. This inclusive and transparent leadership coupled with effective communication has created strong trusting relationships between nurses and senior leadership contributing to nurses' decisions to stay.

> *I think they're the forerunners for me when it comes to equality, diversity, they really promote that really well (…) They seem to be quite inclusive, at least in my services to hear your thoughts and views" (P18, community nurse, band 8, Trust 3, still in post)*

However, many nurses reported that their senior leaders lack visibility, which creates a lack of understanding around what the real issues are and what they are striving to achieve. Community nurses explained how this reflects a leadership team that is disconnected and disengaged with the care of service users and staff. Some community nurses explained how senior leaders have visited their teams, but failed to engage meaningfully with the staff creating a sense of frustration and hopelessness.

"It was super like tokenistic, it was just like we're listening to you, but no you're not actually listening to us, like support and engagement with nurses, listen to what is actually going wrong, don't come around just give us the impression that you think that we're just not working hard enough and that we just need to get on with it" (P10, community nurse, band 6, Trust 1, has since left their post)

Community nurses described how poor visibility has brought about unwelcomed, ineffective, new agendas for practice that, in their view, are unrealistic. Whilst inpatient nurses described what they saw as their senior leaders' clinical experience diminishing rapidly after leaving direct patient care. This coupled with a failure to maintain regular open dialogue with the current clinical inpatient teams, created a growing 'credibility' gap in the eyes of participants.

"Senior leaders that have probably been off the shop floor for far too long are no longer coming at it from what I refer to as real-time experience (…) I don't think they realise how rough it is on the wards and how much you are living on the edge of your nerves and your decision-making processes, and to do that day in, day out, is no small thing". (P17, inpatient nurse, band 7, Trust 2, has since left their post)

Some senior leaders acknowledged the need to ensure ward managers and matrons are working clinically as well as non-clinically to improve their ability to lead and manage their clinical teams. One senior leader described how their entire senior leadership team are committed to working one clinical shift every two weeks, where possible, to improve visibility, which will improve their understanding of the experience of being a current clinical mental health nurse.

"I try to go to different services (…) to work as a nurse (…) the more as leaders we are connected to what's happening on the floor the better, we can start to hear stories and actually be able to address some of the retention issues (…) But we need to know about it first before we do something about it. So, there's something about the visibility of your leadership" (Senior Leader 10, Trust 3)

Visibility incorporates the notion of being approachable. Nurse's experiences from both settings suggested that they find it difficult to approach their managers or senior leaders. Nurses in both settings reported their managers and senior leaders display negative and disrespectful attitudes towards them often lacking basic courtesy when directly interacting with staff. These

experiences have left nurses feeling disrespected and undervalued, which discourages them from approaching their management and senior leadership team.

Senior leaders also perceived the way nurses are treated by their leadership and management team to be a factor influencing retention, with one senior leader demonstrating the importance of treating nurses they lead and manage with respect, empathy, and kindness:

> *"The whole world is trying to recruit, be kind to the people that turn up to work". (Senior Leader 3, Trust 2)*

Nurses in both settings reported that they were often ignored or brushed aside by management and senior leadership when they approached them for support, or to raise concerns around quality of care and risk management. Others believe their senior leadership team have no real desire to make changes, and any attempts made to address nurses' concerns were tokenistic and futile:

> *"They came a few months back and the general consensus was that nobody had been listened to (…) It was more of a tick box exercise than actually wanting to be there and to make changes. (…) They said they'll write it up into a report and send it to us, but I'm assuming that once the report's written it just goes to live in report heaven". (P26, community nurse, band 6, Trust 1, still in post)*

Some nurses explained how they were intimidated by management when trying to raise concerns about poor care and treatment. This left them feeling fearful and apathetic when considering approaching their managers and senior leaders with their concerns. This prevented nurses from feeling as though they could maintain their responsibility to advocate for safe and quality care for their service users.

> *"I was actually told by management at the time to come and see me because I was putting stuff in these [incident reports] that were basically saying this is down to bad management, this is down to bad staffing (…) I was sort of clearly told not to raise and escalate these concerns, but I did it anyway" (P10, community nurse, band 6, Trust 1, has since left their post)*

Ultimately poor visibility and approachability often hindered by poor communication has led to a disconnect between senior leadership and frontline nurses concluding a breakdown in trust.

> *"So, you then start to feel like, you don't trust those that's supposed to be supporting you". (P28, inpatient nurse, band 5, Trust 1, still in post).*

Some senior leaders described being aware of a sense of "them and us" within their Trusts creating negative culture for achieving positive change. Some senior leaders acknowledged that lines of communication within their Trust need to be strengthened between senior leadership down to clinical nurses to ensure nurses feel heard. They acknowledged how a lack of communication, particularly around work being done to address issues raised by nurses, can lead to a misconception that the senior leaders are ignoring the issues, which underpins nurses' hopelessness around future change. Many senior leaders were able to describe strategies, initiatives, support, and changes for improving some of the issues described by the nurses, but they were unable to describe how they ensure nurses become aware of the work being done and how they can access some of the available support and opportunities. Some senior leaders explained they are trying to improve communication beyond email to Trust Facebook pages, apps, and staff survey action plans for dispersing information.

> *"Because that whole apocryphal thing about, we're not doing anything about it, is really dangerous. And actually (...) if the message was out there, I think they would potentially feel a bit more like, yes, we're all in this together". (Senior Leader 3, Trust 2)*

Some senior leaders described platforms for communication, such as nurse councils, where nurses can communicate their issues and concerns to senior leadership but reported that very few nurses attend. They were unable to describe how information about these councils are communicated and how nurses are invited. Most senior leaders described exit interviews as the main mechanism of communication from clinical nurses to senior leadership about factors influencing their decisions to leave. Some senior leaders reported that they are now introducing stay interviews/conversations, whereby line-mangers will be checking in regularly with nurses on a 1:1 basis, particularly with newly qualified nurses, to improve lines of communication and address any factors influencing intention to leave.

Senior leaders acknowledged how poor visibility within the senior leadership team inhibits the process of escalation. They explained how this leaves nurses feeling that their immediate managers are the end of the line for negotiating solutions to problems and raising concerns that influence their decisions to leave, which prevents senior leaders the opportunity to intervene. To combat this issue, some senior leaders have introduced a system whereby if managers are aware nurses are thinking of leaving, they must approach a designated senior leader who can offer to meet with those nurses or support them to reach an appropriate resolution.

> *"We have had a couple of people that have been wanting to leave. We've done those kinds of conversations. They were like, okay, well yeah, if that's what the situation is, then yes please, I'll stay, which has been good". (Senior Leader 1, Trust 3)*

Are you ok? Supportive Management and Leadership

Nurses working in both settings and senior leaders, reported that feeling valued by management and senior leadership is a significant factor influencing nurses' decisions to stay. These nurses reported that their managers understand the current experience of being a mental health nurse and actively support them to manage their responsibilities.

> *"If they feel valued, then I think that you have got a good chance of retaining somebody". (Senior Leader 6, Trust 2)*

Inpatient nurses and senior leaders explained how some managers provide hands-on support by actively engaging in clinical activity, such as attending ward rounds and community meetings. This helps to relieve workload pressures and provides managers with a direct understanding of the challenges faced by the nurses. Some community nurses reported having trusting relationships with their managers who support and empower them to work autonomously and flexibly to improve job satisfaction. One community nurse working in a management position explained how supportive management helped them to retain nurses working in their clinical setting:

> *"The other key things to retaining a nurse would always be about good leadership and management and support (…) It's about being that authentic leader, really thinking about them, showing some empathy (…) nurses stayed with me for a long time, because*

you treat nurses with respect, and you empower them to do things" (P18, community nurse, band 8, Trust 3, still in post)

However, many nurses' experiences described a lack of support to manage their responsibilities from their management and leadership teams. Inpatient nurses described support with the increasing acuity and subsequent complex workloads as *'tokenistic'*. Inpatient nurses explained how the lack of camaraderie role modelled by their managers creates negative and unsupportive work environments. They reported a lack of hands-on practical support from management, leaving them unable to adequately care for service users and take breaks.

Nurses in both settings who were dissatisfied with how incidents of violence and aggression were managed, particularly when senior leaders appeared to support the notion that violence and aggression should be accepted as part of the job, were seriously considering leaving their clinical settings and the profession. Inpatient nurses reported that they did not feel their concerns around risk were taken seriously by their managers and senior leaders, and therefore, did not feel supported in the mitigation and prevention of risk incidents. Moreover, many inpatient nurses reported that they were ignored when they escalated the need for additional support and training to manage the risk on their wards. Instead, inpatient nurses stated that their managers and senior leaders wait until a risk incident has occurred before stepping in to offer support, rather than supporting nurses to prevent foreseen incidents from occurring.

"I felt that we weren't getting the support that perhaps needed. We felt that we needed more training in certain areas, and we just weren't being listened to (…) we weren't able to do our jobs properly. It felt like we were failing the patients". (P11, inpatient nurse, band 5, Trust 1, still in post)

Nurses in both settings also reported that they received a lack of support/debrief from management or senior leaders after serious incidents or complaints, with some believing that management and senior leaders continue to promote a blame culture and workplace bullying.

"Since I've been a nurse I've had several patients complete suicide, and you don't get follow-up after that. No one officially comes up and says are you okay? Your patient's just killed themselves, you know". (P7, community nurse, band 6, Trust 3, has since left her post)

Senior leaders demonstrated insight into the long-term effects of managing risk incidents and highlighted the importance of debriefs. However, some reported that there is room for improvement in this area:

> *"I do think nurses are traumatised and I don't think we do enough as an organisation or as a profession to support the trauma that people receive as a result of nursing, particularly on acute wards" (Senior Leader 9, Trust 1)*

Senior leaders explained how when risk incidents occur in inpatient settings, the risk to the organisation is far higher than when they occur in the community. They explained that this can often be felt by community nurses through the difference in the response to risk incidents, causing community nurses to feel undervalued and less supported and with the aftermath of serious incidents.

Senior leaders also perceived blame cultures to be a significant factor influencing nurses' decision to leave the profession. Some senior leaders acknowledged that previous leadership teams were unsupportive and had created a blame culture that caused many nurses to leave or think about leaving their Trust. However, many senior leaders explained how their current leadership teams are committed to promoting and maintaining a 'no blame culture' through supportive leadership around risk management.

> *"Things will go wrong, but if things go wrong, we need to stand shoulder to shoulder with them and not come and beat them up". (Senior Leader 5, Trust 2)*

Nurses in both settings cited good wellbeing support as a reason for remaining in their clinical settings and Trusts. Some community nurses were satisfied with support for their wellbeing provided by their managers and senior leaders within their Trusts. However, many nurses in both settings did not feel that their wellbeing is important to their managers and leaders. They reported that they did not feel supported in addressing the root causes of their poor wellbeing, with many citing a lack of support to manage the excessive demand for their services, and subsequent complex workloads.

"For a lot of people, wellbeing is having a realistic workload and getting home on time. For any of us, regardless of what level you're at in an organisation, it's that work life balance, and what's being asked of you is realistic and manageable. I think for a lot of nurses in the community, it's not, it's really not". (P30, community nurse, band 8, Trust 3, has since left their post)

Moreover, nurses working in both settings reported that they feel that their managers and senior leaders were contributing to their poor wellbeing through putting excessive and undue pressure on them. They reported finding it impossible to manage the priorities of managers set against their desire to prioritise service user's needs and tasks that are going to directly benefit the service users. These experiences culminated in nurses feeling taken for granted with the expectation that they must put their wards first, at the detriment of their own wellbeing, leading to burnout.

"As much as I tried, I couldn't change the things that were making me feel that way, so I changed the thing that I could which was not working there anymore". (P22, inpatient nurse, band 5 in preceptorship, Trust 2, has since left their post)

Some senior leaders' perceptions of the causes of poor wellbeing mirror the causes identified by the nurses. Some senior leaders reported that they have introduced wellbeing conversations into appraisals or were introducing a dedicated person to look at the health and wellbeing of teams. Many senior leaders spoke of introducing comprehensive wellbeing packages including, but not limited to, physical health checks, access to physiotherapy, massages, yoga, finance support training for mental health resilience, psychological support, reflective supervision, 'calm' or 'wobble' rooms. Gestures, such as generic thank you cards, hampers and sending ice lollies on hot days were also cited. Some senior leaders argued that whilst these types of wellbeing offers are important and done with good intent, they do not get to the root of the issues that contribute to poor wellbeing. Thus, they are seeking to develop a robust wellbeing strategy that addresses the root causes of poor wellbeing at work, whilst acknowledging it will not be an easy task.

"I think we're very good at putting a sticky plaster on things, but we need to get to the bottom of it. And that is about people being able to make a difference, feeling safe at

work (…). and until we fundamentally address those things, people are going to be stressed and are going to leave nursing". (Senior Leader 5, Trust 2).

Support in other areas such as training and development were also described as key influencers of MHNs' intention to leave. Community nurses who describe having mangers who are supportive of their training and development were planning on remaining in their clinical settings.

"My manager certainly seems to be supportive of me pursuing other training in the future. (…) So, there seems to be opportunities for the development" (P27, community nurse, band 7, Trust 3, still in post)

However, many experiences of nurses working across both settings reflected a lack of support with their professional development at all stages of their career, contributing to their intention to leave their clinical settings and Trusts. They reported a paucity of mentorship such as providing awareness around developmental opportunities to support their career progression.

"To go to the ward and think, oh this is great, I'm going to be supported as a preceptee because there's all this kind of scaffolding around you to keep you afloat while you're, kind of floundering as a new nurse (...) I didn't get that either there. So, I think it got to the point where I was very aware that my own mental wellbeing was suffering, and the management of the ward impeded my ability to do my job well". (P22, inpatient nurse, in preceptorship, Trust 2, has since left their post)

Senior leaders reported that conversations around nurses' personal development are usually rooted in appraisals and Personal Development Reviews (PDRs) with their immediate line managers. The explained how there is a tendency to focus on the number of appraisals and PDRs rather than the quality of the conversations occurring within them acknowledging a need for a shift in focus.

Senior leaders placed a strong emphasis on the responsibility of middle management for generating supportive team cultures through role modelling and mentorship, which is necessary for nurses to feel safe and contained. Some senior leaders reported that middle managers who do not lead their teams with compassion and provide quality support, appraisals, supervision,

and mentorship, are not able to retain their nurses, and in some cases are a direct factor causing nurses to leave.

> *"The first thing people will talk about, is about feeling supported, having a good line manager. And where that doesn't happen, which we know we've had some areas where there's been big problems, that can force people out because they just don't feel like they've got the support they need". (Senior Leader 2, Trust 1)*

Senior leaders acknowledged the need to provide more support for middle managers to successfully manage their responsibilities and ensure nurses feel well-led to improve retention. Senior leaders in one Trust have recently introduced a comprehensive leadership and management training program. However, they reported that commitment to this program is not compulsory and often limited by not being able to take time away from their managerial duties.

> *"I think really if we can address that part whatever has been done around really supporting those middle managers because the organisation attracts someone in, but your middle managers get them out". (Senior Leader 10, Trust 3)*

Poorly Managed Services

Frustration over how services were being managed was a central feature across the data set. Feeling embarrassed and disheartened by working in poorly functioning services with poor CQC ratings attributed to inadequate leadership was cited as a factor by nurses in both settings, and senior leaders, as a factor influencing nurses' decisions to leave their Trust. Community nurses described how their senior leadership teams and middle management do not demonstrate any accountability for the poor running of their services. Instead, there was the perception that the responsibility for poor services lay with nursing staff, the implication being that the performance of the care team was not up to standard. Consequently, they described having limited faith that things will change for the better.

> *"I think a lot of people feel quite angry towards the Trust as an organisation. They might be very happy in terms of where they work and who they work with, but they don't really like the organisation very much" (P21, community nurse, band 6, Trust 1, still in post)*

Some senior leaders acknowledged the importance of demonstrating accountability and willingness to acknowledge and address failings. They explained how, if done with a real passion for their teams and services, this will help nurses feel heard and reinstate hope for positive change for the care of service users, which will contribute to the effective design of services that encourage people to stay.

> *"I'm accountable to 7,000 people in this organisation about what we're doing around quality, what are we doing on patient safety, how are we keeping them safe, how do we make sure that actually maybe the environment which we create as an organisation is conducive enough for them to be able to do their work? That's what we're accountable for and I think everything we do has to be leading towards that". (Senior Leader 10, Trust 3)*

Community nurses and senior leaders reported that their services do not have the appropriate funding, resources, or staff to meet their demand, leaving hundreds of people on extremely long waiting lists, which provokes feelings of failure amongst nurses. Senior leaders acknowledged that nurses feel that they are carrying the weight of the waiting lists and the emotional toll associated with this. Nurses described how this leaves them constantly apologising, feeling defeated, and struggling to develop therapeutic relationships with people who are frustrated and angry with them.

> *"Our ASD, autism diagnostic service, has 5,800 people on the waiting list at the moment, 5,800. It is a two-year waiting list. How can anybody sit and think that that's okay? It isn't. You can't justify it. (…) people come into nursing because they want to make a difference, and they can't make a difference to this. And even when they try, it's a mere drop in the ocean". (Senior Leader 5, Trust 2)*

Nurses and senior leaders reported that the response to lengthy waiting lists by senior leaders is introducing care models that aim to get people in and out of services as quickly as possible, prioritising people based on risk, or offering nurses overtime at the weekends. They described how poorly thought-out care models, coupled with a paucity of care pathways and poorly defined task orientated roles, hinders the functioning of their services. This has left nurses feeling helpless and unable to provide appropriate care and treatment, which devastates the

rewarding nature of being a MHN contributing to disillusionment with the profession and their decisions to leave it.

"I'm just really fed up of not really being able to do a job properly. I don't feel like we're helping people (…) it makes me feel like I'm failing at being (..) just a decent person". (P26, community nurse, Trust 1, band 6, still in post)

Many community nurses reported feeling excluded from service development plans, which has led to ineffective changes to their service from which the consequences for nurses are still ongoing. This has caused nurses to feel that their knowledge and experience is undervalued and has further increased their intention to leave their clinical settings and Trust. Community nurses reported that inadequate preparation has created difficulties when trying to implement and embed changes causing frustration and distress for both service users and staff. Whereas inpatient nurses and senior leaders reported concerns over the limited clinical and managerial experience preventing their managers from effectively managing their services and driving necessary change forward.

> *"We've got band sevens at the moment, ward managers who are qualified 18 months, which is quite a scary situation, (…) in terms of their experience and understanding and knowledge". (Senior Leader 9, Trust 1)*

Some senior leaders highlighted the importance of visiting clinical teams and listening to nurses' experiences, acknowledging the issues, allowing nurses to contribute to decisions being made, supporting nurses to develop collective leadership, trusting nurses to drive change forward, and communicating what work is being done and when.

The Impact of the Work Environment

This theme incorporates factors related to nurses' work environments that positively and negatively affect the experience of being a mental health nurse. There are four subthemes within this theme: *"Team Dynamics', 'The ability to work hard and improve your financial situation: Pay', 'Working Hours,* and *'The Physical Working Environment'.*

Team Dynamics

Nurses in both settings and senior leaders held positive team working that is supportive, and allows for growth and development, in very high regard when discussing reasons nurses stay within their clinical settings, Trusts, and the profession. Senior leaders illustrated how positive team dynamics can help improve the resilience of individual team members and enable nurses to cope with the challenges of their profession:

> *"Even though horrific things happen, and you see traumatic things, if you've got that team around you, that you feel are supportive of you and have got your back, then you can actually cope with more than you think you can". (Senior Leader 5, Trust 2)*

Comparatively, nurses in both settings and senior leaders described how negative team dynamics, particularly with immediate line managers, were enough to influence nurses' decisions to leave alone. Furthermore, nurses explained how a rupture in team dynamics, often caused by highly valued and supportive nurses leaving due to poor treatment from management, resulted in a "*mass exodus*" *(P28, inpatient nurse, band 5, Trust 1, still in post)* of staff in all cases.

> *"I think some of it is about having inspirational leaders or leaders that are containing. So if you're in the local team near to your home and you've got good, solid leadership, people stay. They don't move around. So I think some of it is like getting the basics right in terms of what your team structure looks like, you know, and if you go into work and things feel safe and you feel content" (Senior Leader 6, Trust 2)*

Many inpatient nurses described working in teams with positive dynamics filled with support and camaraderie, that were nurtured by management, which provided the foundations for them to feel safe and confident to cope with the ward pressures, maintain safety, and provide quality care. One ward manager explained the benefits of cultivating a positive and supportive team culture for retention and recruitment in their team:

> *"I have got very short-lived vacancies they are always snapped up. And that's not because we pay better, because we don't. It's just because when people are coming to work, they know they are going to be supported." (P15, inpatient nurse, band 7, Trust 2, still in post)*

Many inpatient nurses' experiences demonstrated that they are currently working in teams lacking in experience. This has resulted in insufficient skill mixes limiting the effectiveness of the team and negatively affecting team dynamics. Senior leaders acknowledged how inpatient settings can be the most difficult places to work, yet they tend to be filled with the most inexperienced staff. They explained how these insufficient teams with limited clinical experience can lead to substandard care, which often causes inpatient nurses to become disillusioned with inpatient care and contemplating moving to a community setting.

Inpatient nurses explained how they were often met with conflict within their teams when trying to delegate tasks or manage clinical events. Working within teams comprised of negative attitudes and intentions often caused or escalated risk incidents giving rise to challenging and unmanageable shifts.

> *"I have a massive battle on my hands sometimes when I am trying to send staff [to another ward or to support service users off the ward], (…) they refuse to go, it's a problem for us, I hate asking people to go because I get met with conflict and that's again not the reason I came into nursing"(P25, inpatient nurse, band 6, Trust 1, still in post).*

Some community nurses also described difficult team dynamics lacking in support. They described experiences where their colleagues and managers did not support them with complex caseload decisions. Negative team dynamics that are poorly managed have caused community nurses to feel undervalued and disliked by their teams including their line manager, and in some cases, developing the feeling they are being pushed to leave.

> *"There was no team atmosphere, your caseload was your caseload, and no one would input into your patients unless they were on their caseload, so you were very much alone with it" (P7, community nurse, band 6, Trust 3, has since left their post).*

Inpatient nurses reported difficulties in working alongside members of the wider multidisciplinary team (MDT). They acknowledged that the care and treatment of service users needs to be a team effort involving lots of different professionals and disciplines, but they felt they had a disproportionate number of responsibilities to others. Furthermore, nurses described

unsupportive and disjointed relationships with non-ward-based members of the MDT. These fractured relationships have formed through a lack of understanding around nurses' current clinical pressures and the expectation that nurses should reappraise their priorities.

> *"I must get about 20 emails a day off the Mental Health Act office because I'm not reading someone their rights, but actually what I'm doing instead is probably deescalating situations that might become more difficult, aggressive or violent, and they would rather me just drop that and read someone their rights" (P25, inpatient nurse, band 6, Trust 1, still in post).*

They reported that this has led them to feel as though they are working in split teams where nursing is viewed as the least significant profession.

> *"So, you have got the psychologists, CBT therapists, Social worker, Social worker assistant, the two OTs, et cetera, so they'll be above, and the nurses will be very low down, they are seen as the lower people" (P1, inpatient nurse, band 5, Trust 2, still in post).*

Some senior leaders' perception of how this situation has occurred demonstrates, in their view, the need for nurses to regain a sense of collective leadership over the management of their responsibilities:

> *"You would not see a doctor saying, I'm not going to run a clinic because I've got to go and answer the phone. He'd be saying, or she would be saying, I need a PA, I need someone to do this for me. We've allowed this to happen as nurses" (Senior Leader 5, Trust 2)*

Nurses in both settings reported that supportive working relationships and feeling valued by professionals in other services, beyond their immediate teams, significantly improved their ability to provide safe and effective care. Community nurses and senior leaders emphasised how supportive networks across the organisation help to create a positive work environment for nurses to share knowledge and build confidence to whilst working autonomously to care for people to a high standard.

"I've built up a good network (...) I know if I phone up some service, I'll get a person that I've already spoken to before who knows me quite well and they'll help me out a little bit more. (...) I feel confident that I know who to ask for help. (...) I know I can call up somebody and say, oh, can you just give me advice on this." (P29, community nurse, band 6, Trust 3, has since left their post)

Unfortunately, many inpatient nurses shared how they did not feel a sense of community or connection within their organisation. They reported having small networks often confined to their immediate teams and feeling disconnected from the wider organisation, describing the generation of unhealthy relationships between wards and other services, creating a hostile organisational culture and work environment that significantly impacts efficient and effective care and treatment.

"There's not enough healthy communication between the wards because it can feel a bit us versus them, and that's not helpful either, that's toxic" (P28, inpatient nurse, band 5, Trust 1, still in post).

Senior leaders also perceived a sense belongingness and collaborative working relationships across services as important factors influencing the retention of nurses. Some senior leaders reported how they have worked to try to improve the relationships between services, to diffuse tension to create a more positive environment to care for service users. Some senior leaders described hosting full team away-days to help people understand the wider context beyond their immediate teams, build support networks to improve cross-team working, and bolster job satisfaction.

The ability to work hard and improve your financial situation: Pay

Community nurses who felt that they were well compensated financially were considering staying in the NHS and profession. Nurses in both settings reported job security and the ability to do additional bank shifts to supplement their income as a reason for saying in the NHS and the profession.

"If you look at the package as a whole that the NHS offer, I just don't think people realise what they get. (...) On Agenda for Change you're guaranteed pay rises. (...) I've done 10 years in the NHS, so I've got the full whack holiday. I think it's 39 days a year

including the bank holidays. (…) and the pension is a good package" (P29, community nurse, band 6, Trust 3, has since left their post)

Nurses working in both settings described poor pay as a reason to leave their clinical settings and the profession altogether. They cited living with pay rises below inflation is leading them to feel undervalued posing difficulties for retention as well as attracting people to the profession. Furthermore, they felt that the wider national response to COVID, in terms of pay rises for NHS nurses, has created a sense of anger that could end up in industrial action.

"We are getting poorer and poorer every year (…) how are people supposed to look at healthcare and think they are a really valued member of society when we're not?" (P4, community nurse, band 7, Trust 2, still in post).

Community nurses also spoke about the Agenda for Change and how it takes longer to move up a pay increment within their banding, which prompts people to leave for higher bands for quicker financial increases. Community nurses and senior leaders described disparity in pay for similar roles across Trusts causes nurses to leave one Trust and go to another. Moreover, community nurses considering retirement reported that they would be treated unfairly financially if they were to return to work.

"He retired at a certain level, and when he was sort of coming back to do some part-time work, they were trying to put his salary scale down lower. These sorts of tricks that they pull on people and they've got to stop doing that sort of nonsense really and start treating people more kindly if they're going to retain people" (P21, community nurse, band 6, Trust 1, still in post),

More inpatient nurses referred to pay when describing the reasons behind their intent to leave. Many are contemplating leaving due to lack of pay progression with some being financially capped at the top of their bands despite gaining more skills, experience, and responsibilities. Inpatient nurses and senior leaders also reported a lack of overall developmental opportunities to improve their financial situation, as progressing up the banding system for inpatient nurses often leads to an initial pay cut. This is due to the need to work more office-based hours reducing the number of unsociable hours they work and associated pay enhancements.

"There's no pay progression whatsoever. In fact, the pay progression is in the wrong direction. So, I don't really know how I could stay in (…) What would stop me looking away from it [their job] is if can work hard and make my situation better. Not work hard and make my situation worse" (P12, inpatient nurse, band 5, Trust 1, still in post).

Nurses in both settings shared their frustration over being required to work unpaid overtime due to unmanageable workloads. In addition, nurses in both settings described feeling demotivated by working alongside agency nurses who can negotiate a higher hourly rate. This has caused animosity within their teams and prompted nurses to consider leaving the NHS for higher pay and fair overtime rates.

"When (…) you've got someone else standing next to you that does a lot less than you that's on double the money. So why would people want to stay and work for the NHS if you can go to a nursing agency and get paid double for doing less" (P24, inpatient nurse, band 6, Trust 3, still in post)

Senior leaders acknowledged pay as a factor influencing nurses' decisions to leave the profession, particularly in connection with the current cost of living crisis. Similar to nurses' experiences, senior leaders also perceived speciality settings and locations offering slightly higher pay, reduced Agenda for Change pay points, and pay enhancements for working unsociable hours, as factors influencing nurses' decisions to stay or leave their clinical settings. However, senior leaders' accounts demonstrated an understanding that nurses do not go into nursing for the money, and therefore, pay is perceived to be less important than some of the other factors affecting the experience of being a mental health nurse.

"There's probably a whole load of other things that they've been unhappy about, and actually, money has become the final thing. They get more money, but it hasn't addressed all those other issues, (…) it's just more money (…), I think if you, for example, are unhappy with your manager, more money is not going to make you more happy working there". (Senior Leader 3, Trust 2)

Senior leaders also explained that nurses leave for agencies as they cannot compete with the agency pay rates. To combat this somewhat, senior leaders reported trying to ensure people are on the highest pay point possible under the Agenda for Change taking into consideration their

skills and experience. However, they reported that it rarely closes the gap enough to retain nurses in substantial posts or entice agency nurses into substantial posts.

> *"There's a disincentive really for them to stay on the ward when they can join an agency, and once they join an agency and they move between wards and they get paid as a band 6, we just can't compete with that." (Senior Leader 6, Trust 2)*

There were mixed perceptions regarding financial incentives as a retention strategy amongst the senior leaders. Whilst some do not perceive financial incentives, such as retention bonuses, to be effective for retention, others reported that they were losing nurses to neighbouring Trusts offering recruitment and retention bonuses. With the current cost of living crisis senior leaders explained how they were considering alternative financial incentives, such as paying nurse registration fees and paying for car parking to improve nurses financial situation.

Working hours

Community nurses intending on staying in their clinical setting reported that office-based hours provide them with stability, which enables a better work/life balance especially for those with children. However, some community nurses explained how they could find alternative positions, within the mental health nursing profession, that offer the same working hours with better work environments and less stressful workloads. They shared how they often would need to work overtime to manage their workload contributing to their intention to leave. Moreover, they explained how constantly thinking about work responsibilities or working outside their working hours was significantly affecting their work/life balance resulting in burnout.

> *"A lot of the time I feel like my work takes over everything, and I don't know how much more I've got in me to give (…) emotionally to all these people, when I feel like I'm not giving what I should be to my own family sometimes, and I think I worry about that balance" (P3, community nurse, band 7, Trust 3, still in post)*

For inpatient nurses, unmanageable workloads was also a reason nurses would often need to work through their breaks and stay behind after work to complete all their documentation, which accelerates burnout causing them to consider leaving the profession.

"Most of the time you are staying behind with the paperwork, and obviously nobody will bother to notice that as extra time, we're being told you need to manage your time better, we're not paid extra. Even if you stay an hour or two hours behind to do all the incident forms". (P19, inpatient nurse, band 5, Trust 2, has since left their post).

Inpatient nurses reported that working shifts consisting of too many unsociable hours has a negative effect on their physical and mental wellbeing. Nurses in both settings and senior leaders cited a lack of flexible working patterns as a significant reason influencing nurses' decisions to leave.

"I think I was definitely moving away from I don't want to work nights. And I feel so much better mentally and physically, I feel like a different person actually. So, I think for health reasons I was choosing to go into a Monday to Friday nine to five job" (P5, inpatient nurse, band 5, Trust 2, has since left their post).

Flexible working has contributed to community nurses considering staying by postponing, or returning from, retirement where they have been able to reduce their working hours or offered a job share contract. Inpatient nurses reported that flexible working has enabled them to develop a shift pattern that suits their lifestyle, such as working longer hours and fewer days, which provides them with a better work/life balance, reduced need for childcare, and the ability to pick up additional shifts to supplement their income.

"I am very grateful for being able to do them [night shifts]. (...) I had two young children at the time, and I wasn't stressing out about childcare or anything like that. So, I really valued the nights" (P5, inpatient nurse, band 5, Trust 2, has since left their post)

Senior leaders acknowledged that many nurses were leaving permanent positions for bank and agency work where they can dictate what and when they will work. Senior leaders also acknowledged the need to improve flexible working hours for the ageing workforce to prevent nurses needing to take early retirement. Therefore, senior leaders described that they are committed to offering flexible working to both inpatient and community nurses by providing them with more autonomy over their working pattern, whilst keeping service user outcomes at the heart of these conversations. Senior leaders are now encouraging nurses to choose how and

when they work their contracted hours, with many opting to work longer days in exchange for more days off.

> *"So it's really trusting people, so if you build staff on trust and actually you say, I trust that you're going to do a good job, I trust that you are going to give best outcomes, and actually as managers what we measure, what I expect managers to measure, is the outcomes not really the timesheet of actually what time do you step in, when do you stop out". (Senior Leader 10, Trust 3)*

Many senior leaders reported that they were still working on how they can support their team managers to negotiate flexible working within their teams to provide a better work/life balance for individual nurses.

> *"Your default position should be yes, unless you can think of a really good reason why not (…) The reverse of that is managers really struggle with it. Because where you haven't got enough people, the last thing you want to do is have less of the people you've got. But of course, if you don't, you risk losing them all together." (Senior Leader 3, Trust 2)*

The Physical Working Environment

At the time of the interviews the NHS and Government were trying to manage a global pandemic through lockdowns, social distancing, increased infection prevention methods, and vaccines. To manage social distancing recommendations many community nurses began to work from home. Many of them reported how they enjoy the flexibility that comes with working from home as they benefit from fewer interruptions and distractions, which allows them more time to manage their responsibilities and associated workloads.

> *"I don't miss the office, I don't miss the journeys, the extra time, the travel (…) If I could carry on working like this until I'd retire, I'd be happy" (P23, community nurse, band 6, Trust 1, still in post)*

However, for some community nurses, the shift to working from home created unsupportive isolated work environments that negatively affects team dynamics, particularly if they were new to their role. They explained how working from home restricts information sharing and

the development of skills and knowledge needed to fulfil their roles. The use of online platforms also impacted on their ability to build therapeutic relationships with their service users and elicit their stories to better understand how best they can help. For these nurses working from home created a difficult work environment to manage their responsibilities, manage risk, and provide quality care and treatment, which was negatively impacting their experience of being a mental health nurse.

> *"So, with COVID we were all working from home, and I joined the team during COVID so I never met my colleagues. There was no team atmosphere, your caseload was your caseload, and no one would input into your patients unless they were on their caseload. So, you were very much alone with it" (P7, community nurse, band 6, Trust 3, has since left their post)*

The flexibility that comes with working autonomously in the community environment was reported by community nurses and senior leaders as a significant reason nurses stay in community settings. Community nurses explained how they can manage their own time and decide how to structure their days to manage their workload to provide a good standard of care for their service users. They shared how they have more flexibility to work with service users in less restrictive environments compared with inpatient settings. Moreover, community nurses reported they find it easier to manage their administrative workload in the home or office environment without the added ward pressures.

> *"On the wards, you'd always have someone knocking on the door saying can you do this for me, can you do this for me, you can't sort of sit down and concentrate and do a care plan (…) I've got a bit more time in the community (…) there's less pressure of people knocking on the door and going can you do this, can you do this, can you do this (…)there's an emergency going on here, can you help" (P29, community nurse, band 6, Trust 3, has since left their post)*

Senior leaders acknowledged that working from home can feel isolative and unsupportive, especially if a risk management incident occurs. Therefore, some senior leaders have introduced a hybrid system where people can choose to split their time between the office and home to reduce some of the negative consequences of remote working.

Inpatient nurses reported feeling frustrated by the fact their physical working environments are not fit for purpose. They reported raising concerns about the safety of their environments, which have been backed by the CQC. They report that their wards have ligature points, blind spots, poor quality estates, and a lack of emergency alarms, such as door top alarms. In some cases, this has left nurses responsible for prioritising which service users get to go in the safest bedrooms rooms. Concerns over risk management due to the physical ward environment was having a significant negative impact on the experiences of inpatient nurses influencing their decisions to leave their current clinical settings.

> *"It's sort of managing whose most risky and who needs to go in the bedroom that is most safe for that person, and it's making sure that when you put someone in a room that isn't safe for them, you're heavily documenting the reason why and that sort of is your responsibility at that time" (P25, inpatient nurse, band 6, Trust 1, still in post)*

Some senior leaders reported efforts to improve the physical infrastructure to provide safe and effective therapeutic environments to care for service users.

> *"Our environment's improving, that's got to help people think this might be a nice place to work, or actually as a service user, this might be a nice place to stay". (Senior Leader 4, Trust 1)*

The Impact of Training and development

This theme incorporates factors related to nurses' training and development that affects the experience of being a mental health nurse. This theme is broken down into three sub themes: '*Pre-registration, Mandatory and In-service Training*', '*Skills and Continuing Professional Development (CPD) opportunities'*, and '*Career Progression*'.

Pre-registration, Mandatory and In-service Training

Community nurses who reported that they enjoyed their nurse training were planning on staying in their clinical settings. Community nurses who were seconded by their Trusts to complete their nurse training feel valued by their organisation and intended on staying due to a desire to repay the favour. However, many community nurses felt that their nurse training had not prepared them to fulfil their roles effectively, particularly when newly qualified. They described how their nurse training was focussed on the medical model of mental health

treatment with only brief introductions to psychological interventions. They described how, despite knowing the basic theory behind some of these interventions they use, no specific training on how to use these interventions in practice was provided. Moreover, they are expected to do so without adequate supervision by professional trained in these interventions.

> *"It was just getting me very frustrated, like I was saying about nursing as a whole, and just this feeling of not being trained properly for anything" (P2, community nurse, band 6, Trust 2, has since left their post)*

This often manifested itself in experiences of imposter syndrome whereby they felt that they are doing their service users a disservice or reduced their roles to merely co-ordinating care instead of providing it. This negatively impacted job satisfaction and increased nurses' intention to leave the profession.

Nurses in both settings shared their experiences of supervising current student nurses and expressed concern over how some are being qualified despite demonstrating poor quality practice and professional conduct. This led to nurses feeling disillusioned about the quality of the future nursing workforce they will be working alongside.

Senior leaders reflected on the importance of good clinical nurse training. Some senior leaders stated that they are committed to investing in their nursing workforce from the very start of their nurse training to boost recruitment and retention. They aim to do this by allocating every student a senior leader to act as a "*super mentor*" (*Senior Leader 5, Trust 2)*. Who will meet with their students three times a year throughout their nurse training to prompt them to start thinking about their long-term career plan. This is with a view to support and guide them through placements that will help them to progress into a fulfilling career tailored to their interests.

Nurses in both settings who found their preceptorships to be insufficient to support their development, were considering leaving their clinical setting, Trust, and the profession.

> *"My development was never made a priority, and obviously as a new nurse, that was really important to me. I valued that really highly to be able to grow" (P22, inpatient nurse, band 5 in preceptorship, Trust 2, has since left their post)*

Whereas some newly qualified community nurses reported that their training and development needs have been supported, and therefore, described a positive experience of becoming an experienced community mental health nurse.

> *"I wasn't thrown straight in the deep end. It was all a gradual build-up of a case load. I was observing assessments to begin with, so they were really good and yeah, there were training days that I was able to go on" (P8, community nurse, band 6, Trust 3, has since left their post)*

Senior leaders acknowledged that they need to focus on retaining experienced nurses to welcome and support students and new nurses during their training including preceptorships. Some senior leaders were calling for increased budgets to provide more non-clinical practice facilitators to support students and newly qualified nurses.

> *"Having that person supporting staff, new staff coming in I think needs to be looked at across all the organisations because if we've got a great budget then we'll put it in. If we don't, we're focussing on priorities which are clinical, but you need both of it at the same time" (Senior Leader 7, Trust 3)*

Some community nurses explained how they spent some time rotating around different clinical settings as newly qualified nurses to gain a deeper understanding of different mental health nurse roles and responsibilities in different settings. This enabled them to find a role they enjoyed, which significantly contributed to their longevity in their clinical settings. Senior leaders also perceived rotational posts as a factor that improves retention within their Trusts. They reported that rotational posts allow people to gain experience of different settings without having to leave and apply for new jobs. Ultimately this allows people ambivalent about what type of setting they want to work in to find their home within the organisation.

> *"I really enjoyed working in CAMHS, and that's where I've spent most of my career. But I wouldn't have done that, I would have just probably been stuck in forensics or stuck in adults if I hadn't done the moving around to see what I enjoyed. And even though you get some of that in placement, it's not long enough to give you the understanding of what the job's about" (P18, community nurse, band 8, Trust 3, still in post)*

Newly qualified and experienced inpatient nurses in both settings reported feeling unprepared and unequipped to manage their responsibilities safely and effectively through inadequate induction and orientation periods. This prompted a negative first impression of their Trust causing them to consider leaving it. Some senior leaders demonstrated insight into this issue and reported working with existing nurses to improve their Trust inductions to generate better first impressions. In addition, they reported that they are refreshing their mandatory training to reduce it where possible, to create more time for nurses to engage with training opportunities that will personally develop them in their clinical settings.

Nurses in both settings cited good in-service training opportunities, including secondments, as a reason for staying in their clinical settings, Trust, and the NHS.

> *"They offer really good training. So, not just the course that I've been on but their wider training offer. They have a good variety of options and my manager certainly seems to be supportive of me pursuing other training in the future. So, there seems to be opportunities for the development" (P27, community nurse, band 7, Trust 3, still in post)*

However, many nurses working in both settings were dissatisfied with the frequency and quality of in-service training, such as adequate training on the management and prevention of violence and aggression and self-harm. Inpatient nurses reported that they had minimal training or policies in place for how to manage people whose self-harm risks escalate in the ward environment, resulting in ineffective, and sometimes unsafe, care and treatment. Nurses who felt as though they were prevented from providing good quality evidenced-based care and treatment in-line with best practice guidelines, due to a lack of in-service training, were seriously considering leaving their current clinical settings.

Nurses in both settings described a lack of in-service training in psychological interventions which are regarded the 'gold-standard' treatments for many service users. This left nurses feeling inadequate in their roles and required them to try to find time to learn complex interventions without any support. This resulted in them feeling doubtful about the safety and effectiveness of the care and treatments they were providing. One nurse explained how working with professionals of different backgrounds (e.g., psychology) highlighted the comparisons of the value placed on training in mental health nursing.

"There's more focus on actually you shouldn't be doing stuff unless you're trained in it. Whereas in nursing, it's kind of like you basically know the theory behind a lot of these things, give it a go, and it just doesn't feel safe at all" (P2, community nurse, band 6, Trust 2, has since left their post)

Senior leaders also perceived good in-service training and having the time to access training to benefit retention. Some senior leaders acknowledged that their Trust offered a lot of training opportunities in therapeutic interventions for community nurses, but less so for inpatient nurses:

"We provide more training around therapeutic interventions so, we put nurses on CBT courses, IAPT courses, psychotherapy courses. They can specialise in a particular area such as ADHD, or depression, or crisis interventions, so there's usually ways in which you can support people through appraisals to really identify, you know, what would help them remain" Senior Leader 7, Trust 3)

Skills and Continuing Professional Development (CPD) opportunities

Nurses working in both settings who felt that they have mastered the skills necessary to confidently manage their responsibilities, and provide quality care and treatment that generate impactful outcomes, were planning on remaining in their clinical settings and the profession:

"I held on to still doing some clinical work because I thought I was bloody good at it, and I was really good at engaging families" (P30, community nurse, band 8, Trust 3, has since left their post)

Nurses in both types of setting cited opportunities to develop and learn new skills to improve their practice as a significant reason for staying in their clinical setting and the profession. Some explained how they wanted to stay in their clinical setting to hone and consolidate new skills they have acquired from those opportunities.

"I'm definitely staying for the meantime. And they've been really good this year with – yeah – with allowing me to do this and…so yeah, I've wanted to give something back to them" (P8, community nurse, band 6, Trust 3, has since left their post)

Whereas nurses in both settings were contemplating leaving their clinical setting if they did not feel they were able to acquire new skills or were at risk of losing skills. Nurses in both settings explained how they were considering leaving their current clinical settings to develop existing or additional skills.

> *"I'd quite like to move somewhere like the (community service). Just to develop my assessment skills, really" (P11, inpatient nurse, band 5, Trust 1, still in post)*

Community nurses reported that staying in one job for too long, particularly in roles that have limited patient contact, were causing them to feel deskilled. Nurses in both settings who do not think their skills were being utilised effectively, or lacked autonomy within their current role, were considering leaving for a role more suited to their skill set.

Community nurses and senior leaders reported that regular good quality supervision helps build confidence and supports nurses in both settings to manage their responsibilities and associated complex workloads and risk. Community nurses described the importance of the supervisor and supervisee relationship for successful supervision, which positively impacts their experience of being a mental health nurse:

> *"Good quality supervision is another area that will make or break if somebody stays on the ward". (Senior Leader 6, Trust 2)*

Some senior leaders had introduced regular reflective supervision hosted by psychology colleagues, at the nurses' request, to help them manage complex cases. Senior leaders in another Trust explained how they had introduced training for professional nurse advocates (PNAs) to increase the support in the form of restorative, normative and formative supervision within individual clinical settings, to develop nurses' clinical practice and improve service user outcomes.

Nurses in both settings who were dissatisfied with the amount of CPD opportunities to develop or gain additional skills, including clinical supervision, were significantly contemplating leaving their clinical setting and Trust. Inpatient nurses described a lack of support from management with finding regular protected time for nurses to engage in clinical supervision to

discuss complex clinical scenarios on the wards. Community nurses reported that their supervision was infrequent and less clinically focussed compared with that of their therapy colleagues, leaving them with just as much responsibility for the care and treatment of their service users but less support to provide it. Ultimately, nurses who did not feel they had adequate CPD opportunities to continue to develop and enrich their careers were considering leaving the nursing profession altogether.

> *"I've now not got no master's to stimulate me again, what do I need to do in order to be able to find my role fulfilling. So started applying for jobs" (P13, community nurse, band 8a, Trust 1, still in post)*

Most senior leaders demonstrated insight into the importance of CPD opportunities to retaining nurses and expressed dedication towards investing in nurses' development. They described how they were providing more opportunities to complete Advanced Clinical Practitioner (ACP) training, develop leadership and management skills for nurses of all staff grades, complete post-graduate courses, and engage in research. Beyond going on courses, some senior leaders described the need to offer opportunities such as shadowing, role modelling, and taking on extra responsibilities with support, to gain experience and knowledge necessary to develop in their careers.

Many senior leaders found it difficult to explain how they share information about these opportunities and how nurses can access them. Most senior leaders reported that they hoped developmental opportunities were being discussed in nurses personal development reviews, appraisals, or managerial supervision.

> *"An open and robust appraisal system where all options are on the table for development is a really useful tool to keep people in-house". (Senior Leader 1, Trust 3)*

Some senior leaders described trying to improve the ways in which developmental opportunities are communicated to nurses by distributing information to team managers prior to PDR and appraisal times. They were also trying to encourage managers to reach out to departments, such as the people directorate, if they were having difficulty navigating what is available. Other senior leaders described holding internal conferences to talk about the

developmental opportunities within the Trust that nurses can access. Senior leaders did discuss the difficulties nurses face trying to find the time to engage in developmental activities, and described poor strategies, if any, for finding nurses some protected time to engage in the development opportunities available.

> *"Some of it is just good management as well (…) if people are on an early and a late, when the lates come on, the earlies go and do some development (…) And all that nonsense about we're too busy, well, we're always too busy". (Senior Leader 4, Trust 1)*

Career Progression

Nurses working in both settings across bandings who reported that having a range of developmental opportunities to progress their career at a suitable rate were likely to stay in their clinical settings, Trusts, and the profession. One nurse in a management position explained how increasing the progression opportunities in their inpatient setting significantly improved retention:

> *"I had a ward that had loads of very skilled fives and I only had three band six positions (…) I went to my [senior leadership team] and went, I need to revert this triangle, like they have done in community teams. I need less band fives and a host load more band sixes. (…) So that's what we did. We inverted the triangle. So, I ended up with six band sixes and four fives. And that worked a treat because it meant no one left" (P17, inpatient nurse, band 7, Trust 2, has since left their post)*

Nurses in both settings and senior leaders reported that although nurses who work in bigger Trusts with more opportunities were more likely to leave their current clinical setting, they were more likely to stay in their Trust. Whereas nurses who cannot progress at the rate they think they could, due to working in Trusts with fewer opportunities for progression often felt demotivated by poor job satisfaction, which influenced their decision to leave their clinical settings, Trusts, and the profession.

> *"The thing about nursing is, it's a really decent job, (…) it's an absolutely rubbish career" (P12, inpatient nurse, band 5, Trust 1, still in post)*

Most senior leaders perceived career progression as a critical factor that influences nurses to stay or leave their clinical setting, trust, and the profession altogether. Interestingly, some senior leaders viewed nurses leaving their Trusts to progress as a positive factor, whilst others considered it a negative and emphasised the need to improve opportunities to progress in their Trust to prevent the need to leave to progress. Senior leaders and nurses in inpatient settings acknowledged a paucity of career pathways and opportunities to progress for inpatient nurses, which often leaves nurses in the lowest bands caring for the service users with the highest needs and risks. They discussed increasing senior positions to allow more opportunity for nurses to progress in their clinical settings.

Some senior leaders expressed that nurse's progression is often discussed at the point nurses have decided to leave. In some cases, these last-minute conversations around career progression have influenced nurses' decisions to stay. Other senior leaders demonstrated commitment to providing nurses with opportunities that will enable them to have fulfilling careers from the outset. These senior leaders had set the tone and strategic vision for nurses' career pathways within their organisation. They were in the process of communicating this vision to individual line managers, who can support nurses onto these pathways, and build necessary developmental opportunities that benefit their service into their career plans. One senior leader described an example of creating a personalised career pathway:

> *"She's a really junior nurse. (...) Because we want to keep her. (...) she wants to do a Master's degree, she wants to be a nurse consultant. Nurse consultant's 8b, she hasn't got her Master's yet, so we create an 8a with a Master's attached that then goes to an 8b". (Senior Leader 5, Trust 2)*

Many nurses reported that the only way to progress in their clinical setting is to become a manager, and if they did not want to pursue a career in management, they were seriously contemplating leaving their clinical setting. Most senior leaders acknowledged that clinical career pathways for nurses are less established than managerial ones and were focussing on introducing more clinical career routes.

> *"I think if you are a nurse that has a therapeutic head and you want to pursue that at a higher level, you're a little bit stumped, because there isn't an awful lot available (...) what you tend to find is, they disappear off and they become cognitive behavioural*

therapists or they retrain, because the only way they can pursue that passion is to be a different registered professional.". (Senior Leader 1, Trust 3)

Most senior leaders discussed introducing the ACP route for inpatient and community nurses to become nurse consultants. Some senior leaders also discussed introducing roles such as Professional Nurse Advocates (PNAs), clinical leads, non-medical responsible clinicians, and clinical academic roles to strengthen clinical career routes for nurses. Senior leaders alluded to the lack of knowledge around clinical career routes amongst nurses and illustrated the importance of sharing this information to improve retention. The consensus amongst the senior leaders was that career progression should be continually discussed within individual nurses PDRs, so that nurses can develop and visualise their career progression. Some senior leaders described sharing this information via a flyer illustrating a snapshot of all the different career routes for nurses, but they were unable to explain where these could be found and how they were distributed to the nurses.

"I know people that have remained in trusts because there's been a very clear and obvious career development pathway laid out for them" (Senior Leader 1, Trust 3)

Nurses explained how they were leaving their clinical settings more quickly because they were offered higher bands in other clinical settings as a method of recruitment. Nurses and senior leaders highlighted how progression is now based on financial implications, rather than naturally progressing when they have gained the necessary skills and experience to prepare them for the next set of responsibilities. Moving up through the bands too quickly is leading to poor wellbeing and burnout through difficulty fulfilling roles with greater responsibilities, which subsequently increases intent to leave.

"Retention is based on financial implications, moving up the ladder fast, it's not slowed. And that's why I think there's been such a lot of burnout of nurses, because they've just gone zero to 60 so quick rather than taking their time and learning, understanding the role" (P18, community nurse, band 8, Trust 3, still in post)

Nurses in both settings described how unfair treatment regarding career progression has created a sense of anger and hopelessness around their career progression. Inpatient nurses who were

given extra responsibilities and tasks of a higher band, but not given developmental progression to go with it felt extremely undervalued and overworked.

> *"There were more and more requirements towards myself, and then it wasn't any way resembled in my salary, opportunities for development, any kind of progress with my position in the [name of ward]. So, that started all this, my thought about changing the job" (P19, inpatient nurse, band 5, Trust 2, has since left their post)*

Whereas some community nurses felt that they were prevented from progressing due to unfair processes, such as having already selected the person for the job before the application process or choosing someone external to improve staffing issues.

> *"I'm stuck where I am, I've been told just get on with what you're doing, that's what that's what the feedback was after my interview, just carry on what you're doing and that's where they want me. They want to keep me where I am." (P20, community nurse, band 6, Trust 2, still in post)*

The Impact of Staffing

This theme incorporates factors related to staffing that impact on the experience of being a mental health nurse. This theme is broken down into three sub themes: *'Acknowledgement of Retention Issues', 'Safety in Numbers',* and *'Bank and Agency Staff'*.

Acknowledgement of Retention Issues

Acknowledgement that retention is a growing problem was noted across the data set, with nurses in both settings and senior leaders expressing significant concern over the inability to retain experienced MHNs and the associated consequences.

> *"It's really disheartening when you go in every week, and somebody else's left, and you just think well why am I staying then?" (P26, community nurse, band 6, Trust 1, still in post)*

Nurses working within inpatient settings highlighted that poor retention is not a new problem in their workforce, and that the mental health nursing profession has been under pressure to retain nursing staff for as long as they can remember. Several nurses and senior leaders

discussed the further impact on staffing caused by the global pandemic and subsequent burnout, staff sickness, isolation and shielding. Nurses in both settings and senior leaders illustrated how poor retention has a direct and detrimental impact on the quality and safety of care. They explained how this is caused by simply not having enough nurses to deliver services, and a lack of consistency and continuity necessary for developing therapeutic relationships that underpins quality and safe mental health care. Senior leaders highlighted how this increases the pressures placed on other services, such as the Accident and Emergency departments causing system wide issues within the NHS.

> *"When all of your permanent staff have left, who's going to be looking after the patients to a high level?" (P1, inpatient nurse, band 5, Trust 2, still in post)*

Community nurses spoke about how they, and many of their colleagues, were wanting to reduce their hours, retire, leave the profession, or not even take up nursing as a career after finishing their training. Some senior leaders explained how turnover of nurses has some benefits including refreshing the team with new ideas and preventing closed cultures that negatively influence team dynamics. However, nurses in both settings and senior leaders reported how sustained high turnover of staff damages staff morale and team dynamics; and significantly increases the financial cost and workload through the induction and training requirements associated with new starters. Senior leaders explained how this significantly impacts recruitment through nurses not wanting to encourage others to work with them and being deterred by poor staff survey results.

Many nurses in this study described how a range of factors highlighted in the previous themes, that have been exacerbated by short staffing, have led them to the conclusion that nursing is not a sustainable career.

> *"I don't really see myself doing this for the rest of my career, though. Because I just don't think it's sustainable" (P2, community nurse, band 6, Trust 2, has since left their post)*

Nurses in both settings and senior leaders acknowledged the importance of retaining experienced nurses to support the recruitment of new nurses. However, nurses working in clinical settings where there were continuous failed attempts at recruiting nurses felt hopeless

that their situation will improve and were significantly contemplating leaving. Nurses in both settings reported that their services were losing nurses at a quicker rate than they were gaining them. Nurses explained how experienced and senior nurses who had left their posts were not being replaced, thus creating ineffective work environments causing work-place stress and burnout.

> *"A lot of them were new nurses, which were great you know they were enthusiastic and erm might come at things from a different perspective, but if you lose your really experienced nurses then you can't replace that experience by just new enthusiasm" (P10, community nurse, band 6, Trust 1, has since left their post)*

Inpatient nurses explained how there is a common misconception that newly qualified nurses must gain experience on the wards before they can work in community settings. This limits recruitment to inpatient settings to mainly inexperienced nurses and generates sustained turnover. Some senior leaders described perpetuating a culture that encourages nurses to start out their careers in inpatient settings despite their long-term career ambitions. Inpatient nurses reported how turnover generated by this culture puts more pressure on experienced nurses, as they are constantly working with inexperienced nurses to whom they invest their time to develop and subsequently lose.

Senior leaders reported concerns over their ageing workforce profile and acknowledged that they may soon lose many experienced nurses through retirement. They reported that despite being aware of a national ageing workforce crisis pre-pandemic their Trusts were only turning their focus from recruitment to retention now. Senior leaders in some Trusts were starting to consider targeted retention strategies tailored to different types of clinical settings and career stages.

> *"We are only giving a strategic look to retention now. I think that there's been lots of little things that have been thrown at retention over time, golden handshakes, and bits and bobs that haven't really been thought through". (Senior Leader 8, Trust 1)*

One senior leader outlined the fundamental aspects of retention:

"I think we need to remember that retention isn't a number, it's people. I know that sounds obvious, but at the bottom of this, these are people with feelings, people with salaries, people who want lifelong careers and want to retire well at the end of it. (…) And we have a duty, as a leadership team and as a country, to make sure that we look after them and help them to fulfil their careers". (Senior Leader 5, Trust 2)

Safety in Numbers and Experience

Inpatient nurses and senior leaders cited working in teams with a full complement of permanent staff as a direct reason for staying in their clinical setting. However, many nurses in both settings reported that their core staffing numbers (including staff of all grades and professions), that are deemed appropriate to provide safe and quality care, are sub-optimal. They described how staffing compliments are set by senior leaders who, in their view, have limited knowledge of current clinical activity. Subsequent staffing complements were regarded as insufficient and do not allow for meaningful engagement with service users, proactive or enhanced care, or staff sickness or cancellations. It was the view of nurses in inpatient settings that insufficient core numbers, compounded by poor retention, staff sickness and cancellations, or an increase in clinical activity, often leaves them critically short-staffed on shift. Nurses explained how they often find themselves as the only nurse on shift, trying to complete the job of two or three nurses, making it impossible to care for people in line with policies and procedures.

"You can walk on a ward and, again, we've got 21 patients [on a ward with 19 beds] and one of my nurses has to go [to support another understaffed ward], which means me in charge of 21 patients, maybe someone in seclusion. It's just not physically possible for one nurse to complete all the nursing jobs safely for 21 patients" (P25, inpatient nurse, band 6, Trust 1, still in post)

Senior leaders acknowledged that their wards are often unsafely staffed and described the difficulty in trying to meet staffing regulations:

"Ideally, we'd want three qualified on shift, whereas we tend to just staff with two with the hope that we have one. And certainly, over the last wave of the pandemic, there's been times when one nurse has had to manage two wards, which is not ideal and is in breach of our regulation because the regulation says we must have one qualified nurse on each ward at any one time". (Senior Leader 9, Trust 1)

They acknowledged that their core numbers for inpatient settings are currently insufficient due to underestimating the number of staff needed per shift. Therefore, some senior leaders reported that they had introduced the Mental Health Optimum Staffing Tool, which helps senior leaders to understand how many staff are needed considering acuity levels, by counting how many care hours individual service users require per day. For community settings, senior leaders in one Trust described how commissioners had agreed to invest £4.6 million into community settings, to allow for the recruitment of more nurses to safely meet the current demand for their services.

Inpatient nurses reported that leadership teams were only concerned with the number of staff, with no consideration given to the clinical experience and skill mix within shifts. Experienced inpatient nurses described how working with inexperienced staff over a protracted period creates overwhelming workloads and reduces support, inevitably causing burnout. Nurses in both settings and senior leaders reported that insufficient staff teams lacking in experience makes it even harder for nurses to manage risk, provide quality care, form supportive team dynamics, access training, develop their skills and practice, and receive adequate inductions and support necessary to succeed in their role.

Senior leaders reported how inexperienced staff can often introduce risks through a lack of knowledge around service user care plans including any pre-risk indicators and de-escalation strategies. Senior leader' perceptions also illustrated how nurses with limited nursing experience often perceive risk to be higher and have more difficulty managing risk than nurses with more clinical experience. Senior leaders also recognised how insufficient staffing affects the support and development of newly qualified nurses and new starters. They explained how this can force inexperienced nurses to act outside the limits of their competence without the support and supervision of experienced nurses, causing them to feel overwhelmed and out of their depth.

> *"If you are having to cover a number of gaps, there's more chance that you will have to undertake duties or do tasks that you've not come across, like you're a new band five, you're getting to grips with things, if you're constantly being asked to do things that you haven't done before, you're worried about whether you're doing them right or not, you're concerned about your level of supervision". (Senior Leader 3, Trust 2)*

Senior leaders in one Trust proposed to improve the skill mix by ensuring there are more senior nurses on every shift, including ward managers and matrons acting in a clinical capacity to support less experienced nurses.

Bank and Agency Staff

Nurses in both settings described working in poorly staffed teams with the shortages filled with inexperienced, minimally trained, and transient bank and agency staff. Inpatient nurses and senior leaders reported that their wards were almost completely dependent on bank and agency staff, particularly at night. They explained how the use of bank and agency staff creates a chaotic, unsupportive, and dangerous work environment, which leads to a constant turnover of permanent staff. Nurses in both settings and senior leaders reported that working with excessive bank and agency staff, in their view, negatively affects team dynamics, impedes risk management, and lowers the standard of care and treatment they can provide.

> *"The Trust started using quite a lot of bank staff, so there was a high turnover. People were leaving and coming and leaving, so that sort of transiency within the team was really difficult to manage, because you didn't have stable colleagues that could support you, because people didn't stick around" (P10, community nurse, band 6, Trust 1, has since left their post).*

Inpatient nurses reported how, due to limited experience, training, management and supervision, bank and agency staff often engage in poor practices, such as falling asleep on observations. They described, due to limited knowledge of the ward environment and service users, that bank and agency support staff did not take risks seriously leading to dangerous risk incidents. According to participants this increased risk, caused by an overreliance on bank and agency staff, is significantly influencing inpatient nurses' decisions to leave their clinical settings. Senior leaders acknowledged that whilst some bank and agency nurses have a fantastic range of skills, some do not have the desired skill set necessary for the position they are filling.

> *"We'd been relying on bank and agency (…) a patient attacked me in the corridor, we had two agency trapped on one-to-one observations. They heard the noise, my alarm didn't work, I shouted, they didn't bother to even peek out of the patient's rooms" (P19, inpatient nurse, band 5, Trust2, has since left their post)*

Nurses in both settings explained how the use of agency nurses drastically increased their workload, as many agency staff were prevented from working to their full capacity due to not having access to, or knowledge of, the systems and processes. In addition, extra work was created through the constant need to induct and train new agency members whilst trying to co-ordinate shifts, complete nursing tasks, and care for patients. This increased the pressure placed on the permanent nurses causing burnout.

> *"You're having to induct the agency staff onto the ward, explain what they have to do and leave them to it (…) we had admissions yesterday, someone that came from a prison that needed quite a lot of support (…) a lot of redirection to stop her from being violent, and that was just really hard when five of your seven staff members had never worked in an inpatient ward before". (P25, inpatient nurse, band 6, Trust 1, still in post).*

Senior leaders reported that the current demand for agency nurses is so high they are still unable to cover all the staffing gaps. They acknowledge the need to stop the overreliance of bank and agency staff as a matter of urgency yet were unable to describe a clear plan of action. Some senior leaders believe drastic action should be taken in terms of terminating the use of agency staff in their Trusts to entice nurses into the permanent positions. However, there was no current plan in place for how to achieve that goal whilst ensuring the safety of service users.

> *"You have to cut off…unfortunately, it sounds really mercenary, but I am no fan of agencies, because they are mercenary, you have to cut off that income stream to force them back into the system" (Senior Leader 3, Trust 2)*

Some senior leaders emphasised the importance of progression posts for newly qualified nurses to prevent them from leaving for agencies for pay rates equivalent to the next band up. Some senior leaders reported that their agency staff would come permanent if they could be paid closer to their agency rates. Other senior leaders reported that they are working on a solution for reducing bank and agency staff by trying to instil a Reservists system, but this system was in its infancy and the details had not been thought out at the time of this study.

Summary

The findings presented in this chapter demonstrate a range of experiences related to professional working that influence MHNs intention to leave or stay in their clinical settings, Trusts, and the profession altogether. These experiences were based around five key areas that formed distinctive yet interrelated themes: *Disillusionment with Mental Health Nursing, The Impact of Leadership and Management, The Impact of the Work Environment, The Impact of Training and Development,* and *The Impact of Staffing.* All nurses described a range of experiences contributing to their intentions to leave or stay that spanned across multiple themes rather than one isolated experience. These findings describe an analytical process that occurs between the themes, which illustrates a model of intention to leave for MHNs which will be displayed in the following chapter. The next chapter will also integrate the findings by using the qualitative findings to provide a contextual explanation of the quantitative results.

Chapter 6 – Data integration – Joint display table

A summary of the individual quantitative and qualitative findings can be found in appendix S. Below is a joint display tables used to present the integration of both sets of data in order to draw meaningful insights about the topic under study. Qualitative findings were used to explain, and give context to, the quantitative findings in the form of a table allowing for visual and structured communication of interpretations drawn from the analyses. The first joint display table (Table 6.1) presents the significant associations related on intention to leave and clinical settings with the qualitative findings, which provides the related experiences that provide the context for those associations, followed by an accompanying interpretation. This table allows me to present the answer to both the primary and secondary research questions:

- How does intent to leave or stay for the mental health nursing workforce differ across NHS inpatient and community clinical settings?

- What experiences contribute to intent to leave or stay for the mental health nursing workforce across different NHS inpatient and community clinical settings?

Next, I present a model that explains the process behind MHNs intention to leave in this study. The next three joint display tables (table 6.2-6.4) go on to present the other factors associated with intent to leave for the NHS mental health nursing workforce and the contextual experiences that explain these associations using the model of intention to leave. The findings that answer the third question (What are the perspectives of senior leaders within the NHS on the factors affecting retention of mental health nurses across different inpatient and community clinical settings?) will be used to inform the discussion and recommendations for change in the following chapter.

Table 6.1 – Joint display table presenting the findings related to intention to leave and different clinical settings.

Quantitative findings	Qualitative findings		Interpretations
	Leadership and management		Respondents working in inpatient settings are significantly more likely to leave their organisation and the profession than respondents working in community and other settings. This confirms that there are differences in the experiences of being a MHN that affect retention in different settings. Whilst many factors were common to both settings there were some differences in factors and how certain factors were experienced by participants. For example, although high workloads are an issue for both settings, huge differences in inpatient and community nurses' workloads, including the intensity and management of risk and the nature of the care and treatment, were described. Differences exist in all themes with the least differences occurring in the training and development theme. The findings suggest that are many factors caused by poor staffing unique to inpatient settings that impact participating inpatient nurses' ability to provide safe and effective care. Staffing issues were felt heavily by the participating inpatient nurses due to the reliance on a certain number of staff to maintain safety. Poor staffing often gives rise to risk incidents in inpatient settings
Clinical setting Respondents working in inpatient settings are **significantly more likely to look for a new job at a new organisation in the next 12 months** and **leave their organisation as soon as they can find another job** than respondents working in community or other clinical settings (*p=0.19*). Respondents working in community settings are significantly **more likely to retire or take a career break** than respondents working in inpatient settings (*p=0.18*).	***Leave factors*** **Supportive management and leadership** Lack of support with risk management* **Poorly managed services** Waiting lists ** Feeling excluded from service development plans ** Managers with a lack of clinical and managerial experience* Over occupying wards* Task orientated managers*	***Stay factors*** **Visible and approachable leadership** Well defined, visible, inclusive leadership** **Supportive management and leadership** Trusting and empowering relationships** Support with development** Hands-on support*	
	Training and development		
	Leave factors **Training** Poor experience of nurse training** **Career progression** Unfair HR processes** Being given extra responsibilities but no progression opportunity*	***Stay factors*** **Training** Nurse training secondments** Rotational posts**	
	Work environment		
	Leave factors **Team dynamics** Insufficient team meetings to discuss cases** Lack of camaraderie, conflict, and inadequate skill mixes* Difficult relationships with the MDT, other wards, and services* **Pay** Pay below inflation** Progression leads to pay cut* **Working hours** Thinking about work beyond working hours** Working too many unsociable hours* **Physical work environment** Working from home** Unsafe ward environments*	***Stay factors*** **Team dynamics** Supportive networks across the organisation** **Pay** Pay enhancements for unsociable hours* **Working hours** Office-based hours** **Physical work environment** Working from home** More autonomy over the management of their responsibilities** Less restrictive**	
	Disillusionment with mental health nursing		
	Leave factors	***Stay factors***	

	Risk management Solely responsible for the safety of huge caseloads** Responsible for the safety of acutely unwell service users and large staff teams* Too many high-risk cases ** Inability to share risk** Frequent emergency interventions* **Care and treatment** Premature discharges* Task orientated* Specialist community teams*	**Risk management** Smaller caseloads** Ability to share responsibility** Manage less risk**	causing them to have to manage more frequent emergency interventions with fewer and inexperienced staff to support them. This eventuates in work-related stress centred around fear over the safety of the service users, themselves, and their nursing registrations. This then accelerates disillusionment with the profession and intention to leave.
	Staffing		
	Leave factors **Unsafe staffing** Unable to work in line with policies and procedures* Increase in violence and aggression* Prevents training and development* Lack of support* Working outside the limits of their competence* Inadequate skill mix* Poor staff morale and team dynamics* **Bank and agency staff** Lack of support** Creates a chaotic and dangerous work environment* Bank and agency staff engaging in poor practice* Increase in risk incidents*	***Stay factors*** Working in teams with a full complement of permanent staff	*Data derived from inpatient nurses **Data derived from community nurses

The themes generated from the data illustrate an underlying process whereby experiences within the *Leadership and Management, Work Environment,* and *Training and Development* themes have a positive or negative impact on the experience of being a MHN. Those who have a positive experience of being a MHN are likely to remain in their clinical settings, NHS Trust, and the mental health nursing profession. Those who have a negative experience of being a MHN often become disillusioned with mental health nursing and are at risk of leaving their clinical settings, Trusts, the NHS, or the profession altogether. MHNs who have become disillusioned with the profession and decide to leave cause detrimental staffing issues, which then exacerbate the negative experiences and decreases the positive experiences of *Leadership and Management, Work*

Environment, and *Training and Development*. The impact of these staffing issues then further devastates the experience of being a MHN causing more MHNs to become disillusioned and contemplate leaving, which culminates in a negative cycle underpinning the current mental health nursing crisis (see figure 6.1 for an overview of the themes and process).

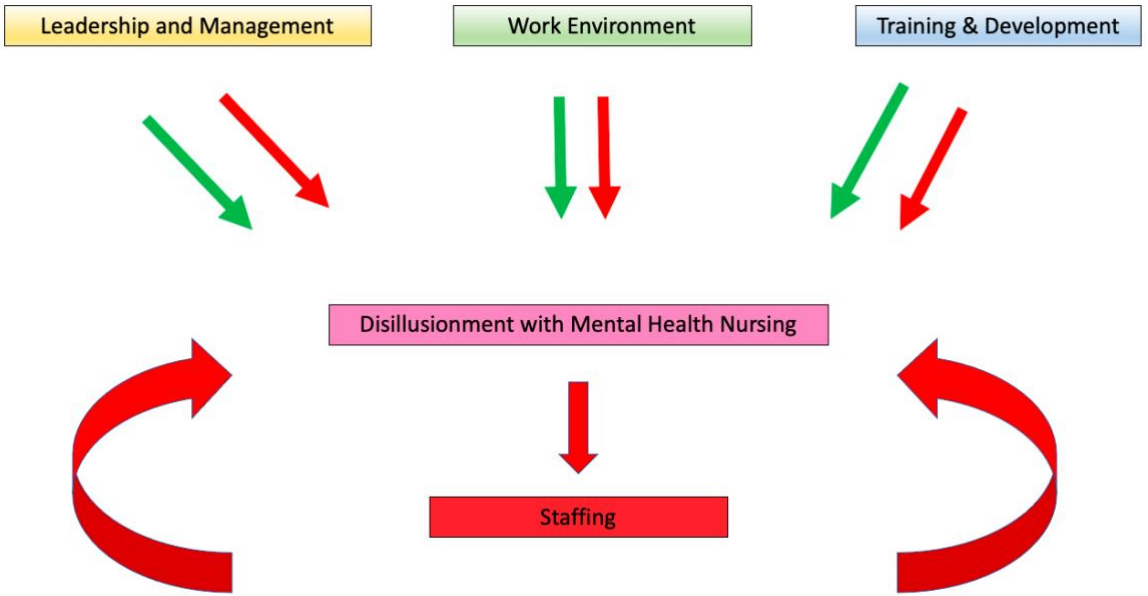

Figure 6.1 – Model of intention to leave for mental health nurses.

The next three joint display tables only present the experiences related to four themes (Leadership and Management, Training and Development, Work Environment, and Disillusionment with Mental health Nursing), as the model of intention to leave demonstrates that it is experiences within these key areas of professional working that influence whether or not someone becomes disillusioned and intends to leave or stay. Experiences related to staffing only exacerbate or mitigate negative experiences described rather than generate new experiences influencing intention to leave.

Table 6.2 - Joint display table presenting the findings related to intention to leave and different NHS Trusts

Quantitative	Qualitative findings			Interpretations
Trust Respondents in Trust 1 are **significantly more likely to often think of leaving their organisation** (*p=.029*) and **move to a job outside of nursing** (*p=.001*) than respondents in Trusts 2 and 3.	**Leadership and management** Lack of visible and approachable leadership. Lack of clarity. Lack of trust. Lack of support/debrief after serious incidents. Lack of support with training and development. Constant changes in leadership and management. Poor communication. Blame culture and bullying. Poor management of violence and aggression. Ignoring risk management concerns* Underperforming services with poor CQC ratings. Insufficient care pathways. Over occupying wards* Feeling excluded from service development plans** Lack of accountability.	**Training and development** Inadequate induction and orientation. Insufficient in-service training specific to clinical setting. Lack of CPD opportunities to develop and acquire new skills. Fewer opportunities to progress. Lack of clinical progression pathways.	**Work environment** Negative team dynamics involving conflict. Highly valued nurses leaving. Inadequate skill mixes* Difficult relationships within the MDT* Lower salaries post retirement** Unhealthy relationships between wards and other services* Lower salaries post retirement* Unsafe ward environments*	Respondents in Trust 1 described many negative experiences related to leadership and management within the Trust. They described a lack of visible and approachable leadership, with many nurses not knowing who their senior leaders are and what their responsibilities are; a lack of support from leadership and management around risk management and workload; and poorly managed services with insufficient care models and pathways. They also described issues with training and development including inadequate induction and orientation and in-service training; along with poor work environments consisting of negative team dynamics and unsafe physical work environments. These experiences were described as preventing participating MHNs from fulfilling their responsibility to provide safe and effective care; and caused them to feel distrustful of their managers and senior leaders' intentions. This eventuated in disillusionment with the profession which is significantly increasing their intent to leave their Trust and the profession altogether.

Being a mental health nurse
Solely responsible for the safety and care of huge caseloads**
Responsible for the care and safety of acutely unwell service users and large staff teams*
Responsible for the management of frequent emergency interventions*
Too many high-risk cases**
Inability to share risk**
Violence and aggression.
Poor clinical outcomes.
Lack of recognition.
Inappropriate cases/admissions.

*Data derived from inpatient nurses
**Data derived from community nurses

Table 6.3 - Joint display table presenting the findings related to intention to leave and MHNs stress and mental wellbeing

<table>
<tr><th>Quantitative findings</th><th colspan="3">Qualitative findings</th><th>Interpretations</th></tr>
<tr>
<td><u>Work-related stress</u>
Respondents that have felt unwell because of work-related stress during the last 12 months are significantly more likely to leave their organisation as soon as they can find another job (<i>p=<.001</i>) and move to a job outside of nursing (<i>p=<.001</i>).

<u>Mental wellbeing</u>
Respondents with below average mental wellbeing are significantly more likely to leave their organisation as soon as they can find another job (<i>p=<.001</i>) and move to a job outside of nursing (<i>p=<.001</i>).</td>
<td><u>Leadership and management</u>
Lack of wellbeing support/debrief/root causes.
Lack of hands-on support with clinical activity and workload.
Blame culture.
Bullying.
Ignoring risk management concerns*
Underperforming services with ineffective care models with poor CQC ratings.</td>
<td><u>Training and development</u>
Inadequate preceptorships.
Inadequate induction and orientation.
Lack of good quality supervision.
Fewer opportunities to progress.
Lack of CPD opportunities to develop and acquire new skills.</td>
<td><u>Work environment</u>
Negative team dynamics.
Feeling disconnected from the wider organisation.
Working overtime.
Pay below inflation**
Lack of flexibility.
Working too many unsociable hours*
Working from home**
Unsafe ward environments*</td>
<td rowspan="2">Respondents who indicated they have felt unwell because of work related stress and have poor mental wellbeing described feeling as though they were unable to provide safe and effective care, giving rise to poorer clinical outcomes, leading to moral distress. This was impacted by insufficient training, lack of regular supervision, and lack of CPD opportunities, causing them to doubt their practice and experience imposter syndrome. They also described how a lack of supportive leadership and management, blame cultures, bullying, and working in underperforming services with poor CQC ratings with ineffective care models, creates a sense of fear over their registrations and hopelessness around positive change contributing to poor mental wellbeing.

MHNs' narratives also illustrated how their wellbeing is significantly impacted by an overall poor work/life balance stemming from experiences related to their work environments such as working overtime, a lack of flexible working, and poor pay.

MHNs in this study who indicated that they have felt unwell due to work-related stress and have poor mental wellbeing are highly likely to become disillusioned with mental health nursing and leave their current jobs, their organisation, and the profession.</td>
</tr>
<tr>
<td colspan="3"><u>Being a mental health nurse</u>
Solely responsible for the safety and care of huge caseloads**
Responsible for the care and safety of acutely unwell service users and large staff teams*
Excessive workloads.
Responsible for the management of frequent emergency interventions*
Too many high-risk cases**
Inability to share risk**
Violence and aggression.
Poor clinical outcomes.
Lack of recognition.</td>
</tr>
</table>

*Data derived from inpatient nurses
**Data derived from community nurses

Table 6.4 - Joint display table presenting the findings related to intention to leave and demographic and background factors.

<table>
<tr><th>Quantitative findings</th><th colspan="3">Qualitative findings</th><th>Interpretations</th></tr>
<tr>
<td rowspan="2"><u>Age</u>
Younger respondents were significantly more likely to look for a new job at a new organisation in the next 12 months (<i>p=0.43</i>) and move to a job outside of nursing (<i>p=<.001</i>) than respondents in the 51-65 age category.

<u>Staff grade</u>
Band 5 nurses not in preceptorships within the study sample are significantly more likely to often think of leaving their organisation than nurses in their preceptorships or higher Bands (<i>p=<.001</i>). Band 5 nurses not in their preceptorships within the study sample are also significantly more likely to move to a job outside of nursing than Band 5 nurses in their preceptorships (<i>P=005</i>).

<u>Nursing experience</u>
Respondents with 1-2 years' experience are significantly more likely to move to a new job in a new organisation than respondents with 10+years' experience (<i>p=<.001</i>).</td>
<td><u>Leadership and management</u>
Lack of hands-on support with clinical activity and workload.
Lack of support with training and development.
Lack of support with risk management*
Lack of wellbeing support/debrief/root causes.</td>
<td><u>Training and development</u>
Inadequate preceptorships.
Lack of regular good quality supervision.
Insufficient in-service training specific to clinical setting.
Poor experience of nurse training**
Being given responsibilities of a higher band but no progression*
Progress too quickly.</td>
<td><u>Work environment</u>
Negative team dynamics.
Inadequate skill mixes*
Highly valued nurses leaving.
Insufficient team meetings to discuss complex cases**
Agenda for change.
Progression leads to pay cut*
Agency pay rates.</td>
<td rowspan="2">Younger respondents in lower bands with less nursing experience are at the highest risk of leaving their current posts and the profession altogether. These nurses described finding their responsibility to provide safe and effective care to their service users unmanageable due to excessive workloads consisting of too much risk.

This is impacted by a lack of support from leadership and management; inadequate preceptorships; and insufficient training and supervision; poor work environments consisting of negative team dynamics; and issues surrounding poor pay and progression. This prompts disillusionment with mental health nursing causing nurses within this study to contemplate leaving their job, Trust, and in some cases, the profession altogether.</td>
</tr>
<tr>
<td colspan="3"><u>Being a mental health nurse</u>
Solely responsible for the safety and care of huge caseloads**
Responsible for the care and safety of acutely unwell service users and large staff teams*
Excessive workloads.
Responsible for the management of frequent emergency interventions*
Too many high-risk cases**
Inability to share risk**
Inability to share risk**
Excessive workloads.</td>
</tr>
</table>

*Data derived from inpatient nurses
**Data derived from community nurses

Chapter 7 - Discussion

The literature review identified several gaps in the literature and areas for future study:

- There is scope for studies using qualitative methods to further explore the factors affecting MHN retention to identify any important factors that may have been missed by the domination of quantitative methods used in the field.
- There is a need to explore if there are any differences in retention/intention to leave in mental health clinical settings within the English NHS.
- There is a need to explore what factors exist in which mental health clinical settings to provide more specific findings to better tailor retention strategies.
- The perceptions of senior leaders on MHN retention and their strategies to address retention is missing in the research literature.

To fill these gaps in the evidence base I conducted a mixed methods study to answer the following three research questions:

- How does intent to leave or stay for the mental health nursing workforce differ across NHS inpatient and community clinical settings?

- What experiences contribute to intent to leave or stay for the mental health nursing workforce across different NHS inpatient and community clinical settings?

- What are the perspectives of senior leaders within the NHS on the experiences affecting retention of mental health nurses across different inpatient and community clinical settings?

This is the first mixed methods study exploring MHNs' intention to leave their current employment across different clinical settings in the English NHS. During the first phase of this study the clinical setting (inpatient or community) was identified as a potentially important factor in respondents' intention to leave. The results identified respondents potentially at high risk of intention to leave based on the clinical setting and NHS Trust they work in, their mental wellbeing, age, staff grade, and nursing experience. The second phase of the study captured the experiences contributing to respondents' intention to leave across inpatient and community

clinical settings highlighting commonalities and differences between clinical settings. The qualitative findings also generated a novel theoretical model, detailed on page 151, that explains the process behind intention to leave for MHNs working in the English NHS included in this study. This model can help policy makers and senior leadership to understand and address some of the issues within three key areas (Leadership and Management, Training and Development, and the Work Environment) to improve the experience of being a mental health nurse and reduce intention to leave to improve retention.

This chapter will set out to discuss and contextualise the findings within the existing literature. It will also present the strengths and limitations of the study before concluding and providing tangible recommendations for change.

Discussion

Over two thirds (n=246, 68.2%) of participating MHNs in this study indicated they were considering leaving their current job, with almost half (n=192, 49%) indicating that they often think about leaving their organisation, and 28.6% (n=112) were considering leaving nursing altogether. These results are higher than those of the RCN employment survey in 2021 where 56.8% of respondents indicating they were planning on leaving their current post (RCN, 2021). The RCN employment survey includes registered nurses, support workers, students, and nursing associates in all areas of health and social care which may partly explain this difference and confirms that MHNs are a particularly high-risk group. Age, staff grade, nursing experience, mental wellbeing and work-related stress, individual Trusts, and different clinical settings were significantly associated with intention to leave for MHNs in this study to some extent. Five themes were generated from the qualitative interviews that explain the influencing experiences behind MHNs' intentions to leave through the generation of a theoretical model: *Disillusionment with Mental Health Nursing, The Impact of Leadership and Management, The Impact of the Work Environment, The Impact of Training and Development,* and *The Impact of Staffing.*

The theoretical model generated from the qualitative findings is the first model that aims to explain the process behind intention to leave for the MHNs working in the English NHS. There are similarities across models of intention to leave for other nursing professions in different countries that suggest nurses go through a process whereby multiple factors affect a centralising concept such as job satisfaction, organisational commitment, or professional

commitment, which influences decision making around intention to leave (Takase *et al,* 2014; Slater *et al*, 2020; Hallaran, 2020; Phuekphan *et al*, 2021; & Alexander *et al*, 1998). However, these models were all derived from quantitative data and lack qualitative data capturing the in-depth experiences from participants that provides the nuanced context for the complex constructs impacting intention to leave. Phuekphan *et al's* (2021) study of nurses working in government hospitals in Thailand presents a similar model demonstrating how *work-family conflict, burnout, nurse practice environment,* and *employment opportunity* have either a direct impact on intention to leave or indirect impact through *job satisfaction* and/or *professional commitment.* An earlier model by Alexander *et al* (1998) based on nursing personnel working in psychiatric facilities in the United States goes on to explain the importance of mitigating intention to leave, as their model concludes that intention to leave is the strongest predicter for nursing personnel actually leaving their jobs.

The theoretical model generated from this study may also help to understand the impact the that the global pandemic has had on the MHN profession. It suggests that the existing experiences affecting retention have mainly been exacerbated rather than created by the global pandemic. This was mainly due to working with even lower staffing levels due to sickness, isolation, and shielding. Many MHNs in this study cited poor staffing levels as a reason behind their intent to leave which did generate a distinctive theme and key aspect of the model. However, this theme largely provided context for how other factors that cause disillusionment with mental health nursing, such as poor team dynamics, limited time for training and development, substandard care, and frequent avoidable risk incidents, are exacerbated. Therefore, targeting interventions within three key areas of professional working (leadership and management, work environments, and training and development) will help to improve the retention of existing staff, and potentially entice bank and agency staff back into permanent positions, which will help to reduce the impact of poor staffing and break this cycle.

Clinical setting

This study found that MHNs working in inpatient settings were significantly more likely to leave their organisation as soon as they could find another job than MHNs working in community and other clinical settings. Similarly, the RCN employment survey also found intention to leave to be the highest among nursing staff working in NHS hospital settings (RCN, 2021). Recent NHS Digital data shows that large reductions in MHNs were most noticeable in inpatient settings from 2009-2022, which could be partly attributed to bed closures (NHS

Digital, 2022b). However, qualitative findings from this study suggest that the experiences of being a MHN, that influence intention to leave, differ across clinical settings. Whilst there are many experiences affecting intention to leave common to both inpatient and community settings, there are experiences that are unique to each type of setting influencing intention to leave, which may explain the difference in retention rates. These findings provide a good argument for taking the time to develop specific retention strategies for inpatient and community settings.

Higher intention to leave amongst inpatient MHNs may suggest that the negative cycle underpinning the model of intention to leave is more impactful within these settings. Findings from this study suggest that poor staffing is more detrimental to the experience of participating inpatient MHNs where the reliance on large teams with adequate experience, training, and skill mix is key to safe and quality direct care. There were several factors identified in this study unique to inpatient settings impacted by unsafe staffing levels such as the inability to work in line with policies and procedures, an increase in violence and aggression, and the need to work outside the limits of their competence. There are very limited solutions available to solve last minute staffing issues in inpatient settings with the responsibility to find solutions often being left with the MHN on shift, whilst trying to co-ordinate the direct care of the service users. These issues have a profound negative impact on the experience of being a MHN accelerating the rate at which MHNs become disillusioned with the profession and either migrate to community settings or leave the profession altogether. There is a lack of evidence pertaining to effect staffing levels have on service user's safety and care in mental health inpatient settings (NICE, 2015). However, it is evidenced in the literature that should safe staffing levels be prioritised, MHNs would perceive their workload to be conducive to providing safe and quality care increasing job satisfaction, thus improving retention (Long *et al*, 2023). The Mental Health Staffing framework provides guidance around workforce calculator tools that can help to plan and deliver safe staffing (NHS England, 2015), with many Trusts currently using the Mental Health Optimal Staffing Tool, commissioned by HEE, to measure acuity and inform evidence-based decision making around staffing (The Shelford Group, 2019). Future research should set out to explore the impact of staffing levels on service user safety and care in inpatient settings and evaluate the impact of any workforce calculator tools used.

Another factor affecting retention rates unique to inpatient settings identified in this study is the common misconception, sometimes perpetuated by senior leaders, that MHNs must start

their career in inpatient settings, despite new MHNs expressing a desire to move from inpatient settings and progress their career in the community (Durcan *et al*, 2021). This misconception accelerates disillusionment within the profession and generates inevitable constant loss of experienced nurses in inpatient settings leaving the most unwell services users constantly being cared for by the least skilled and experienced MHNs (Durcan *et al*, 2021). Senior leaders should move away from enticing all newly qualified MHNs into inpatient settings, regardless of their career ambitions, to cover the most extreme shortages. Instead, the focus of senior leaders and future research should be directed at making inpatient settings more attractive places to work and build fulfilling careers to improve retention of experienced MHNs in these areas.

It is important to note that this study focussed on inpatient and community settings on a broad scale. There are a huge range of clinical settings within these two types of settings, which offer different types of services and cater to different service user populations. These differences will influence the range of experiences/factors affecting retention of MHNs in individual clinical settings. Therefore, the factors identified within this study can be used to inform overarching retention strategies for inpatient and community settings, but they will need to be tailored to individual clinical settings to achieve the best retention outcomes. Future studies may want to focus on the influence of different services and patient populations on experiences/factors affecting MHNs' retention.

NHS Trust

This study found that significantly more respondents in Trust 1 are thinking about leaving their Trust and the mental health nursing profession than Trusts 2 and 3. These results were largely explained by experiences related to leadership and management that contribute to negative organisational cultures. MHNs who indicated they were intending on leaving their Trust cited a lack of visible and approachable leadership, and a management structure that lacks clarity. This lays a foundation for unreliable, unsupportive, and inconsistent work environments for nurses to manage their responsibilities including escalating concerns beyond line managers. MHNs also described working in poorly functioning services with difficult work environments and ineffective solutions from senior leaders and managers, often derived from an apparent lack of understanding of the current clinical pressures MHNs are facing. These findings add to the extensive evidence that visible and approachable leadership and management, that fosters regular open communication around the vision and goals of the organisation, is key to creating a safe and positive work environments necessary for retaining nurses of all disciplines

(Upenieks, 2003; Force, 2005; Duffield *et al*, 2011; Numminen *et al,* 2016; Zaheer *et al*, 2021). Senior leaders from Trust 3 demonstrated insight into the importance of improving their visibility at the frontline. To achieve this, the leadership team have committed to working regularly alongside clinical nurses to better understand and address the issues affecting retention. According to Benjamin and Chung's (2022) study, active participation, proactive engagement, and working in partnership with staff to solve problems described by senior leaders in Trust 3 is likely to elicit higher staff engagement and produce a continuous improvement culture that could generate more sustained workforce improvement initiatives.

Many MHNs intending on leaving their Trust in this study expressed frustrations over the management of their services. They described feeling embarrassed by working in underperforming services poorly rated by the CQC, with insufficient care models and pathways, that tolerate poor practice and lead to substandard care. Failing to address ineffective services and poor standards of care not only diminishes nurses' job satisfaction but could lead to an insidious culture whereby the consequences could lead to patient suffering (Francis, 2013). Many community MHNs in this study described feeling excluded from service development plans, which contributes to the development of unrealistic agendas and ineffective care models, as a reason to leave. These findings are consistent with those of Robinson *et al,* (2022) who found a significant positive correlation between nurses' involvement in improving health care services and retention in mental health NHS Trusts. Failure to include MHNs in decision making is a long-standing problem indicative of poor organisational cultures affecting retention globally and must be addressed (ICN, 2022).

Participating MHNs in both settings who value the importance of evidence-based psychological interventions, which are scarcely provided by their services, expressed dissatisfaction with the care and treatment they provide within their Trust. Inpatient nurses in particular described working in services predominantly based on the medical model that prioritise medicating service users over addressing underlying trauma. The medical model dominates the field of mental health and if this model does not align with MHNs beliefs around aetiology it may cause tensions over how to address people's mental distress in practice and restricts care and treatment choices (Carlyle *et al,* 2011). MHNs with these misaligning beliefs are at risk of becoming disillusioned with their role in mental health care and treatment, and are considering leaving the profession altogether. These findings suggest a need to incorporate more evidenced-based psychosocial interventions into all mental health settings to improve

service user care and treatment experience and outcomes, which will improve job satisfaction and prevent disillusionment. This supports the call for revolutionising mental health care, starting by addressing the disproportionate funding given to services based on the biomedical model of psychiatry (ICN, 2022), and offering alternative explanations of mental distress during MHN training and within current mental health services (Stickley & Timmons, 2007. In the meantime, Trust leaders and managers should be aiming to deliver innovative up-to-date evidenced-based care models in collaboration with MHNs, other professionals, and service users (Mental Health Taskforce, 2016). For inpatient services in particular, Trust leaders and managers should adhere to the recent guidance by NHS England for achieving effective care in adult and older adult acute mental health services (NHS England, 2023). To complement these care models, leaders and managers should also focus on how to expand the role of MHNs to support the provision of evidence-based practice, including psychological interventions, within their clinical settings (HEE, 2022).

Findings from this study illustrate that improving leadership and management will improve organisational cultures and help to develop high-quality services MHNs are proud to work within. This could prevent MHNs becoming disillusioned and contribute to their intention to stay in their clinical settings, Trust, and in turn, the profession. Strengthening leadership and management is firmly on the agenda of the NHS Long-Term Plan, People Plan, and the new NHS Long-Term Workforce Plan, with an aim to embed the right culture and provide frontline staff the required support to deliver effective care for service users (NHS, 2019a; NHS, 2020b; & NHS, 2023). There are several actions set out in the interim NHS people plan to achieve compassionate and inclusive cultures, such as developing a set of competencies, values, and behaviours, to provide consistent expectations and support to develop effective senior leaders (NHS, 2019b). Increasing access to structured training, such as the NHS Graduate Management Training Scheme and the NHS Leadership Academy, and making training compulsory, will be beneficial to ensuring the development of effective leadership and management skills (Jones *et al,* 2022). Alongside training it will be beneficial for senior leaders and managers to focus on understanding and developing their own leadership styles and behaviours. The literature suggests transformational leaders are highly effective in reducing turnover of nurses by inspiring positive and supportive organisational cultures and work environments that will mitigate factors leading to poor job satisfaction and retention (West *et al,* 2015; Jambawo, 2018; Alkarabsheh *et al,* 2022). Leaders and managers should also proactively address

concerns around poor practice including poor inappropriate and unacceptable behaviours to improve standards of care within their services (West *et al,* 2015).

Work-related stress and mental wellbeing

Over half (n=242, 61.7%) of the MHNs in this study reported having felt unwell with work-related stress in the last twelve months, with 42.9% (n=168) reporting below average mental wellbeing. These nurses indicated that they were significantly more likely to leave their organisation and the profession altogether. With nurse sickness rates of approximately 7.5% (NHS Digital, 2022a), addressing the poor wellbeing of nurses should be a priority of any workforce improvement strategy. Whilst some senior leaders in this study felt that they offer comprehensive wellbeing packages, others demonstrated insight into the need to address the root causes of nurses' wellbeing rather than reactive and temporary fixes. Previous research similarly suggests that effective strategies aimed at improving the mental wellbeing of MHNs will be preventative by addressing the risk and barriers to staff wellbeing in addition to promoting resilience programmes (Kinman *et al,* 2020; Foster *et al,* 2018).

Findings from this study demonstrate that mental health nursing is an emotionally intensive, challenging, and potentially high-risk profession whereby MHNs are frequently exposed to distressing and traumatic events. Factors such as providing poor-quality care, being exposed to risk behaviours (suicide, self-harm, and violence and aggression), and high workloads, have all been shown to negatively affect MHNs psychological wellbeing (Lee *et al,* 2014; Foster *et al,* 2018; Foster, 2019: Foster *et al,* 2020). MHNs in this study echoed these findings and shared how providing substandard care along with anxiety around risk management, due to excessive workloads, enormous waitlists, lack of training, insufficient staffing, and minimal support from leadership and management, is manifesting in imposter syndrome, moral distress, and work-related stress leading to overall poor mental wellbeing. To enable MHNs to feel safer at work it will be important to improve the management of risk incidents by providing more support for MHNs to proactively mitigate risks, particularly in acute inpatient settings (Hiebert *et al,* 2022), and improving support after risk incidents occur (Hilton *et al,* 2022). To help MHNs cope with workplace stressors it is important to draw attention to the wealth of research that supports introducing robust resilience strategies for MHNs to overcome and recover from workplace challenges, such as violence and aggression, to improve wellbeing (Foster *et al,* 2018; Foster *et al,* 2019; Delgado *et al,* 2019; Wood *et al,* 2019; Collard *et al,* 2020; Delgado *et al,* 2021; Foster *et al,* 2021). A study by Foster *et al* (2020) found that younger MHNs with

less experience reported substantially lower mental health suggesting the need to prioritise interventions for this group.

Findings from this study also show that certain factors within the work environment, such as negative team dynamics with insufficient skill mixes exacerbated by poor staffing, are key factors inhibiting MHNs within this study from maintaining a sense of safety and mental wellbeing. It is well established in the literature that negative team dynamics contribute to intention to leave within the MHN workforce (Jack *et al,* 2013; Cosgrave *et al,* 2015; Adams *et al,* 2021; Joseph *et al,* 2022). Senior leaders' perceptions within this study align with the existing literature, as they acknowledged that positive team dynamics can help improve the resilience of individual team members and enable nurses to cope with the challenges of their profession (Scanlan *et al,* 2018). To improve team dynamics in inpatient settings, some senior leaders plan to improve the skill mix by ensuring that there are more senior and experienced nurses on every shift. This will include ward managers and matrons regularly acting in a clinical capacity to demonstrate effective leadership and support junior nurses to manage complex clinical scenarios and cultivate positive team dynamics.

In addition to poor team dynamics, working hours consisting of large amounts of involuntary overtime, or working too many unsociable hours, are negatively impacting MHNs work-life balance and mental wellbeing in this study. Senior leaders perceived this to be a main reason MHNs leave permanent positions for bank and agency work where they can choose when and where they work. To reduce workplace stressors and improve work/life balance the NHS is committed to providing flexible working arrangements (NHS, 2019a; NHS, 2020b, NHS, 2023), with all NHS employees in England and Wales now having right to request flexible working from the outset of their employment (RCN, 2022c). It is important that senior leaders and managers create an organisational culture that supports flexibility and utilises the guidance provided to embed successful flexible working policies (NHS England, 2022b). Flexibility and choice are the key components to flexible working that improve wellbeing and retention, with current research suggesting the need to avoid compulsory extended shifts in acute mental health settings (Suter *et al,* 2020).

Younger nurses, lower staff grades, and less nursing experience.

Age, staff grade, and nursing experience were all significantly associated with intention to leave to some extent for MHNs in this study. Younger MHNs with less nursing experience

who are in lower bands (not in preceptorships) within this study are at the highest risk of leaving their current post, their Trust, and the profession altogether. This is in keeping with the Health Education England's (HEE) literature review on nurses leaving the NHS, which found turnover rates to be particularly high amongst newly qualified nurses in their first year of practice due to stress and burnout, with turnover rates remaining high or rising in their second year (HEE, 2014). Younger nurses aged 21-30 formed the largest proportion of nurses citing workplace pressure as a top three reason for leaving in the NMC's leavers survey 2022 (NMC, 2022). Being a newly qualified nurse is a time of extreme stress and pressure as they try to fulfil their new responsibilities and expectations as they transition from student nurse to registered nurse (HEE, 2022). Findings from this study demonstrate that MHNs intending on leaving are finding their responsibility to provide safe and effective care unmanageable within the context of their current working conditions. Alongside improving working conditions, these findings could suggest that increasing opportunities and access for mature students may be beneficial for retention (Adams *et al,* 2021). Future studies focussed on mature student MHNs in their first two years of practice are required form more robust conclusions.

Many younger MHNs in lower bands with less nursing experience in this study reported a lack of support from management and senior leaders with their clinical pressures, with particular emphasis on risk management. A lack of support from leadership and management features as a key factor affecting the retention of nurses within the literature (The Kings Fund, 2015; Adams *et al,* 2021; Marufu *et al*, 2021; Ball & Ejebu, 2021; Labrague *et al,* 2020; Joseph *et al,* 2022), with 45.2% of nurses citing insufficient managerial support as a reason they are considering leaving their current post in the RCN employment survey 2021 (RCN, 2021). Increased support from management and senior leaders will be particularly crucial for retaining junior MHNs (Joseph *et al,* 2022). Whilst senior leaders perceived poor support from middle management to significantly reduce retention, it will be important for senior leaders to understand the pressures and constraints affecting their ability to provide high-quality supportive management and leadership (Jones *et al,* 2022). Senior leaders will need to address some of the pressures and constraints and ensure managers have the time and support to develop the skills they need to successfully support their clinical teams and service users (Jones *et al,* 2022).

MHNs in this study who were dissatisfied with the quality of their preceptorships were considering leaving their clinical settings, and in some cases, the profession altogether.

Whereas MHNs who did feel supported in their preceptorships to manage the clinical pressures associated with becoming a registered MHN were intending on staying in their post. This confirms that good quality preceptorship programmes that support newly qualified MHNs as they transition from student nurses to registered nurses can improve the retention (Taylor *et al*, 2018; Aparicio & Nicholson, 2020). Senior leaders and managers, with the support of NHS England promised in the recent NHS workforce plan (NHS, 2023), should focus on implementing robust and meaningful preceptorship programmes recommended by the NMC (RCN, 2022a) following the National Preceptorship Framework for nursing (NHS England, 2022a) to reduce future loss in transition. It will also be important to consider extending support to MHNs second year of practice, as band 5 MHNs not in their preceptorship within this study indicated they are significantly more likely to think about leaving their organisation than all other bands. Senior leaders perceived rotational posts to positively influence retention of junior MHNs by allowing them to find their home within the organisation and reduce turnover. Therefore, senior leaders may want to consider adopting the Beyond Preceptorship framework (Capital Nurse, 2019) to help guide this process and retain nurses in their second year of practice and beyond. This framework recommends a set of common standards to support junior nurses to navigate career pathways and build fulfilling careers they are committed to.

This study identified that poor work environments including negative team dynamics, poor pay, and issues related to career progression, were negatively affecting the participating junior MHNs' experiences of being a MHN prompting disillusionment with the profession. MHNs in the lowest bands are often directly responsible for the care and safety of service users and receive the lowest pay. MHNs in this study who do not feel their pay matches their skills, experience, and responsibilities are considering leaving the profession. More experienced MHNs in lower bands in this study described being particularly frustrated about being financially capped at the top of their bands despite gaining more skills and experience. Moreover, inpatient nurses in this study described how they are often trapped by facing pay cuts when progressing to the next band up, due to needing to work more office-based hours reducing any financial enhancements associated with working unsociable hours. This is in keeping with the existing literature that demonstrates poor pay has been a longstanding factor affecting the retention of nurses of all disciplines around the world (Cowin, 2002; Newman & Maylor, 2002; Shaffer & Curtin, 2020; Bimpong *et al,* 2020; Adams *et al*, 2021, RCN, 2022b). Although, it is unlikely that increasing pay alone is enough to influence MHNs decisions to remain, pay matters and will be an important part of any retention strategy. Therefore, the

government should respond urgently to the current industrial action with a reasonable pay increase to improve recruitment, retention, and in turn, patient care and safety.

Ageing workforce

In addition to the younger nursing workforce, the ageing nursing workforce is also an increasing global concern with findings ways to prevent early retirement gaining popularity in nursing literature (Uthaman *et al*, 2016; Ryan *et al*, 2018, Fackler, 2019, Markowski *et al*, 2020, Buchan *et al*, 2020). A total of 42.9% of nurses who left the NMC register between January 2021 and December 2021 did so due to retirement, with MHNs making up the largest proportion (46.1%) of nurses citing retirement as their top reason for leaving (NMC, 2022). Significantly more MHNs working in community settings aged 51+ in this study indicated they would like to retire or take a career break, with 35.9% (n=47) of MHNs aged 51-65 considering taking early retirement. This finding is similar to the NMC leavers survey where a high proportion of respondents aged 51-60 citing retirement as a reason for leaving indicating a fair proportion taking early retirement (NMC, 2022). Like younger MHNs in this study, the literature documents that older nurses cite pressure, stress, unrealistic workload, and burnout as reasons behind the decision to retire (Duffield *et al*, 2014; Buchan *et al*, 2020; NMC, 2022). To combat this Buchan *et al* (2020) have developed a 10-point plan for supporting older nurses at work. Senior leaders of Mental Health Trusts will benefit from integrating the 10-point plan into a policy that can be tailored to individual MHNs to improve job satisfaction and retention. This includes recommendations such as introducing flexible working opportunities; job re-design to reduce heavy workload and stress; and supporting older nurses into mentor/preceptorship roles.

Training and development

Factors related to training and development were cited by MHNs in this study as reasons behind intention to leave by MHNs irrespective of age, experience, staff grade, Trust, and clinical setting. Insufficient CPD opportunities, lack of clinical supervision, inadequate in-service training clinical setting specific, and career progression pathways being some of the most significant factors influencing participating MHNs decisions to leave their clinical settings, Trusts, and the profession altogether. They described how without adequate supervision and CPD opportunities, they are having to work with uncertainty around the safety and quality of their practice. This reduces confidence and negatively affects MHNs wellbeing contributing to intention to leave. Insufficient CPD has previously been identified as well-established factor

affecting retention of nurses of all disciplines (Chan *et al,* 2013; Adams *et al,* 2021; Ball & Ourega-Zoe, 2021; Jackson & Manley, 2022), and is essential for the growth and development of the mental health nursing profession (HEE, 2022). Findings from this study support the need to enable MHNs more CPD opportunities to fulfil their clinical interests before they look beyond nursing to other career paths such as therapy (McCrae *et al,* 2014). Whilst the NHS Long Term Workforce Plan (NHS, 2023) has confirmed a £250 million investment into career development for registered nurses including CPD (NHS, 2019a), Trust leaders and managers should ensure MHNs have protected time to access CPD and training relevant to their clinical setting and specific to their needs (HEE, 2022).

MHNs in this study also cited a lack of overall opportunities to progress their career particularly if they did not want to pursue a career in management. Many senior leaders within this study demonstrated passion and commitment to investing in MHNs career development with many focussing on improving opportunities for MHNs to progress in a clinical capacity to improve retention. HEE (2022) recognises that career pathways for MHNs have been lacking and emphasise the need to develop more clear and concise career pathways as a priority to improve retention within the NHS. They recommend a continued focus on implementing ACP training posts, and the development of a clear pathway to nurse consultant and responsible/approved clinician roles. They state that clinical academic and implementation scientist roles must be developed in every mental health NHS Trust to provide alternative opportunities for MHNs to progress their careers, advance knowledge in the field of mental health, and influence policy and organisational change to improve service user outcomes. Thought must also be given to how information around these pathways, and how to access opportunities within them, will be communicated to MHNs from the outset of their careers. Future research should set out to evaluate these new roles to better understand the barriers and facilitators for embedding the roles in Trusts, and their impact on job satisfaction and service users care and safety.

Strengths and limitations

Strengths

The main strength of this study is its explanatory mixed methods design. The quantitative phase of the explanatory design allowed for examination around the scope of MHNs intention to leave or stay. The qualitative phase provided a detailed explanation of the quantitative results giving meaningful insight from which recommendations for change could be made. Therefore, the sequential explanatory mixed methods design was able to provide a deeper understanding

of the research problem from which stronger inferences could be drawn, than if either quantitative or qualitative methods were used in isolation (Wasti *et al,* 2022).

Another strength of this study was that the quantitative phase achieved the desired sample size. This allowed sufficient statistical power for more valid and generalised conclusions to be generated about the population under study (Singh & Masuku, 2014).

In addition, the qualitative MHN sample contained strong information power for developing new knowledge (Malterud *et al*, 2016). This was based on increasing the sample to compliment the broad aim, limited established theory and cross-case analysis; selecting participants with characteristics specific for the study (MHNs with high intent to leave or stay); and good quality interview dialogue consisting of clear and focussed communication generating lots of data relevant to the study (Malterud *et al,* 2015).

The study sample appeared to be largely female, from a white ethnic background, and between the ages of 21 and 65 years old. The demographic data appeared to be similar across the three included Trusts and comparable to the overall mental health workforce, with 77.36% of respondents to the NHS staff survey working within mental health Trusts in 2022 reporting they were female, 97.96% reporting they were aged between 21 and 65, and 82.75% reporting they were from a white ethnic background (NHS, 2022). The sample also appeared to be representative across other variables, for example, 122 (31.1%) of MHNs in my sample reported that they had a physical or mental health condition or illness expected to last for 12 months or more. This is comparable to the mental health workforce overall with 27.82% of all staff working within mental health Trusts in England, that responded to the NHS staff survey in 2022, reporting that they have a physical or mental health condition or illness expected to last for 12 months or more NHS (2022). Registered nurses were the occupational group with the largest proportion of respondents to the NHS staff survey for mental health Trusts in 2022 (29.86%). This suggests that my sample is likely to be representative of the overall mental health workforce, mental health nursing workforce, and the workforce within the participating Trusts.

Limitations

The first limitation to note was the sampling methods used to obtain the samples for both phases of the study. Convenience sampling was used within Trust 3 to recruit for the quantitative phase

of the study and purposeful sampling was used recruit all participants for the qualitative phase. Convenience and purposeful sampling methods do not impact on the internal validity of this study, but they do limit the external validity meaning that the findings can only be generalised to the population from which the sample was selected (Andrade, 2021). However, due to the range of Trusts included in the study, the representativeness of the sample, and similarities between the study findings and the existing literature, many of the findings from this study may be applicable to MHNs in other NHS Trusts. Therefore, these findings may cautiously be generalised to other Mental Health Trusts in the English NHS.

It is also important to note that the response rates for each of the individual Trusts were low. Low response rates can decrease the likelihood of a representative sample by increasing the possibility of non-response bias, which poses a threat to the generalisability of the results (Burkell, 2003). However, response rates alone do not always mean the sample is of low quality (Holtom *et al,* 2022), and should not render results as uninformative (Meterko *et al,* 2015).

In addition, the sample size did not achieve large enough numbers in all specific clinical settings. Therefore, clinical settings were collapsed into three broader types of settings (community, inpatient, and other) to allow for meaningful statistical analysis. As a result, this study was not able to identify differences across more specific inpatient and community settings. Despite collapsing some categories there were still some smaller than expected frequencies in some cells limiting power for detecting smaller differences using post-hoc tests (Van Voorhis & Morgan, 2007). Furthermore, the Bonferroni method is a conservative method, which can also inflate the risk of a type two error (failure to detect a real difference) (Lee & Lee, 2018).

Within the qualitative phase, the interviews with senior leaders were susceptible to social desirability response bias, tainted by their own agendas, due to their position and responsibility related to the research problem. At times, their responses felt like prepared political type responses trying to make a favourable impression, rather than their own authentic perceptions and experiences related to the research problem. Social desirability response bias can negatively impact on the study's rigor by leading the researcher to weaker conclusions for the sample and research phenomenon (Junior Bishop, 2022). Moreover, this often led to participants' responses often drifting far from the question asked and required a lot of redirection back to the original topic under study. For example, recruitment was not the focal

point of this study and there were no interview questions pertaining to recruitment, yet there was a continuous need to redirect responses away from efforts around recruitment and back to retention. This has implications for the information power of the senior leader sample as they generated less information specific to the study aim.

A final note to consider is that the study was conducted during the initial phases of the global pandemic. Therefore, although the mean SWEMWBS score for the MHNs in this study is significantly lower than the population norms, MHNs in this study completed the SWEMWBS in the context of the global pandemic. For example, a large portion of nurses reported feeling close to other people some of the time (37%) and often (29.3%), but 24.2% reported that they rarely feel close to other people. This may have been influenced by the national lockdowns preventing people from seeing their anybody outside of their household for long periods at the time the study was conducted. Therefore, these results are tentative and should be treated with caution. The qualitative findings show that the pandemic mainly exacerbated existing factors that affect retention through absence of even more staff due to sickness, isolation, and shielding policies. The development of vaccines, subsequent changes in social isolation rules and policies at work may resolve some of the challenges introduced by the pandemic and improve mental wellbeing.

Conclusion

With large numbers of MHNs within this study intending on leaving their current post, organisation, and the profession, substantial investment in the retention of mental health nurses including increased funding from the government and individual Trusts is non-negotiable. This study has provided valuable context behind MHNs intentions to leave that can be used to inform policy and tailor retention strategies. To succeed, retention will need to be the sole priority of a senior leadership position within each Mental Health NHS Trust to identify the factors affecting nurses within their Trust, develop an overarching retention strategy, and lead and evaluate its implementation. The theoretical model illustrating the process of intention to leave for MHNs suggests that it is unlikely that addressing any factor in isolation will achieve meaningful outcomes for retention. Therefore, effective retention strategies will include multiple linked policies aimed at improving leadership and management, training and development, and work environments for MHNs. It will be important when designing policies to pay attention to the commonalities and differences in factors experienced in different clinical settings to create more targeted interventions generating more beneficial outcomes.

Recommendations for practice

Improving retention of the mental health nursing workforce is going to be big undertaking. Therefore, retention should now be made the sole priority of a senior leadership position within every Mental Health NHS Trust. The retention lead will need to hold regular consultations with clinical nurses focussing on high-risk groups, and pay attention to staff surveys and exit interviews, to identify the factors affecting retention using the model of intention to leave. They will then need to adopt the relevant recommendations targeting the three key areas identified in the model of intention to leave. Recommendations will need to be adapted to cater to the differences in clinical settings to inform policy and create a tailored retention strategy. The retention lead will need to work closely with line managers who will be key to the successful implementation and evaluation of the majority of policies within the overarching strategy to improve retention of frontline MHNs.

Leadership and management

- Senior leaders should improve visibility and approachability of the senior leadership team by increasing meaningful engagement with frontline clinical teams to promote and embed a compassionate, inclusive, and values-based culture. Senior leaders and managers may wish to regularly act in a clinical capacity, where possible, to maintain relevant clinical experience and provide a better understanding of the current issues MHNs are facing.

- Senior leaders should provide more clarity around senior leaders' roles and responsibilities. This is particularly important when there are several changes within senior leadership teams. Senior leaders should ensure there is an up-to-date organisational structure situated in each clinical setting that details the names, roles, and responsibilities of all senior leaders. Each clinical setting should display their own up-to-date management structure detailing the names, roles, and responsibilities of each layer of middle management.

- Senior leaders should improve lines of communication to MHNs. Many senior leaders discussed several initiatives and opportunities but were unable to describe how information around these initiatives and opportunities is made accessible to MHNs.

Filtering important information about initiatives and opportunities aimed at retaining MHNs may be best filtered through line managers during PDRs, alongside indirect forms of communication such as email, websites, and social media.

- Senior leaders and team managers should increase support around risk management with a particular focus on promptly addressing risk management concerns raised by MHNs and supporting them to develop satisfactory risk management plans. Senior leaders and team managers should also improve debriefs and psychological support for MHNs post risk incidents.

- Senior leaders should improve the quality of services by including MHNs in service development plans to implement appropriate care models that allow nurses to deliver effective care and treatment.

- NHS England and senior leaders should increase access to, and strongly encourage, training and development for leaders and managers at all levels. Leadership programmes aimed at delivering the NHS people plan and our People Promise can be accessed through the NHS Leadership Academy https://www.leadershipacademy.nhs.uk/programmes/

- Service managers should support MHNs to tackle unmanageable workloads by working in partnership with MHNs to find appropriate solutions. This should be done with an aim to reduce or outsource administration and non-clinical tasks, to find more time for MHNs to spend meaningful time with service users delivering nursing interventions and build relational security.

- Team managers should improve PDRs/line management to include wellbeing, career development, and intention to leave/stay conversations with associated action plans.

- Senior leaders and team managers should improve the quality and consistency of exit interviews. Consider a policy whereby immediate line managers must inform the senior leader next in-line to offer them the opportunity to intervene.

- Team managers should introduce regular stay interviews which can be used to evaluate the risks or benefits of any new changes implemented.

Training and development

- Senior leaders should improve the quality of local inductions to create a good first impression. They should ensure new starters are introduced to members of the senior leadership team who emulate the Trust values and reinforce a positive organisational culture from the outset.

- Policy makers, senior leaders, and managers should improve the quality of preceptorships in line with the National Preceptorship Framework. Consider extending support for newly qualified nurses in their second year of practice using the Beyond Preceptorship Framework toolkit of resources - https://www.hee.nhs.uk/sites/default/files/documents/CapitalNurse%20Beyond%20Preceptorship%20Toolkit%20of%20Resources.pdf.

- Policy makers should develop clear and concise career pathways to Advance Clinical Practitioner, Nurse Consultant, Responsible/Approved Clinician, Clinical academic, and Implementation Scientist roles.

- NHS England, senior leaders, and team managers should improve access to CPD and in-service training opportunities. CPD and in-service training should be specific to MHNs clinical settings so they can implement new skills directly into their practice to improve care and treatment.

- Policy makers and nurse educators should increase access to training in evidence-based psychological interventions. Nurse educators could consider introducing an optional 4th year for MHNs to undergo standardised training to deliver psychological interventions.

- Ensure MHNs have regular protected time to engage in clinical supervision to develop, and reflect on, their practice. Consider introducing resilience building programmes that can be incorporated into clinical supervision or reflective practice (Forster *et al*, 2018).

Work environment

- Team managers must take the time to facilitate positive team dynamics. Ensure there is a clear leadership structure within individual teams with clear roles and responsibilities. Encourage ward managers and matrons to regularly act in a clinical capacity where possible to improve skill mix, role model best practice, and cultivate positive team dynamics.

- Senior leaders and managers should minimise the use of agency staff where possible and promote block booking for bank staff to act as effective and reliable team members reducing the negative consequences of excessive transiency on team dynamics.

- Senior leaders should create an organisational culture that promotes flexible working within reason. Allowing MHNs in both settings autonomy over their working patterns and trusting them to deliver good clinical outcomes will improve work-life balance. For community nurses, hybrid systems that allow choice around working in the home or office environment where possible should be promoted.

- Senior leaders should proactively invest in the development of MHNs by building in progression posts to career pathways. This will help to prevent MHNs leaving for agencies for financial increases by being able to visualise pay and developmental progression.

- There were mixed perceptions regarding retention bonuses. However, it may be worth offering retention bonuses up to a year for services with the highest turnover. This year will provide the time for MHNs to benefit from the implementation of additional recommendations aimed at encouraging intention to stay there after.

- Senior leaders and managers should ensure physical working environments are safe, therapeutic, and conducive to a high standard of care and treatment.

Dissemination

Dissemination within the academic community will be achieved by publishing the thesis in its entirety to the White Rose thesis repository; and via publication in a peer-reviewed journal such as the International Journal of Mental Health Nursing. Beyond publication I aim to present the findings of this study at the International Mental Health Nursing Research Conference in

2024. I also aim to produce a visual story of the findings using Nifty Fox Creative (https://www.niftyfoxcreative.com/about) to present the findings in a simple and creative way to drive impact and engage lay, policy, and funding audiences pending funding. The visual story will be shared via social media (Twitter) and will be sent to all the MHNs and senior leaders who participated in the study.

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Appendix A – Examples of search strategies.

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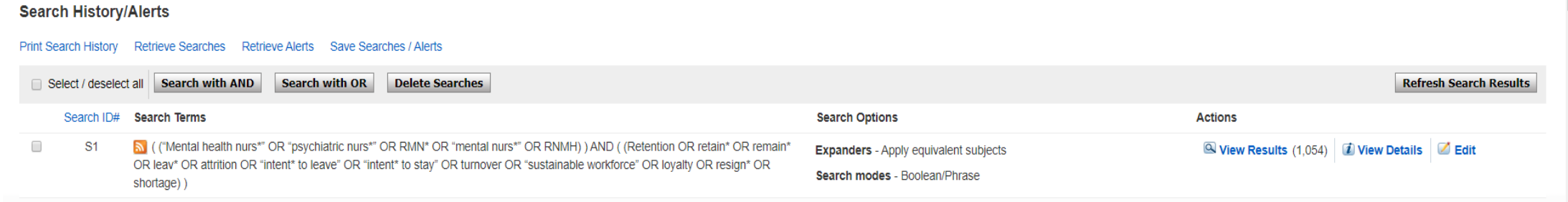

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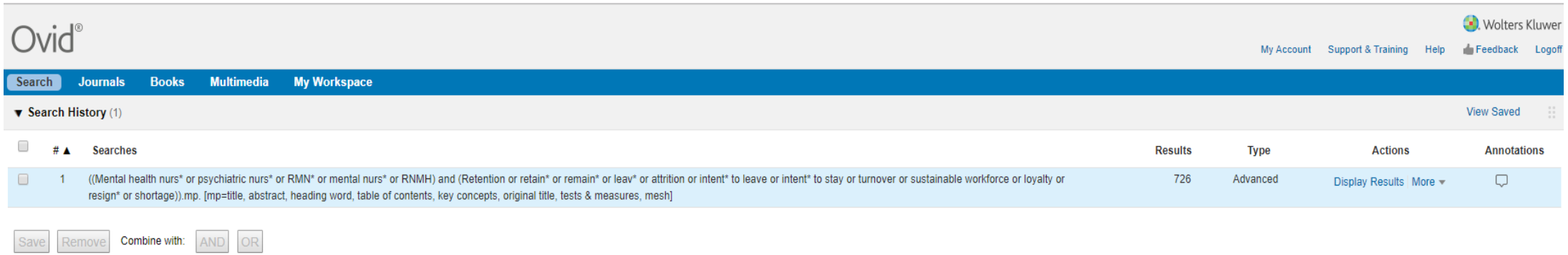

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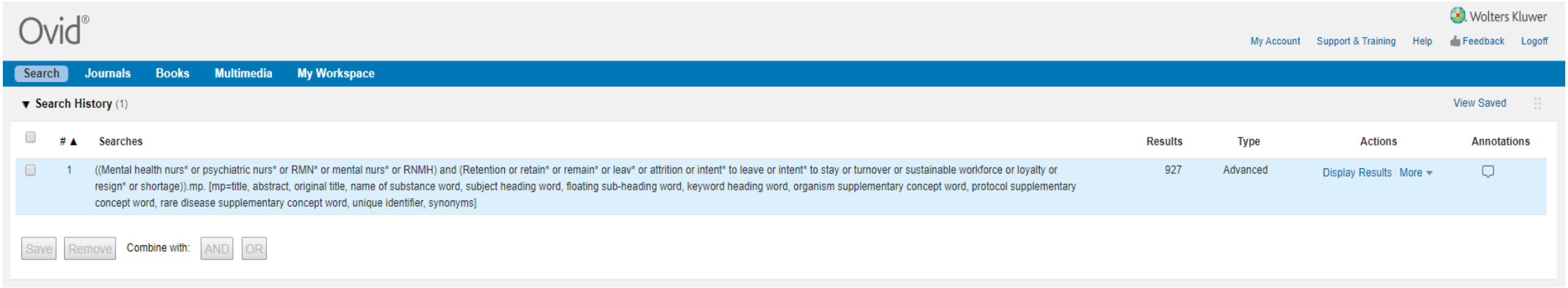

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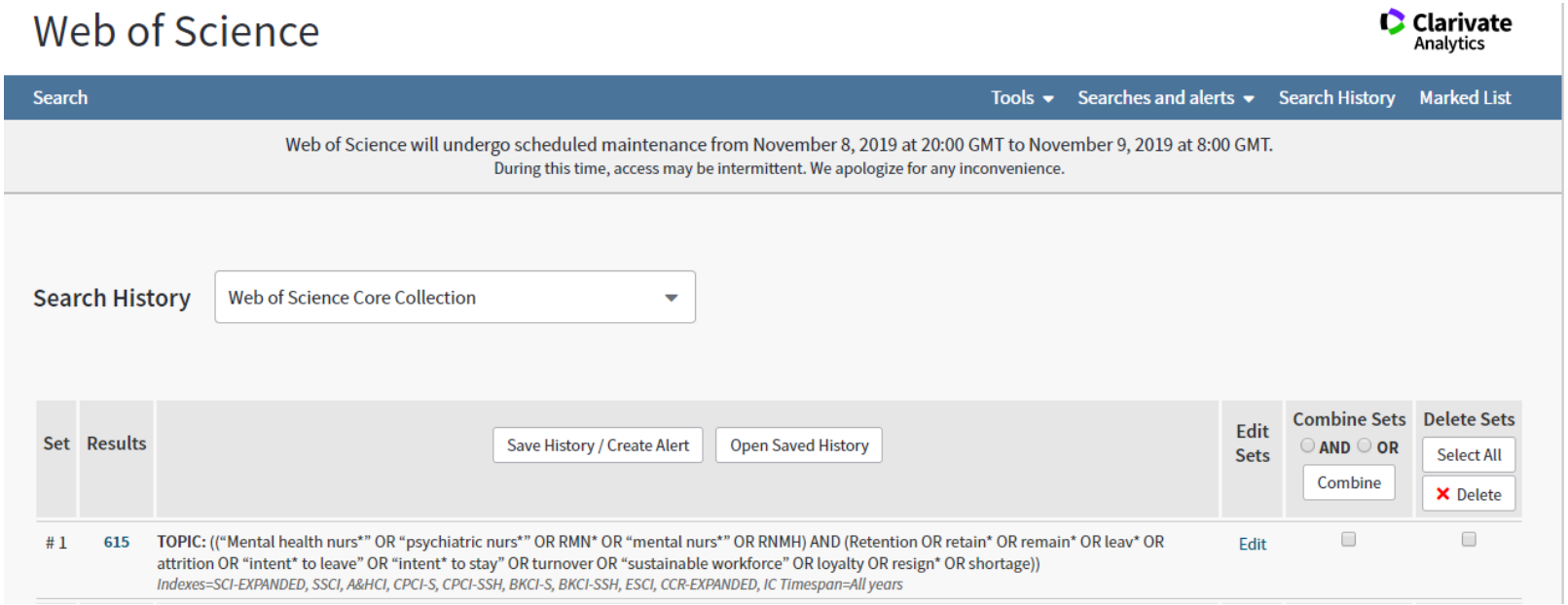

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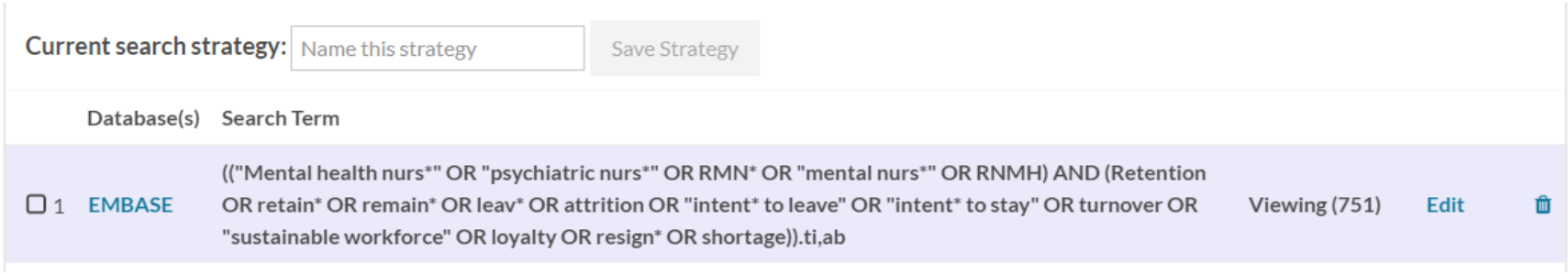
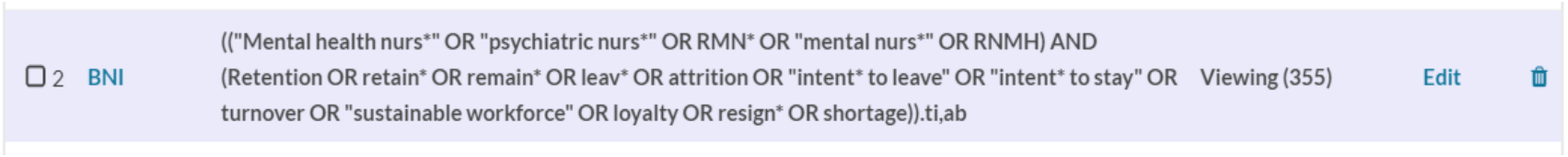


BNI 07/11/2019:



Appendix B – Data extraction form

Authors	Year	Title	Study deign	Country	Setting	Aims	Research question	Ethical approval

Sample and sample size	Recruitment strategy	Data collected	Data collection method	Response rate	Data analysis method	Intervention	Outcome measures	Results/findings

Age	Gender	Qualifications/training	Years' experience	Marital status

Appendix C – Data transformation table

If textual data was provided by the author of the studies to supplement their statistical analysis these statements were taken verbatim to keep the findings as close to the original data as possible. Where there was no textual data I 'qualitised' the quantitative data by writing a narrative of the quantitative results to change the data into qualitative form. It is also important to note that there is variation within the aims of the included studies, therefore, some provided more findings on factors that affect retention than others. Some studies include other health care professionals therefore these studies generated less results pertaining to nurses required for this review, but important, nonetheless. The Qualitised data will be 'copy and pasted' verbatim in to Quirkos alongside the data from the qualitative studies ready for the thematic analysis process to begin.

Authors	Verbatim quantitative results relating to factors that affect retention	Qualitised data.
Alsaraireh *et al* (2014)	"The Pearson correlation between job satisfaction and turnover intention was r = −0.796 (P < 0.01). Job satisfaction was very strongly negatively correlated to turnover intention" (Alsaraireh *et al*, 2014, pp.462-464).	As job satisfaction increases turnover intention decreases.
	"Male participants (mean = 12.11, SD = 3.31) scored significantly higher than the female participants ((mean = 9.83, SD = 2.92), t (152) = 4.54, P = 0.000) on turnover intention" (Alsaraireh *et al*, 2014, pp.462-464).	Male nurses had significantly higher turnover intention than female nurses.
	"There was a significant difference in turnover intention; single participants (mean = 11.81, SD = 3.23) scored significantly higher than married participants ((mean = 10.20, SD = 3.20), t (152) = 3.072, P = 0.003). Participants with a bachelor degree (mean = 13.25, SD = 3.19) scored significantly higher than participants with an associate degree ((mean = 10.34, SD = 3.09), t (152) = −4.477, P = 0.000). There was no statistically-significant difference between two conditions (day shift and evening shift, t (152) = −1.963, P = 0.052)" (Alsaraireh *et al*, 2014, pp.462-464).	Nurses with single status had significantly higher turnover intentions than those who were married. Nurses with a bachelor degree had significantly higher turnover intentions than those with an associate degree. Shift times did not have a significant impact on turnover intention.
	"Acute male units showed the highest score for turnover intention (mean = 12.16, SD = 3.42), while long-term female units showed the lowest score (mean = 9.77, SD = 2.65). There was a significant	Nurses working in acute male units had the highest turnover intention in comparison to nurses

	difference in turnover intention between acute male and female units (mean = 12.16, SD = 3.42 and mean = 9.85, SD = 3.16, respectively; P = 0.017); acute male units showed higher turnover intention. There was also a significant difference in turnover intention between acute male and long-term female units (mean = 12.16, SD = 3.42, and mean = 9.77, SD = 2.65, respectively; P = 0.010); acute male units showed higher turnover intention" (Alsaraireh *et al*, 2014, pp.462-464). "There was no significant difference in turnover intention between acute male and long-term male units (mean = 12.16, SD = 3.42 and mean = 12.00, SD = 3.28, respectively). There was a significant difference in turnover intention between the long-term male and acute female units (mean = 12.00, SD = 3.28 and mean = 9.85, SD = 3.16, respectively; P = 0.038); long- term male units showed higher turnover intention. There was also a significant difference in turnover intention between the long-term male and female units (mean = 12.00, SD = 3.28 and mean = 9.77, SD = 2.65, respectively; P = 0.024); long-term male units showed higher turnover intention. There was no significant difference in turnover intention between acute female and long-term female units (mean = 9.85, SD = 3.16 and mean = 9.77, SD = 2.65), respectively" (Alsaraireh *et al*, 2014, pp.462-464). "Turnover intention was significantly and negatively correlated with age (r = −0.467, P = 0.01); turnover intention was significantly and strongly negatively correlated with experience (r = −0.564, P = 0.01); and turnover intention was significantly and strongly negatively correlated with satisfaction with salary (r = −0.689, P = 0.01)" (Alsaraireh *et al*, 2014, pp.462-464).	working in the long-term female units which had the lowest. Nurses working in male acute units showed significantly higher turnover intentions than those working in female acute and long-term units. Nurses working in long-term male units showed significantly higher turnover intentions than those working acute and long-term female units. There was no significant difference in turnover intentions among those working in acute male and long-term male units, and acute female and long-term female units. As age, experience, satisfaction and salary increases turnover intention decreased.
Jiang *et al* (2019)	"Male nurses were more likely to have an intention to leave than female nurses (odds ratio [95% confidence interval]: 1.879 [1.605 to 2.199]). Compared to those with poor health status, those reporting fair and good health status had a significantly lower likelihood of reporting an intention to leave (0.512 [0.446 to 0.587] for fair status, 0.373 [0.308 to 0.452] for good status). Nurses who had worked more than 20 years were less likely to have an intention to leave compared to those working less than 5 years (0.479 [0.389 to 0.590]; those working 5 to 9 years (1.106 [0.933 to 1.312]) and those working 10 to 20 years (0.958 [0.804 to 1.142]) showed no significant difference. Monthly income level was inversely associated with intention to leave (0.826 [0.697 to 0.978]. Working more than 40 hours per week and having experienced patient-initiated violence were associated with an increased likelihood of intending to leave (1.584 [1.374 to 1.825], 1.566 [1.376 to 1.781]). Nurses satisfied with the respect they receive from patients, the physician-nurse	"All individual characteristics, job-related factors, and job satisfaction were significantly associated with an intention to leave. Nurses of male gender, single status, a higher level of education, working more than 40 hours per week and experiencing patient-initiated violence were more likely to have an intention to leave. Nurses who were older, had better self-rated health, a higher professional title, more years employed, a higher average monthly income, who were more satisfied with the amount of patient respect, social recognition, physician-nurse coordination and trust, and who were overall

	coordination, and their jobs had a lower odds of reporting an intention to leave (0.727 [0.623 to 0.849], 0.549 [0.480 to 0.629], 0.355 [0.2885-0.438], respectively)" (Jiang *et al,* 2019, pp.162-163).	satisfied with their job were more likely to be stayers in their current position (Jiang *et al,* 2019, pp.162-163)".
Agyapong *et al* (2015)	"Only 12 (16.2%) of CMHOs, 1 (5.3%) CPO and 20 (28.2%) of CPNs reported they had considered leaving the mental health profession because of the stigma" (Agyapong *et al,* 2015, pp.5-8). "16 (21.6%) CMHOs, 4 (22.1%) CPOs and 38 (53.5%) CPNs said they had considered leaving the mental health profession because of concerns about risk" (Agyapong *et al,* 2015, pp.5-8). "Consistent with this, 33 (43.2%) CMHOs, 7 (36.8%) CPOs and 37 (52.1%) CPNs said they will probably leave the mental health profession if they find a better paying job in other sectors of the economy" (Agyapong *et al,* 2015, pp.5-8).	Twenty CPNs had considered leaving the mental health nursing profession because of stigma. Over half of the CPNs had considered leaving the profession due to concerns about risk. Over half of the CPNs reported that they are likely to leave the profession if they find a higher paying job elsewhere.
Walrath (2011)	"Supervisor leadership and communication was positive significantly correlated (r = .76, p = .00) with nurse job satisfaction (see Table 18). Supervisor leadership and communication was inverse significantly correlated with nurses intent to leave (r = -.45, p = .04)" (Walrath, 2011, p.95).	"Significantly high levels of supervisor leadership and communication were associated with high job satisfaction and retention; and low leadership and communication was significantly correlated with low job satisfaction and retention" (Walrath, 2011, p.95).
Rollins (2014)	"During the three months pre-intervention, the mean retention rate was 51.9%, as compared to the three month post-intervention rate of 87.0%, thus identifying an increase in retention rates (see Table 2). According to SPSS, p= .012 for length of employment in those trained on the new versus old training. An independent samples t-test revealed that the average retention rate for nurses trained on the old versus new trainings did differ significantly for old training (M=7.31, SD=2.553) to new training (M=3.15, SD=1.833), t (56.801) =8.333, p=.000 Consequently, the researcher rejected the null hypothesis and identified a difference" (Rollins, 2014, pp.35-39). "Statistical analysis shows that preintervention retention rates were 40-72.7% variably and post intervention retention rates have improved to 72-100% at three months post- intervention thus showing a significant difference in the 2 training groups (p=.012)" (Rollins, 2014, pp.35-39).	The new Healthy Work Environment Orientation Training increased retention rates significantly, and there were no significant differences in those still working in the organization and those that had left.

	"According to SPSS, p = .220, which is > .05 for length of employment in retained nurses. The alternate hypothesis stated that there was a difference in nurses who remained employed with the organization and those who left. However, the independent samples t- test revealed differences in those still working (M = 5.55, SD = 2.879) versus no longer working (M = 3.58, SD = 2.705), t (95) = -3.177, p = .002 (see table 6)" (Rollins, 2014, pp.35-39).	
Ito *et al* (2001)	"Nurses who intended to leave their job were significantly more likely to feel that they had other opportunities elsewhere (Kendall's tau b=–.063, p=.005) and reported fewer previous job changes (Kendall's tau b=–.147, p<.001). Nurses who had supervisory support were significantly less likely to say they intended to leave than those who did not have support (Kendall's tau b=–.163, p<.001)" (Ito *et al,* 2001, p.233). "On average, the nurses who intended to leave their job were significantly younger than those who did not (mean±SD, 35.8±11.4 versus 41.9± 12.3; t=9.9, df=1,492, p<.001). Time in current job was significantly longer among those intending to stay (mean=6 years; third quartile minus first quartile, Q3–Q1=9 years) than among those intending to leave their job (mean=5 years; Q3–Q1=7 years; z=3.1, p=.002)" (Ito *et al,* 2001, p.233). "Although we examined the patient- to-staff ratio and stress level as organizational and personal factors, respectively, we found no significant differences in these measures between respondents intending to leave and those intending to stay" (Ito *et al,* 2001, p.233). "Younger age, fewer previous job changes, less supervisory support, lower job satisfaction, and higher perceived risk of assault were significant predictors of nurses' intention to leave their job" (Ito *et al,* 2001, p.233).	"Nurses who intended to leave their job were significantly more likely to feel that they had other opportunities elsewhere and reported fewer previous job changes" (Ito *et al,* 2001, p.233). "On average, the nurses who intended to leave their job were significantly younger than those who did not. Time in current job was significantly longer among those intending to stay than among those intending to leave their job" (Ito *et al,* 2001, p.233). "Younger age, fewer previous job changes, less supervisory support, lower job satisfaction, and higher perceived risk of assault were significant predictors of nurses' intention to leave their job"(Ito *et al,* 2001, p.233).
Murrells & Robinson (1999)	"In the first question respondents were presented with four options and asked which one most closely described what they planned to do immediately after qualifying. The options and the proportion selecting each were as follows: obtain a post as a psychiatric nurse in the NHS (73%, 328); obtain a non-NHS post which used knowledge and skills gained during the RMN course (20%, 89); obtain a post not related to the RMN course (3%,15); not take up paid employment (2%, 11)" (Murrells & Robinson, 1999, pp.62-65). "The first group of respondents, comprising just over a third (36%) of the cohort as a whole, could be described as `stayers' in that they planned to obtain a psychiatric nursing post in the NHS and	

	remain in such posts for the foreseeable future. The next four groups of respondents, a total of 49% of the cohort, all expressed uncertainty in some way. Either they planned to obtain an NHS psychiatric post but uncertain as to how long they would stay in the NHS (28%) or to pursue an activity outside the NHS, at the outset, but with the proviso that they might return. The final four groups of respondents (13% of the cohort) were classified together as `leavers' ± some planned to leave the NHS after a while, whereas others were not intending to seek an NHS post in the immediate or longer term future" (Murrells & Robinson, 1999, pp.62-65). "Each independent variable was first examined separately for a significant association with the dependent variable, i.e. plans to stay in the NHS" (Murrells & Robinson, 1999, pp.62-65). "Age had a significant association with the dependent variable (c 2=9.60, 2 df, p<0.01). The mean age of stayers was 30.4 and this compares with 29.0 for the `uncertains' and 27.8 for the `leavers' . Course preparation was also significantly associated (c 2=11.60, 1 df, p<0.001). The mean overall scores for stayers were 9.0, 8.3 for uncertains and 7.5 for leavers. None of the other independent variables were associated with plans to stay in the NHS" (Murrells & Robinson, 1999, pp.62-65). "The parameter estimates for age (0.32 and -0.0041) for linear and quadratic components, respectively, and adequacy of course preparation (0.096) suggest that respondents in their mid- to late thirties or early forties who are well prepared are the group most likely to be planning to stay in psychiatric nursing in the NHS" (Murrells & Robinson, 1999, pp.62-65).	Age and course preparation were significant factors associated with plans to stay in the NHS.
Bamber (1991)	"Overall level of job satisfaction: Leavers were found to be significantly more dissatisfied on overall job satisfaction that the stayers' group (t = - 1.95 with 80 degrees of freedom, significant at 0.05 level)" (Bamber, 1991, p.10). "Quality of decision-making: Leavers were found to be significantly more dissatisfied with the perceived 'quality' of decisions being made by those in managerial positions than were stayers (t = - 2.62 with 80 degrees of freedom, significant at 0.01 level)" (Bamber, 1991, p.10). "In-service training: Leavers were significantly more dissatisfied with the amount of in-service training offered than were stayers (t = - 1.98 with 80 degrees of freedom, significant at 0.05 level).	Leavers (nurses who had left their jobs within the studies two-year follow up) showed significantly lower job satisfaction than the stayers (those still in their jobs). "Leavers were found to be significantly more dissatisfied with the perceived 'quality' of decisions being made by those in managerial positions than were stayers" (Bamber, 1991, p.10).

	Physical working conditions: Leavers were significantly more dissatisfied with their physical working conditions than stayers (t = - 2.92 with 80 degrees of freedom significant at 0.01 level). Burnout: Leavers scored significantly higher on the burnout scale than did stayers (t = - 2.68 with 80 degrees of freedom, significant at 0.01 level) Personality: Using the Framingham Type A personality scale, leavers were found significantly more likely to be Type A personality than stayers (t = - 2.35 with 80 degrees of freedom, significant at 0.02 level) Mobility: Leavers were significantly more 'mobile' than stayers (t = - 3.31 with 80 degrees of freedom, significant at 0.001 level), that is, younger, less experienced and more highly qualified" (Bamber, 1991, p.10).	"Leavers were significantly more dissatisfied with the amount of in-service training offered than were stayers" (Bamber, 1991, p.10). "Leavers were significantly more dissatisfied with their physical working conditions than stayers" (Bamber, 1991, p.10). "Leavers scored significantly higher on the burnout scale than did stayers" (Bamber, 1991, p.10). "Using the Framingham Type A personality scale, leavers were found significantly more likely to be Type A personality than stayers" (Bamber, 1991, p.10) Leavers were younger, less experienced, and more highly qualified than stayers.
Robinson & Tingle (2003)	Satisfaction with opportunities for continuing education in first job "All those with a first job were asked to rate their satisfaction with various aspects of this job: working conditions, providing care, working relationships, reflection on practice and CPD (34 aspects in total). Respondents were then asked whether dissatisfaction with one or more of these aspects had impacted on decisions to stay in this job. A third (33%, 141) of those with a first job said dissatisfaction with one or more of these aspects had been sufficient to cause them to leave, or consider leaving, this job. What is important from the perspective of CPD is the extent to which opportunities for continuing education featured in diplomates' deliberations. Lack of opportunities to start courses other than study days was the third most frequently cited source of dissatisfaction (33 diplomates accounting for 8% of the cohort). Lack of opportunities to attend study days was joint 8th (26 diplomates accounting for 6% of the cohort). Thirty diplomates had left their first job	A third of the nurses in the study with a first job reported one or more of the following aspects had caused them to leave or consider leaving their job: working conditions, providing care, working relationships, reflection on practice and CPD. Thirty of the nurses had left their first job within 6 months and twelve of these nurses reported that lack of opportunities to go on study days was an important reason that contributed to their decision

	within 6 months after qualifying. When asked to rate the importance of 32 separate reasons in their decision to do so, lack of opportunities to go on study days was regarded as important by 12 and lack of opportunities to go on courses other than study days as important by 13. Although these are early days in these diplomates' careers, dissatisfaction over continuing education opportunities is already emerging for a small proportion and for some is a reason in decisions to leave, or considering leaving, a job" (Robinson & Tingle, 2003, p.665).	to leave, and thirteen reported that lack of opportunities to go on courses was an important reason that contributed to their decision. "Although these are early days in these diplomates' careers, dissatisfaction over continuing education opportunities is already emerging for a small proportion and for some is a reason in decisions to leave, or considering leaving, a job" (Robinson & Tingle, 2003, p.665).
Sherring & Knight (2009)	"Mean emotional exhaustion scores were higher in those who were considering leaving their job (M=29.80, SD=11.23) than those who were not (M=15.11, SD=9.56).This difference was significant (t=8.64; P<0.005). The magnitude of difference in mean scores was large. The effect size, calculated by eta squared, was 0.31" (Sherring & Knight, 2009, pp.1236-1239). "There was also a significant difference in the depersonalization scores between those who were considering leaving their job (M=5.98, SD=5.05) and those who were not (M=3.65, SD=4.03; t=3.17), at the P<0.05 level. The magnitude of the difference was moderate. The effect size, calculated by eta squared, was 0.06" (Sherring & Knight, 2009, pp.1236-1239). "The proportion of the sample considering leaving the NHS was 17.1%. There was a significant difference in emotional exhaustion scores between those who were considering leaving the NHS (M=32.11, SD=11.58) and those who were not (M=17.01, SD=10.66). This was significant (t=6.72; P<0.005). The magnitude of the difference was large. The effect size, calculated by eta squared, was 0.22" (Sherring & Knight, 2009, pp.1236-1239).	"The results suggest that participants considering leaving their jobs had higher levels of emotional exhaustion and depersonalization and that those with higher levels of emotional exhaustion were more likely to be considering leaving the NHS" (Sherring & Knight, 2009, pp.1236-1239).
Yanchus *et al* (2017)	"Job satisfaction and supervisory support both displayed the expected negative relationship with turnover intention. Emotional exhaustion was positively related to turnover intention, as expected. Civility and supervisory support both directly impacted job satisfaction, as expected, and indirectly impacted turnover intention and turnover plans via job satisfaction. Job satisfaction was negatively	"Job satisfaction and supervisory support both displayed the expected negative relationship with turnover intention. Emotional exhaustion was positively related to turnover intention, as

	related to turnover plans, whereas turnover intention was positively related to it. Finally, job satisfaction was negatively related to emotional exhaustion" (Yanchus *et al,* 2017, p.49).	expected. Civility and supervisory support both directly impacted job satisfaction, as expected, and indirectly impacted turnover intention and turnover plans via job satisfaction. Job satisfaction was negatively related to turnover plans, whereas turnover intention was positively related to it. Finally, job satisfaction was negatively related to emotional exhaustion" (Yanchus *et al,* 2017, p.49).
Robinson *et al* (2005)	"Reasons for remaining in their first job most likely to be rated as 'very important' or 'quite important' related to: consolidation of skills (having more to learn, 87%); job security (feeling the job was secure (79%) and having a permanent contract (73%)); and good working relationships (with staff on the same grade (80%), staff on lower grades (83%), and working as part of a good team (84%))" (Robinson *et al,* 2005, pp.235-238). "For each aspect of first job, information was sought as to whether dissatisfaction was sufficient to cause diplomates to leave, or consider leaving, this job (Table 3). In order of frequency, aspects cited by more than 5% of the cohort were: pay in relation to level of responsibility; frequency of career development discussions; opportunities to attend courses other than study days; quality of career development discussions; day-duty staffing levels; amount of clinical supervision; amount of preceptorship; quality of preceptorship; and combining work hours with life with spouse/partner" (Robinson *et al,* 2005, pp.235-238). "Only two moderating variables, ethnicity and gender, in combination, were associated with likelihood of nursing at 5 years (Table 5). White British and Irish women were more likely to anticipate being in nursing compared with other groups (OR 1.19 vs 0.25–1.00). However, the reasons for this are complex and these findings need to be treated with caution" (Robinson *et al,* 2005, pp.235-238). "Diplomates who were satisfied with support from their immediate line manager were the group most likely to anticipate remaining in nursing" (Robinson *et al,* 2005, pp.235-238).	Reasons for diplomates remaining in their first job related to: consolidation of skills (having more to learn; job security (feeling the job was secure and having a permanent contract; and good working relationships (with staff on the same grade, staff on lower grades, and working as part of a good team. Aspects of first job that were sufficient to cause diplomates to leave or consider leaving were: "pay in relation to level of responsibility; frequency of career development discussions; opportunities to attend courses other than study days; quality of career development discussions; day-duty staffing levels; amount of clinical supervision; amount of preceptorship; quality of preceptorship; and combining work hours with life with spouse/partner" (Robinson *et al,* 2005). "White British and Irish women were more likely to anticipate being in nursing compared with other groups. However, the reasons for this are complex and these findings need to be treated with caution"(Robinson *et al,* 2005).

	"Diplomates who were neither satisfied nor dissatisfied with support from their immediate line manager were least likely to anticipate remaining in nursing" (Robinson *et al,* 2005, pp.235-238). "Those who were satisfied with the ratio of qualified to unqualified staff were less likely to anticipate being in nursing whereas those who were neither satisfied nor dissatisfied were more likely" (Robinson *et al,* 2005, pp.235-238).. "Those who were dissatisfied with the amount or quality of clinical supervision were the group most likely to anticipate being in nursing, followed by those who were satisfied, with those who were neither satisfied nor dissatisfied least likely" (Robinson *et al,* 2005, pp.235-238). "Ten years The hierarchical log-linear model identified five moderating variables that were associated with likelihood of nursing 10 years after qualification. These were age and children (in combination), education qualifications and time in first job (in combination), and ethnic group (Table 7). Diplomates aged 20–29 who had children living with them (OR 1.20) and those aged 30 or over without children (OR 1.00) were more likely to intend remaining than other combinations (ORs 0.63– 0.66). Overall, those who entered via an Access course or direct entry test (DC test) were more likely to anticipate remaining than those with other educational back- grounds. Although numbers are small, those who entered with a degree and had been in their first nursing job for less than 6 months were the group least likely to intend remaining (OR 0.13). Similarly, those who entered with qualifications sufficient for degree entry and had been in their first job for less than 6 months were also less likely to intend remaining (OR 0.43). Interestingly, the effect of time in job was reversed for those diplomates who entered with qualifications not sufficient for degree entry; those who had been in the job for less than 6 months were more likely to remain than those who had been in the job for 6 months (OR 1.20 vs 0.49). The effect of ethnic group was independent of gender with White British and Irish diplomates more likely to intend nursing than those from other ethnic groups (OR 2.70)" (Robinson *et al,* 2005, pp.235-238). "Three job satisfaction items were statistically associated with likelihood of nursing at 10 years at the 10% level of significance (Table 8). Satisfaction with proportion of time spent on paperwork was positively associated with intentions to nurse; those who were satisfied were most likely and those who were dissatisfied were least likely. The relationships with amount and quality of clinical supervision were similar to that seen for the 5-year time point, with a higher proportion of those who were dissatisfied than those who were satisfied intending to nurse. The effect of satisfaction	"Diplomates who were satisfied with support from their immediate line manager were the group most likely to anticipate remaining in nursing. Diplomates who were neither satisfied nor dissatisfied with support from their immediate line manager were least likely to anticipate remaining in nursing. Those who were satisfied with the ratio of qualified to unqualified staff were less likely to anticipate being in nursing whereas those who were neither satisfied nor dissatisfied were more likely. "Diplomates aged 20–29 who had children living with them and those aged 30 or over without children were more likely to intend remaining than other combinations Overall, those who entered via an Access course or direct entry test (DC test) were more likely to anticipate remaining than those with other educational back- grounds. Although numbers are small, those who entered with a degree and had been in their first nursing job for less than 6 months were the group least likely to intend remaining. Similarly, those who entered with qualifications sufficient for degree entry and had been in their first job for less than 6 months were also less likely to intend remaining. Interestingly, the effect of time in job was reversed for those diplomates who entered with qualifications not sufficient for degree entry; those who had been in the job for less than 6 months were more likely to remain than those who had

	with quality of supervision was stronger than at 5 years with the OR comparing those who were satisfied with those who were dissatisfied decreasing from 0.85 to 0.46" (Robinson *et al,* 2005, pp.235-238).	been in the job for 6 months. The effect of ethnic group was independent of gender with White British and Irish diplomates more likely to intend nursing than those from other ethnic groups. (Robinson *et al,* 2005, pp.235-238). Those who were dissatisfied with the amount or quality of clinical supervision were the group most likely to anticipate being in nursing, followed by those who were satisfied, with those who were neither satisfied nor dissatisfied least likely" (Robinson *et al,* 2005, pp.235-238). "Satisfaction with proportion of time spent on paperwork was positively associated with intentions to nurse; those who were satisfied were most likely and those who were dissatisfied were least likely. The relationships with amount and quality of clinical supervision were similar to that seen for the 5-year time point, with a higher proportion of those who were dissatisfied than those who were satisfied intending to nurse" (Robinson *et al,* 2005, pp.235-238).
Hamaideh (2014)	"Educational level and intention to leave the current job were correlated positively with moral distress" (Hamaideh, 2014, pp.37-38). "Moral distress was higher among younger nurses, nurses with low income level, nurses with less experience, nurses working in wards that have higher caseloads, nurses with higher educational level, and nurses who intend to leave their current job" (Hamaideh, 2014, pp.37-38).	"Educational level and intention to leave the current job were correlated positively with moral distress" (Hamaideh, 2014, pp.37-38). "Moral distress was higher among younger nurses, nurses with low income level, nurses with less experience, nurses working in wards that have

		higher caseloads, nurses with higher educational level, and nurses who intend to leave their current job" (Hamaideh, 2014, pp.37-38).
Hamaideh (2011)	"Occupational stress correlated significantly and negatively with QOL-physical, QOL-mental, and social support, and positively correlated with being physically assaulted, being verbally assaulted, and having the intention to leave the current job. Occupational stress did not significantly correlate with age, gender, caseload, and years of psychiatric experience" (Hamaideh, 2011, p.19).	As occupational stress increased intention to leave the current job increased.
Pelletier *et al* (2019)	"The overall RN turnover rate for the hospital during the study period decreased from 7.8% to 6.6% (see Figure 1), supporting the hypothesis that social support for NGNs enhances various workplace domains. Thirty-four new nurse graduates were selected for the NRP. Of those, 5 resigned within 1 year, yielding a turnover rate of 11.7% (88.3% retention rate). In Year 2, only 1 NRP participant left the organization, yielding a turnover rate of 2.9% (97.1% retention rate) for the study period (see Figure 2 for Year 1 and Year 2 turnover compared with national averages)" (Pelletier, 2019, pp.69-70).	The new graduate nurse residency programme (NRP) was associated with lower turnover "supporting the hypothesis that social support for NGNs enhances various workplace domains" (Pelletier, 2019, pp.69-70).
Baum & Kagan (2015)	"A quite strong negative correlation emerged between job satisfaction and intent to leave, both psychiatric nursing (r=−.38,pb.001) and the nursing profession itself (r=−.33,pb.05)" (Baum & Kagan, 2015, pp.214-215). "Quite strong negative correlations were found between age and all categories of seniority on the one hand, and on the other, intent to leave nursing itself and psychiatric nursing in particular" (Baum & Kagan, 2015, pp.214-215). "Closed-ward nurses did report a higher intention to leave psychiatric nursing (t= 3.05,pb.005). It should also be recalled that open-ward nurses were significantly older than closed-ward nurses (M= 49 vs. M = 39 respectively) (t=4.77,pb.001)" (Baum & Kagan, 2015, pp.214-215). "Dividing the sample into two age groups, under and over 35, the younger group reported a significantly higher intent to leave psychiatric nursing (t= 3.35,pb.01) but no similar difference was found with respect to leaving the nursing profession as a whole. Comparing full- and part-time workers, job satisfaction was significantly higher among the full-time workers (t= 2.05,pb.05). Part-time workers also reported a higher intent to leave, both psychiatric nursing (t=3.37,pb.01)and the	"Job satisfaction made a statistically significant contribution to the explanation of both intent to leave psychiatric nursing" (Baum & Kagan, 2015, pp.214-215). Younger nurses had a significantly higher intention to leave psychiatric nursing. Nurses working on closed wards reported a higher intention to leave psychiatric nursing, although nurses working on the closed wards were significantly younger. Nurses working part-time reported a higher intent to leave.

	nursing profession (t=2.10,pb.05). No differences were found by gender or ethnicity (country of birth) either on job satisfaction or on intent to leave" (Baum & Kagan, 2015, pp.214-215). "Job satisfaction made a statistically significant contribution to the explanation of both intent to leave psychiatric nursing (t= 2.5, beta = .31,B= .36,pb.05) and intent to leave the nursing profession (t= 2.03, beta = .31,B=.27,pb.05)" (Baum & Kagan, 2015, pp.214-215).	No difference were found by ethnicity or gender on intent to leave.
Kagwe *et al* (2019)	"Better pay was listed as the most likely reason respondents would contemplate leaving the hospital n=33, while a heavy workload was the least often cited n=7. Fear if losing nursing skills n=15. Fear of assault n=28. Workplace bullying n=21" (Kagwe *et al,* 2019, p.757). "Partial correlations between the independent variables and the outcome variables of seeking outside employment, job satisfaction, and intent to leave are reported in Table 2. Significant correlations ranged from small (0.2) to moderate (0.5). In the category of work environment, opportunity for feedback before disciplinary action, acknowledgment of additional credentials, and opportunities for growth and development were all significantly ($p < .05$) related to higher job satisfaction, lower intention to leave and lower likelihood of seeking outside employment. Work environment factors related to adequate support and time (having enough time to complete work, additional help during higher acuity) were also significantly associated with all three outcomes ($p < .05$)" (Kagwe *et al,* 2019, p.757). "All of the variables in the category of workplace relationship were significantly correlated with the three outcome variables ($p < .05$). Correlations between workplace relationships and actively seeking outside employment ranged from –0.441 to –0.317. Correlations for job satisfaction and workplace relationships were between 0.427 and 0.556. For intention to leave the organization in the next 12 months, the correlations with workplace relationships ranged from –0.297 to –0.250" (Kagwe *et al,* 2019, p.757). "Only 66 of the 94 respondents answered the reasons for leaving questions, possibly because nurses who were not seriously considering leaving opted to skip the questions. Better pay, fear of losing nursing skills, fear of being assaulted and workplace bullying did not have statistically significant correlations with the outcomes of seeking outside employment, job satisfaction, or intention to	"Better pay was listed as the most likely reason respondents would contemplate leaving the hospital, while a heavy workload was the least often cited. [other factors cited were:] Fear of losing nursing skills, fear of assault and Workplace bullying" (Kagwe *et al,* 2019, p.757). "In the category of work environment, opportunity for feedback before disciplinary action, acknowledgment of additional credentials, and opportunities for growth and development were all significantly related to higher job satisfaction, lower intention to leave and lower likelihood of seeking outside employment. Work environment factors related to adequate support and time (having enough time to complete work, additional help during higher acuity) were also significantly associated with all three outcomes" (Kagwe *et al,* 2019, p.757). All of the variables in the category of workplace relationship ["participants were asked about their perceptions and attitudes regarding peer and co-worker relation- ships, including whether they felt respected and valued and whether their input was considered in making patient treatment plans. Nurses were also asked about their perception of

	leave. Workload was significantly related to intention to leave ($r = –0.360$, $p < .05$) but not job satisfaction or seeking outside employment ($p > 0.05$)" (Kagwe *et al*, 2019, p.757).	workplace bullying in their current position, and whether this was a factor related to intent to leave. In addition, nurses were asked about opportunities for correction and feedback before disciplinary action was taken" (Kagwe et al, 2019, p.757)] Were significantly associated with Job satisfaction, intent to leave within the next twelve months, and actively seeking employment outside of the state-run hospital. "Better pay, fear of losing nursing skills, fear of being assaulted and workplace bullying did not have statistically significant correlations with the outcomes of seeking outside employment, job satisfaction, or intention to leave. Workload was significantly related to intention to leave" (Kagwe *et al,* 2019 p.757).
Gunn (2015)	"The reason for choosing a career and staying employed in MH nursing are listed below with data represented respectively: the nurse's confidence level (n = 26, 44.83%; n = 32, 55.17%) readiness to practice safely and effectively (n = 37, 63.79; n = 71, 70.69%) amount of time able to be spent with clients (n = 37, 63.79%; n = 39; 67.24%) job is rewarding (n = 48, 84.21%; n = 53, 91.38%). Additionally, others reported having satisfying relationships with co-workers as the reason for staying in MH nursing (n = 29, 50%) and 49 participants (84.48%) reported the job as exciting, never having a dull moment as the reason for staying in MH nursing" (Gunn, 2015, pp.49-50). "Forty-six participants (79.31%) did not perceive salary as a reason for staying in the MH profession" (Gunn, 2015, pp.49-50).	Reasons the nurses in the study reported for choosing and staying in employment in mental health nursing are: the nurses confidence level, readiness to practice safely and effectively, the amount of time able to be spent with clients, and the job is rewarding. Additionally, fifty percent of the nurses reported having satisfying relationships with co-workers as the reason for staying in MH nursing and eighty-four percent reported the job as exciting, never having a dull moment as the reason for staying in MH nursing.

	"29 participants (50%) reported that nurse to client ratio was not a factor in remaining employed in MH nursing" (Gunn, 2015, pp.49-50). "Participants reported the job as rewarding (n = 53, 91.38%), the job is exciting, never having a dull moment (n = 49, 84.48%), readiness to practice safely and effectively (n = 41, 70.69%), and the amount of time able to spend with clients (n = 39, 67.24%) as what had influenced one to remain in MH nursing" (Gunn, 2015, pp.49-50).	"Seventy-nine percent did not perceive salary as a reason for staying in the MH profession" (Gunn, 2015, pp.49-50). "Fifty percent reported that nurse to client ratio was not a factor in remaining employed in MH nursing" (Gunn, 2015, pp.49-50).
Yanchus *et al* (2015)	"We examined four workplace characteristics (civility, procedural justice, autonomy, and psychological safety) and their indirect effect on turnover intention through job satisfaction We learned that there was no difference between the predictors across the occupations and that all of the predictors significantly related to turnover intention either directly or indirectly through job satisfaction" (Yanchus *et al,* 2015, pp.235-236). "for all occupations, civility, procedural justice, and autonomy predicted job satisfaction, which in turn predicted turnover intention. Psychological safety directly predicted turnover intention, a unique finding to this study" (Yanchus *et al,* 2015, p.219).	"for all occupations [including mental health nursing], civility, procedural justice, and autonomy predicted job satisfaction, which in turn predicted turnover intention. Psychological safety directly predicted turnover intention, a unique finding to this study" (Yanchus *et al,* 2015, p.219).

Appendix D – Study Characteristics

Table 1.2 - Study characteristics

Authors and year	Aim(s)	Study design	Country	Setting	Sample and sample size	Outcome measures	Factors affecting retention identified
Alexander *et al* (2015)	To explore how nurses came to choose and remain in mental health nursing careers.	Qualitative Descriptive Phenomenology	United states	Acute inpatient settings	MHNs who have worked in acute inpatient settings for 5 years or longer. **n=8**	1 hour face-to-face, semi-structured interviews	Stereotypes and Career pride Positive team dynamics Remaining hopeful Leadership
Musto & Schreiber (2012)	To develop a theory of the process used by mental health nurses when they experience moral distress.	Qualitative Grounded theory	Canada	Inpatient units and community settings for adolescents with mental health issues.	RNs who work in the included clinical settings. **n=12**	60-120 minute semi-structured interviews.	Moral distress
Stacey *et al* (2011)	To explore how values influence the experience of nursing practice for nurses working in inpatient setting.	Qualitative Narrative	United Kingdom	Adult inpatient settings	MHNs with between 6 months and 3 years' experience in adult inpatient settings. **n=12**	One-to-one interviews	Conflict of values in practice
Karlowicz & Ternus (2009)	To gain understanding of and describe psychiatric nurses' experiences within their first year of employment, and identify the factors that influenced their decision to remain in or leave the organisation.	Qualitative Case analysis	United States	Inpatient psychiatric services	MHNs employed by the organisation and those who left the organisation within the first year of employment. **n=14**	Telephone interviews	Role and identity Orientation Education and training Organisational expectations Team dynamics Leadership Salary
Rollins (2014)	To determine how recent changes to the length and content of the psychiatric nurse orientation training impacted psychiatric nurse retention rates.	Quantitative non-randomised Pre and post-intervention design PhD Thesis	United States	Inpatient Outpatient Residential Partial Day	All RNs working within the 4 clinical settings. **n=88**	Human Resources data set for retention rates pre and post-intervention.	Healthy Work Environment Orientation training

Pelletier *et al* (2019)	To examine the effectiveness of a new nurse residency programme for retaining new graduate nurses in a mental health setting.	Quantitative non-randomised Comparative study design	United States	Inpatient units	New graduate nurses hired into the new nurse graduate programme. **n=34**	Human Resources data set to measure turnover rates **Job/Work environment Nursing Satisfaction Survey Eisenberger Social Support Scale OCB scale CIV ACS POF WBI CSE Occupational commitment tool**	Nurse Residency Programme
Alsaraireh *et al* (2014)	"To fill a gap in the understanding of psychiatric nursing in Jordan and provide information for future human resource planning".	Quantitative descriptive Cross-sectional	Jordan	A governmental hospital for mental health consisting of 1 male acute and long-term unit, and 1 female acute and long-term unit.	Nurses working in the hospital. **n=154**	**MSQ-Short form** to measure job satisfaction. **WSC** to measure turnover intention.	Job satisfaction Gender Marital status Nurse training Nursing experience Salary Different inpatient settings Age
Jiang *et al* (2019)	"To investigate the intention to leave among psychiatric nurses in China, and to identify associated factors".	Quantitative descriptive Cross-sectional	China	Tertiary psychiatric hospitals	MHNs working in tertiary psychiatric hospitals. **n=7933**	**MSQ-Short form** (Weiss *et al*, 1967) to measure job satisfaction. Researcher developed questionnaire to measure individual characteristics, job related variables, and intention to leave.	Gender Age Marital status Level of education Amount of working hours Time in job Patient initiated violence Health Staff grade Salary Patient respect Self-recognition Physician nurse co-ordination and trust Job satisfaction

Walrath (2011)	"To examine the correlation, if any, between nurse leaders' communication effectiveness and nurses' perceived job performance and satisfaction".	Quantitative descriptive Quantitative correlational design PhD Thesis	United States	State government treatment centre.	MHNs (including direct care and supervisory nurses) working at the psychiatric treatment centre **n=21**	**SLCI** to measure supervisor leadership and employee performance. **JSS** (to measure communication and supervision subscales. Research developed questions regarding individual characteristics and intent to stay employed.	Supervisor leadership Supervisor communication
Ito *et al* (2001)	To examine psychiatric nurses' intention to leave their job in relation to their job satisfaction, perceived risk of assault, and supervisory support.	Quantitative descriptive Cross-sectional	Japan	Psychiatric hospitals	All licensed nurses working in the included psychiatric hospitals. **n=1494**	**NIOSH** job stress questionnaire to measure job satisfaction, perceived risk of assault and supervisory support.	Other available opportunities Age Time in current job Previous job changes Supervisory support Perceived risk of assault Job satisfaction
Murrells & Robinson (1999)	To document career plans and histories of mental health nurses post qualification, and identify and explore factors which may impact directions followed inside and outside the NHS.	Quantitative descriptive Longitudinal	United Kingdom	NHS and non-NHS settings	Last groups of students completing traditional routes to the RMN qualification prior to the new diploma (project 200) courses. **n=447**	Researcher developed questionnaire.	Age Course preparation
Bamber (1991)	To Provide a detailed analysis of reasons for leaving among psychiatric nurses.	Quantitative descriptive Two-year prospective study using survey design	United Kingdom	NHS psychiatric hospital	Staff nurses working within the psychiatric hospital. **n=82**	Researcher developed questionnaire to measure job satisfaction. **BI** (Berkley Planning Associates) to measure stress. **Framingham Type A Personality questionnaire** to measure personality type.	Job satisfaction Perceived quality of decisions made by those in managerial positions. In-service training Physical working conditions Burnout Personality type Clinical experience Age Level of education
Robinson & Tingle (2003)	To ascertain diversity of the workforce, describe career plans and pathways post qualification, investigate	Quantitative descriptive Longitudinal	United Kingdom	Various NHS psychiatric settings	Mental health diplomates **n=678**	Researcher developed questionnaires	Working conditions Providing care Working relationships Reflection on practice

	experiences relevant to careers, and identify relationships between career plans, plans followed and profile and experience.						CPD opportunities
Sherring & Knight (2009)	To describe burnout and develop an understanding of the variables involved in burnout for mental health nurses working in a city Trust.	Quantitative descriptive Cross-sectional	United Kingdom	City NHS Trust.	MHNs working at the included Trust. **n=172**	**MBI**	Emotional exhaustion Depersonalisation
Yanchus *et al* (2017)	To examine predictors of turnover intention, or employee's cognitive withdrawal from their job amongst direct care mental health professionals.	Quantitative descriptive Cross-sectional	United States	VHA	Veterans Affairs employees including RNs, Social workers, psychologists, and psychiatrists. **RNs n=2432**	**Veterans Affairs All Employee Survey 2015** to measure: civility, emotional exhaustion, supervisory support, job satisfaction, workgroup and supervisory psychological safety, turnover intention and turnover plans.	Supervisory support Job satisfaction Emotional exhaustion Civility
Robinson *et al* (2005)	To ascertain diversity of the workforce, describe career plans and pathways post qualification, investigate experiences relevant to careers, and identify relationships between career plans, plans followed and profile and experience.	Quantitative descriptive Longitudinal	United Kingdom	Various NHS psychiatric settings	Mental health diplomates. **n=678**	Researcher developed questionnaire.	Consolidation of skills Job security Time in job Working relationships/good team Staff grade Salary Career development CPD opportunities Staffing levels and ratios Clinical supervision Preceptorship Work to life balance Ethnicity Leadership support Paperwork Age
Hamaideh (2014)	To describe the levels and predictors of moral distress of mental health nurses, and relationships of moral distress	Quantitative descriptive Cross-sectional	Jordan	Ministry of Health sector of the mental health care	MHNs working in the Ministry of Health sector. **n=130**	**MDS-P** **MBI** **JSS**	Moral distress

	with nurses' intention to leave, burnout, job satisfaction.			system (one hospital and clinics).			
Hamaideh (2011)	To examine levels of occupational stress, quality of life and social support among Jordanian mental health nurses.	Quantitative descriptive Correlational design	Jordan	All mental health care settings in Jordan.	All MHNs working in mental health settings in Jordan. **n=181**	**MHPSS** **SSS** **SF-36** version 2	Occupational stress
Baum & Kagan (2015)	To investigate the association between sociodemographic variables of psychiatric nurses and their intent to leave psychiatric nursing, the nursing profession and their job satisfaction, and the differences of these associations for nurses working on open and closed wards.	Quantitative descriptive Cross-sectional	Israel	Open and closed psychiatric wards.	MHNs working on open and closed wards. **n=52**	**Job satisfaction questionnaire** Intent to leave was measured by researcher developed questions.	Job satisfaction Age Different inpatient settings Working part-time
Kagwe *et al* (2019)	To describe factors associated with job satisfaction and intent to leave among psychiatric nurses working in an inpatient state-run hospital.	Quantitative descriptive Cross-sectional	United States	State-run psychiatric hospital.	All RNs working in the state-run psychiatric hospital. **n=94**	Researcher developed questionnaire	Salary Workload Fear of losing nursing skills Fear of assault Workplace bullying Feedback before disciplinary action Acknowledging additional credentials Opportunities for development Support Time to complete work Workplace relationships
Yanchus *et al* (2015)	To evaluate a model of turnover intentions across four VHA occupations: Psychologists, Psychiatrists, mental health nurses and social workers.	Quantitative descriptive Cross-sectional	United States	VHA	VHA employed working in mental health services. **Nurses n=4073**	**Veterans Affairs All Employee Survey 2011**	Civility Procedural justice Autonomy Psychological safety
Agyapong *et al* (2015)	To examine stakeholder views about the factors influencing career choices and retention of	Mixed methods Cross-sectional survey	Ghana	Three of the mental health hospitals	Psychiatrists, other doctors not specialising in	Researcher developed questionnaire.	Stigma Concerns about risk Salary

	community mental health workers.	including quantitative and qualitative methods		which are integrated with mental health outpatient facilities.	psychiatry, CPNs, clinical psychologists, occupational therapists, social workers and other mental health workers. **CPNs n=71**		
Gunn (2015)	To explore mental health nurses' perceptions of their career choice, and identify what factors influenced decisions to choose or remain employed in mental health nursing.	Mixed methods Descriptive Cross sectional PhD Thesis	United States	One private and one state-run hospital.	MHNs working within the two hospitals. **n=58**	Researcher developed questionnaire and Interviews	Confidence level Readiness to practice safely and effectively Time to spend with service users Workplace relationships Interesting and exciting nature of the job Staffing levels and ratios Salary (state facility) Burnout Returning to studies Rewarding nature of the job Stigma Personal qualities (compassion and patience)
MHN = Mental health nurse. RN = Registered nurse. CPN = Community psychiatric nurse. NHS = National Health Service. MSQ = The Minnesota Job Satisfaction Questionnaire. WCS = Withdrawal Cognition Scale. SLCI = Supervisor Leadership and Communication Inventory. JSS = Job Satisfaction Survey. NIOSH – The National Institute for Occupational Safety and Health. BI = Burnout Inventory. MBI = Maslach Burnout Inventory. MDS-P = Moral Distress Scale for Psychiatric Nurses. MHPSS = The Mental Health Professionals Stress Scale. SSS = The Social Support Scale. SF-36 = The Short Form Health Survey. CPD = Continuing Professional Development. VHA = Veterans Health Administration. OCB = Organisational Citizenship Behaviour. CIV = Civility. ACS = Affective Commitment Scale. POF = Person-Organisation fit scale. WBI = Work Burnout Inventory. CSE = Coping Self-efficacy scale.							

Appendix E– Individual quality assessments using the MMAT.

Qualitative studies appraised using the MMAT version 2018 (n=4)

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Alexander *et al* (2015)	Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
		1.2. Are the qualitative data collection methods adequate to address the research question?	x			
		1.3. Are the findings adequately derived from the data?	x			
		1.4. Is the interpretation of results sufficiently substantiated by data?	x			
		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Musto & Schreiber (2012)	Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
		1.2. Are the qualitative data collection methods adequate to address the research question?	x			
		1.3. Are the findings adequately derived from the data?	x			
		1.4. Is the interpretation of results sufficiently substantiated by data?	x			
		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Stacey *et al* (2011)	Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
		1.2. Are the qualitative data collection methods adequate to address the research question?	x			
		1.3. Are the findings adequately derived from the data?	x			
		1.4. Is the interpretation of results sufficiently substantiated by data?	x			
		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Karlowicz & Ternus (2009)	Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
		1.2. Are the qualitative data collection methods adequate to address the research question?	x			
		1.3. Are the findings adequately derived from the data?	x			
		1.4. Is the interpretation of results sufficiently substantiated by data?	x			
		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			

Quantitative non-Randomised studies appraised using the MMAT version 2018 (n=2)

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Rollins (2014)	Quantitative non-randomised PhD Thesis	3.1. Are the participants representative of the target population?	x			
		3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	x			
		3.3. Are there complete outcome data?	x			
		3.4. Are the confounders accounted for in the design and analysis?			x	
		3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Pelletier *et al* (2019)	Quantitative non-randomised	3.1. Are the participants representative of the target population?	x			
		3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	x			
		3.3. Are there complete outcome data?		x		Only 33% response rate due to attrition over time.
		3.4. Are the confounders accounted for in the design and analysis?	x			

		3.5. During the study period, is the intervention administered (or exposure occurred) as intended?			x	

Quantitative descriptive studies appraised using the MMAT version 2018 (n=15)

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Alsaraireh *et al* (2014)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Nonprobability
		4.2. Is the sample representative of the target population?		x		Not representative of those working in private hospitals.
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?	x			Response rate 86%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Jiang *et al* (2019)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?		x		Not representative of nurses working in hospitals in smaller cities and rural areas.
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?	x			Response rate 85.7%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Walrath (2011)		4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability

	Quantitative descriptive PhD Thesis	4.2. Is the sample representative of the target population?		x		Small sample
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?		x		Response rate 42%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Ito *et al* (2001)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?	x			Response rate 76.50%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Murrells & Robinson (1999)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			Not validated but pre-tested
		4.4. Is the risk of nonresponse bias low?	x			Response rate 80%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Bamber (1991)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?		x		Only included nurses working in one hospital

		4.3. Are the measurements appropriate?		x		Some measures were developed by the author and not validated and no report of a pre-test.
		4.4. Is the risk of nonresponse bias low?			x	Response rate not reported.
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Robinson & Tingle (2003)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Part random part non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			Not validated but pretested
		4.4. Is the risk of nonresponse bias low?	x			Response rates 80-82%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Sherring & Knight (2009)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?		x		Small sample size
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?		x		Response rate 35%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
		4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability

Yanchus *et al* (2017)	Quantitative descriptive	4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?		x		Not specific to the topic the study was examining
		4.4. Is the risk of nonresponse bias low?			x	Overall response rate 61%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	**Category of study design**	**Methodological quality criteria**	**Response**			
			Yes	**No**	**Can't tell**	**Comments**
Robinson *et al* (2005)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			Not validated but pre-tested
		4.4. Is the risk of nonresponse bias low?	x			
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	**Category of study design**	**Methodological quality criteria**	**Response**			
			Yes	**No**	**Can't tell**	**Comments**
Hamaideh (2014)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?			x	65% response rate and no statistical compensation reported.
		4.5. Is the statistical analysis appropriate to answer the research question?	x			
Authors	**Category of study design**	**Methodological quality criteria**	**Response**			
			Yes	**No**	**Can't tell**	**Comments**
Hamaideh (2011)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			

		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?	x			Response rate 82.3%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Baum & Kagan (2015)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?	x			95% response rate
		4.5. Is the statistical analysis appropriate to answer the research question?			x	Not all statistical analyses were clearly stated and justified.

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Kagwe *et al* (2019)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			
		4.2. Is the sample representative of the target population?		x		Small sample size and no reported reasons why potential participant chose not to participate
		4.3. Are the measurements appropriate?		x		Measures not 'gold standard', validated or pre-tested.
		4.4. Is the risk of nonresponse bias low?		x		Response rate 36%
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Yanchus *et al* (2015)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			
		4.4. Is the risk of nonresponse bias low?		x		65% response rate and no

						reported reasons for non-response
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Mixed methods study appraised using the MMAT version 2018 (n=2) (5+1+4)

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Agyapong *et al* (2015)	Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?		x		
		5.2. Are the different components of the study effectively integrated to answer the research question?		x		Limited qualitative data and no information on how and when integration occurred
		5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?		x		Limited qualitative data and no information on how and when integration occurred
		5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	x			
		5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?		x		Adhered to 80% of the criteria for the 'quantitative descriptive' component and 60% of the 'Qualitative' component.

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Agyapong *et al* (2015)	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?	x			
		4.3. Are the measurements appropriate?	x			Non-validated but pre-tested.

		4.4. Is the risk of nonresponse bias low?		x		Possible response bias due to not all potential respondents consenting to participate
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Agaypong *et al* (2015)	Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
		1.2. Are the qualitative data collection methods adequate to address the research question?		x		Limited qualitative data. Possible result of paper and pen approach for the open-ended questions in the survey.
		1.3. Are the findings adequately derived from the data?			x	Not enough information on thematic analysis approach
		1.4. Is the interpretation of results sufficiently substantiated by data?	x			
		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Gunn (2015)	Mixed methods PhD Thesis	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?		x		The study is described as a qualitative study
		5.2. Are the different components of the study effectively integrated to answer the research question?		x		
		5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?		x		
		5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	x			
		5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?		x		100% criteria met for qualitative

						component but only 60% for quantitative descriptive.

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Gunn (2015)	Qualitative PhD Thesis	1.1. Is the qualitative approach appropriate to answer the research question?	x			
		1.2. Are the qualitative data collection methods adequate to address the research question?	x			
		1.3. Are the findings adequately derived from the data?	x			
		1.4. Is the interpretation of results sufficiently substantiated by data?	x			
		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			

Authors	Category of study design	Methodological quality criteria	Response			
			Yes	No	Can't tell	Comments
Gunn (2015)	Quantitative descriptive PhD Thesis	4.1. Is the sampling strategy relevant to address the research question?	x			Non-probability
		4.2. Is the sample representative of the target population?		x		Sampling of MH facilities in only one area of the south-eastern region of the U.S.
		4.3. Are the measurements appropriate?	x			Not validated but pre-tested.
		4.4. Is the risk of nonresponse bias low?			x	69.87% response rate and no reported reasons for non-response
		4.5. Is the statistical analysis appropriate to answer the research question?	x			

Appendix F – REC approval letter

The University Of Sheffield.

Downloaded: 13/01/2021
Approved: 13/01/2021

Rosie Adams
Registration number: 190215754
School of Nursing and Midwifery
Programme: PhD

Dear Rosie

PROJECT TITLE: A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce.
APPLICATION: Reference Number 036316

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 13/01/2021 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 036316 (form submission date: 07/01/2021); (expected project end date: 29/04/2022).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Kate Chadwick
Ethics Administrator
Health Sciences School

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/approval-procedure
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix G – HRA approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Tony Ryan
Health Sciences School
Division of Nursing and Midwifery
The University of Sheffield
S10 2LA

Email: approvals@hra.nhs.uk

27 January 2021

Dear Professor Ryan

HRA and Health and Care

Study title:	**A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce.**
IRAS project ID:	**288626**
Sponsor	**The University of Sheffield**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **288626**. Please quote this on all correspondence.

Yours sincerely,

Juliana Araujo

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Miss Rosie Adams, The University of Sheffield* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Confirmation review approved by Faculty]		25 August 2020
Copies of materials calling attention of potential participants to the research [Study promotion poster. [redacted]]	1	20 November 2020
Copies of materials calling attention of potential participants to the research [Study promotion poster. [redacted]]	1	20 November 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Public liability insurance]		20 November 2020
IRAS Application Form [IRAS_Form_24112020]		24 November 2020

IRAS Application Form XML file [IRAS_Form_24112020]		24 November 2020
IRAS Checklist XML [Checklist_24112020]		24 November 2020
Letter from funder [Email from Funder]		10 January 2021
Letter from funder [Funding Agreement]		21 May 2019
Letter from sponsor [Welcome letter from sponsor for the PhD course.]		01 October 2019
Non-validated questionnaire [Survey questions]	1	20 November 2020
Organisation Information Document [OID]	1	20 November 2020
Other [University Ethical Approval]	1.2	13 January 2021
Participant consent form [Consent form [redacted]V1.2]	1.2	15 January 2021
Participant consent form [Consent form [redacted].V1.2]	1.2	15 January 2021
Participant information sheet (PIS) [PIS. Interviews. MHNs. [redacted] V1.2]	1.2	15 January 2021
Participant information sheet (PIS) [PIS. Interviews. MHNs. [redacted] V1.2]	1.2	15 January 2021
Participant information sheet (PIS) [PIS. Interviews. Senior leaders. [redacted]. V1.2]	1.2	15 January 2021
Participant information sheet (PIS) [PIS for survey. [redacted]]	1	20 November 2020
Participant information sheet (PIS) [PIS for survey. [redacted]]	1	20 November 2020
Research protocol or project proposal [Research protocol]	1	20 November 2020
Schedule of Events or SoECAT [Schedule of Events Validated]	1	20 November 2020
Summary CV for Chief Investigator (CI) [CV - Primary supervisor and Chief Investigator]		24 November 2020
Summary CV for student [CV - Student and PI]		24 November 2020
Summary CV for supervisor (student research) [Primary supervisor and CI]		24 November 2020
Validated questionnaire [SWEMWBS used in survey]		
Validated questionnaire [NHS staff survey questions used in survey]		
288626, 20/HRA/5820, SE04 HRA Approval non REC email confirmation template.eml		24 November 2020
288626, 20/HRA/5820, SE15 Application valid - Non-REC application.eml		14 January 2021
288626, 20/HRA/5820, SE17 Application valid under consideration - Non-REC - non-commercial.eml		23 December 2020

IRAS project ID	288626

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
This a multi-site study undertaking the same research activities. There is therefore one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	The sponsor has secured funding from the Health Foundation. Evidence of funding provided.	As per the Organisation Information Document, a Principal Investigator will be in place at each participating NHS organisation. No assistance to identify potential principal investigators will be required from the participating NHS organisation.	It is unlikely that letters of access or honorary research contracts will be applicable, except where external staff employed by another Trust (or University) are involved (and then it is likely that arrangements are already in place). Where arrangements are not already in place, external staff would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
• The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix H - Participant information sheets

The University Of Sheffield.

Faculty
Of
Medicine, Dentistry and Health

Professor Dame Pamela Shaw
Vice President and Head of the Faculty

The Health Foundation

A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce.

My name is Rosie Adams and I am a registered mental health nurse (MHN) and PhD student. I am conducting a research project focused on the retention of MHNs. [redacted] has agreed to take part in the project.

You are also personally being invited to take part in this research project. Firstly, it is important for you to understand the purpose of this research and what it will involve. Please read the following information carefully. Please feel free to contact me if there is anything you do not understand or if you would like more information. Take your time to consider whether or not you would like to take part. Thank you!

Purpose of the research

We are currently in the middle of a nursing crisis with more people now leaving the nursing profession than joining it. The mental health nursing workforce is one of the most affected areas, and with such few MHNs patient care and safety is at serious risk. This project will focus on the retention of MHNs because if we can retain the MHNs we already have, we can stop more nurses from leaving, which will provide the new nurses coming through a better chance at succeeding and remaining in the profession. Retention rates are likely to differ across clinical settings, and if this is the case, the factors that affect retention are likely to differ. In order to develop effective retention strategies, we need to know what factors are important to address and strengthen in which clinical settings.

This project will aim to identify any differences in MHNs' intentions to leave or stay in their jobs, the NHS, and the profession in different clinical settings across two mental health NHS Trusts. It will then aim to explore why MHNs intend to leave or stay in different clinical settings. It will also include senior leaders working within the Trusts, to gain their perspectives on the factors affecting retention and explore any past, current or planned retention strategies. All this information will then be used to provide direct recommendations for change to improve MHNs' job satisfaction, well-being, and improve retention within the two Trusts. The findings may also help to inform retention strategies that could benefit MHNs working within other NHS Trusts.

Method

This is a two phased mixed methods study. The first phase includes a survey and the second phase includes individual interviews. You may be invited to take part in one or both of these phases.

Why have I been chosen?
I am asking all the MHNs working in a clinical role within [redacted] to participate in this project.

What are you asking me to do?
At this point I am only asking for your participation with the first part of the project which is the survey. You can access the survey by clicking on the link in the email and it should take approximately 10 minutes to complete. The survey will include background and demographic questions, a short well-being scale, and additional questions asking you if you have any intentions to leave your job, the NHS, and the profession. The survey will collect your Trust email address automatically so that I can contact you if you are selected for Phase 2. There will be an optional box for you to put down a preferred email if you do not want to be contacted via your Trust email address.

Do I have to take part?
It is completely up to you whether or not you take part. If you do wish to participate there will be a statement at the beginning of the survey which you will need to agree to so that you can complete the survey. If you later change your mind about participating, you can withdraw from the study at any time, but any data collected up until you withdraw may still be used. If you do not wish to participate at all there will not be any negative consequences.

What are the possible disadvantages and of taking part?
The survey will take approximately 15 minutes of your time. The survey is an online survey to minimise the time it takes to complete and return the survey. It is possible that any psychological distress caused by the research problem may be exacerbated through responding to the survey. The well-being of the participants is of utmost priority and if you experience any distress during your participation you can withdraw from the study without negative consequences.

There are some contact details at the bottom of this information sheet provided by the Trust, which can be used if you are experiencing distress and would like to speak to someone independent from the research project and your work team.

What are the possible benefits of taking part?
This research project will allow MHNs like yourself currently in post a chance to share their experiences and be heard. There is no direct benefit to research participants, but the insight you provide will help generate direct recommendations for change. If implemented, these changes could improve the job satisfaction and well-being of yourself, your colleagues and other MHNs, which will improve the overall retention of MHNs within the two participating Trusts. The information you provide could also help to inform retention strategies used in other NHS Trusts to improve the retention of MHNs in the UK. Subsequently, this will improve the care and safety of the service users we look after.

Will my taking part be kept confidential?
All the information that is collected from you during the course of the research will be kept strictly confidential and will only be accessible to myself and my two supervisors. Everyone involved in this study will follow all privacy rules and keep your data safe and secure. The

Trust does not have any right to see the identifiable information and I would not offer it. You will not be identified in my thesis or subsequent publications. Trusts will be described in a non-identifying manner e.g. a northern city trust and a southern county trust or pseudonyms will be used. Workplace descriptors used in the CQC reports of both Trusts will be used to explain the results to maintain confidentiality of individual teams.

If you agree for me to share the anonymised information you provide with other researchers for future research studies, your personal details such as your name and email address will not be included.

What is the legal basis for processing my personal data?
According to the data protection legislation, I am required to inform you that the legal basis I am applying in order to process your personal data is that *'processing is necessary for the performance of a task carried out in the public interest'.*

As I will be collecting some data that is defined in the legislation as more sensitive (ethnic origin) I also need to tell you that I am applying the following condition in law: that use of your data is '*necessary for scientific or historical research purposes'.*

What will happen to the data collected, and the results of the research project?
During the course of the research your data will be stored securely in password protected and encrypted folders in the University of Sheffield's file store (X:Drive). The X:Drive is backed up automatically by the University's IT services to prevent the loss of your data. Only myself and my two supervisors will have access to these folders.

When the study is complete all anonymised data will be uploaded to the University of Sheffield's data repository ORDA (Online research data) and preserved for a minimum of 10 years. Email addresses will be kept in a restricted access file in ORDA until publication to be able to demonstrate the integrity of the research if required. Only myself and my two supervisors will have access to this file. After publication I will request that IT services permanently delete the file containing the email addresses. The completed thesis containing the anonymised data will be uploaded to the White Rose Research Online (WRRO) repository and made public.

Due to the nature of this research it is very likely that other researchers may find the data collected to be useful in answering future research questions. At the end of the study I will save some of the data in case I need to check it and/or for future research. I will ask you specifically for your explicit consent for your data to be shared in this way.

Who is organising and funding the research?
The University of Sheffield is the host organisation and the research is being funded by The Health Foundation.

Who is the Data Controller?
The University of Sheffield will act as the Data controller for this study. This means that the University is responsible for looking after your information and using it properly.

Who has ethically reviewed this project?

This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Health Sciences School, the Division of Nursing and Midwifery. The project has also been approved by the Health Research Authority (HRA).

What if something goes wrong and I want to complain about the research?
You can contact the Principal Investigator whose contact details are at the bottom of this information sheet. If you feel unable to contact the Principal Investigator, or do not feel the complaint has been handled to your satisfaction, you can contact the Head of Department who will then escalate your complaint through the appropriate channels.

Where can you find out more about how your information is used?

- At www.hra.nhs.uk/information-about-patients/
- By contacting myself (Principal investigator) or the project supervisors.

Contact for further information

Principal Investigator
Rosie Adams
raadams1@sheffield.ac.uk
07715691765

Supervisors:
Professor Tony Ryan
t.ryan@sheffield.ac.uk

Dr Emily Wood
e.f.wood@sheffield.ac.uk

Dean of the Health Sciences School
Tracey Moore
tracey.moore@sheffield.ac.uk

Contact details for the Trust's wellbeing service
Information removed to protect anonymity.

Thank you for reading this information and feel free to download and keep a copy of this information sheet.

The University Of Sheffield.

Faculty
Of
Medicine, Dentistry and Health

Professor Dame Pamela Shaw
Vice President and Head of the Faculty

The Health Foundation

A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce.

My name is Rosie Adams and I am a registered mental health nurse (MHN) and PhD student. I am conducting a research project focused on the retention of MHNs. [redacted] has agreed to take part in the project.

You are also personally being invited to take part in this research project. Firstly, it is important for you to understand the purpose of this research and what it will involve. Please read the following information carefully. Please feel free to contact me if there is anything you do not understand or if you would like more information. Take your time to consider whether or not you would like to take part. Thank you!

Purpose of the research

We are currently in the middle of a nursing crisis with more people now leaving the nursing profession than joining it. The mental health nursing workforce is one of the most affected areas, and with such few MHNs patient care and safety is at serious risk. This project will focus on the retention of MHNs because if we can retain the MHNs we already have, we can stop more nurses from leaving, which will provide the new nurses coming through a better chance at succeeding and remaining in the profession. Retention rates are likely to differ across clinical settings, and if this is the case, the factors that affect retention are likely to differ. In order to develop effective retention strategies, we need to know what factors are important to address and strengthen in which clinical settings.

This project will aim to identify any differences in MHNs' intentions to leave or stay in their jobs, the NHS, and the profession in different clinical settings across two mental health NHS Trusts. It will then aim to explore why MHNs intend to leave or stay in different clinical settings. It will also include senior leaders working within the Trusts, to gain their perspectives on the factors affecting retention and explore any past, current or planned retention strategies. All this information will then be used to provide direct recommendations for change to improve MHN's job satisfaction, well-being, and improve retention within the two Trusts. The findings may also help to inform retention strategies that could benefit MHNs working within other NHS Trusts.

Method

This is a two phased mixed methods study. The first phase includes a survey and the second phase includes individual interviews. You may be invited to take part in one or both of these phases.

Why have I been chosen?
You have already responded to the survey and you have been selected for Phase 2 of the study as the responses to the survey you provided are very interesting, and it is felt that exploring your responses will generate a better understanding of the research problem.

What are you asking me to do?
I am inviting you to an interview to talk about why you intend to leave or stay in your job, the NHS, or the profession. The interviews will be approximately 1 hour long. Interviews will be audio-recorded and transcribed onto a password protected university computer. I will ask you if you would like to review the transcript to check the accuracy of your documented experiences. You do not have to do this if you do not want to.

A choice of interview setting will be offered which are likely to be in either Trust or University premises. More informal settings selected and identified by yourself, telephone and secure online platforms may also be used. To maintain confidentiality, consideration will be given to the privacy of the interview setting prior to conducting the interview.

Do I have to take part?
It is completely up to you whether or not you take part. If you do wish to participate there will be a statement at the beginning of the survey which you will need to agree to so that you can complete the survey. If you later change your mind about participating, you can withdraw from the study at any time, but any data collected up until you withdraw may still be used. If you do not wish to participate at all there will not be any negative consequences.

What are the possible disadvantages and of taking part?
It is possible that any psychological distress caused by the research problem may be exacerbated through the interview process. The well-being of the participants is of utmost priority and if you experience any distress during your participation you can withdraw from the study without negative consequences. Debrief interviews can be arranged. Alternatively, you can take your concerns to your line manager who will be able to provide support or signpost you to the relevant support. If I am worried about your safety immediate action will be taken by myself to alert the appropriate services.

There are also some contact numbers at the bottom of this information sheet provided by the Trust, which can be used if you are experiencing distress and would like to speak to someone independent from the research project and your work team.

What are the possible benefits of taking part?
This research project will allow MHNs like yourself currently in post a chance to share their experiences and be heard. There is no direct benefit to research participants, but the insight you provide will help generate direct recommendations for change. If implemented, these changes could improve the job satisfaction and well-being of yourself, your colleagues and other MHNs, which will improve the overall retention of MHNs within the two participating Trusts. The information you provide could also help to inform retention strategies used in other NHS Trusts to improve the retention of MHNs in the UK. Subsequently, this will improve the care and safety of the service users we look after.

Will my taking part be kept confidential?

All the information that is collected from you during the course of the research will be kept strictly confidential and will only be accessible to myself and my two supervisors. Everyone involved in this study will follow all privacy rules and keep your data safe and secure. You will not be identified in my thesis or subsequent publications. Trusts will be described in a non-identifying manner e.g. a northern city trust and a southern county trust or pseudonyms will be used. Workplace descriptors used in the CQC reports of both Trusts will be used to explain the results to maintain confidentiality of individual teams.

Should you disclose information to suggest that the actions of you or others has resulted in serious harm I may need to share this information with other relevant agencies. In keeping with University of Sheffield policy I will inform you of my actions. Similarly, if anything else is disclosed that gives cause for concern, i.e. bullying or harassment, it will be reported and dealt with in accordance with the Trust and University policy. You can also get in touch with the Trust's Well-being Service for support and guidance on a range of issues including bullying and harassment (contact details are provided at the end of this information sheet).

If you agree for me to share the anonymised information you provide with other researchers for future research studies, your personal details such as your name and email address will not be included.

What is the legal basis for processing my personal data?
According to the data protection legislation, I am required to inform you that the legal basis I am applying in order to process your personal data is that *'processing is necessary for the performance of a task carried out in the public interest'.*

As I will be collecting some data that is defined in the legislation as more sensitive (ethnic origin) I also need to tell you that I am applying the following condition in law: that use of your data is '*necessary for scientific or historical research purposes'.*

What will happen to the data collected, and the results of the research project?
During the course of the research your data will be stored securely in password protected and encrypted folders in the University of Sheffield's file store (X:Drive). The X:Drive is backed up automatically by the University's IT services to prevent the loss of your data. Only myself and my two supervisors will have access to these folders. Interviews will be audio recorded using an approved encrypted recording device. Immediately after interviews the audio-recordings will be saved to the university network file store and the recordings will be deleted from the encrypted recording device. The audio recordings will then be transcribed. The audio recordings and transcripts will be stored in the encrypted folders in the X:Drive during the course of my studies.

When the study is complete all anonymised interview data will be uploaded to the University of Sheffield's data repository ORDA (Online research data) and preserved for a minimum of 10 years. Trust email addresses and audio recordings will be kept in a restricted access file in ORDA until publication to be able to demonstrate the integrity of the research if required. Only myself and my two supervisors will have access to this file. After publication I will request that IT services permanently delete the file containing the email addresses and audio recordings. The completed thesis containing the anonymised data will be uploaded to the White Rose Research Online (WRRO) repository and made public.

Due to the nature of this research it is very likely that other researchers may find the data collected to be useful in answering future research questions. At the end of the study I will save some of the data in case I need to check it and/or for future research. I will ask you specifically for your explicit consent for your data to be shared in this way.

Who is organising and funding the research?
The University of Sheffield is the host organisation and the research is being funded by The Health Foundation.

Who is the Data Controller?
The University of Sheffield will act as the Data controller for this study. This means that the University is responsible for looking after your information and using it properly.

Who has ethically reviewed this project?
This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Health Sciences School, the Division of Nursing and Midwifery. The project has also been approved by the Health Research Authority (HRA).

What if something goes wrong and I want to complain about the research?
You can contact the Principal Investigator whose contact details are at the bottom of this information sheet. If you feel unable to contact the Principal Investigator, or do not feel the complaint has been handled to your satisfaction, you can contact the Dean of the Health Sciences School who will then escalate your complaint through the appropriate channels.

Where can you find out more about how your information is used?

- At www.hra.nhs.uk/information-about-patients/
- By contacting myself (Principal investigator) or the project supervisors.

Contact for further information

Principal Investigator
Rosie Adams
raadams1@sheffield.ac.uk
07715691765

Supervisors:
Professor Tony Ryan
t.ryan@sheffield.ac.uk

Dr Emily Wood
e.f.wood@sheffield.ac.uk

Dean of the Health Sciences School
Tracey Moore
tracey.moore@sheffield.ac.uk

Contact details for the Trust's well-being service:
Information removed to protect anonymity.

Thank you for reading this information and feel free to download and keep a copy of this information sheet.

Appendix I - Consent form

The University Of Sheffield.

Faculty
Of
Medicine, Dentistry and Health

Professor Dame Pamela Shaw
Vice President and Head of the Faculty

The Health Foundation

A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce.

Consent form

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated 20/11/2020 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the project. I understand that taking part in the project will include being interviewed for approximately 1 hour.	☐	☐
I understand that by choosing to participate as a volunteer in this research, this does not create a legally binding agreement nor is it intended to create an employment relationship with the University of Sheffield.	☐	☐
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw. However, the data collected up until the point I withdraw may still be used.	☐	☐
I consent to be contacted for research projects in the future	☐	☐
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs.	☐	☐

I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I give permission for the interview data that I provide to be deposited in University of Sheffield's data repository ORDA, so it can be used for future research and learning	☐	☐
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐	☐

Name of participant [printed]……. Signature……

Date…….

(Signed by the researcher, on behalf of the participant, after the participant has provided verbal consent if consent is collected remotely)

Name of researcher [printed] Rosie Adams Signature…….

Date…….

Project contact details for further information:

Principal Investigator
Rosie Adams
raadams1@sheffield.ac.uk
07715691765

Supervisors:

Professor Tony Ryan
t.ryan@sheffield.ac.uk

Dr Emily Wood
e.f.wood@sheffield.ac.uk

Dean of the Health Sciences School
Tracey Moore
tracey.moore@sheffield.ac.uk

Appendix J – Data management plan

A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce

Description of the data

Type of study
Up to three lines of text that summarise the type of study (or studies) for which the data are being collected.

An explanatory sequential mixed methods design. The first phase will use quantitative methods to identify the scope of research the problem. The second phase will use qualitative methods to explain the quantitative results and provide a deeper understanding of the problem.

Types of data
Outline the types of research data that will be managed in the following terms: quantitative, qualitative; generated from surveys, clinical measurements, models, interviews, medical records, electronic health records, administrative records, genotypic data, images, audio-visual data, tissue samples. Include the raw data arising directly from the research, the reduced data derived from it, and published data.

Quantitative data generated from a survey, which will include background and demographic information, which includes GDPR defined personal (email addresses) and sensitive/special category data (ethnic origin). Email addresses will be collected as they will be used to invite participants to the second (qualitative) phase of the study. Statistical analysis using SPSS will be conducted on the quantitative data including both descriptive and inferential statistical analysis, and this data will be presented in the final thesis in tabular and graph form.

Qualitative data generated from audio-recorded interviews. Interviews will be transcribed into written documents. A thematic analysis will be conducted, and analysed data will be anonymised using pseudonyms and presented in narrative form in the final thesis.

Format / scale of the data
Outline and justify your choice of file formats, software used, number of records, databases etc. in terms that are meaningful in your field of research. Do formats and software enable sharing and long term validity of data? Using standardised and interchangeable data formats ensures the long-term usability of data.
Estimate the volume of data in Mb/Gb/Tb and how this will grow to make sure any additional storage and technical support required can be provided.

Quantitative data

Qualtrics software will be used to develop and administer the survey. Qualtrics was chosen over Google forms as one of the research sites is unable to use Google forms. Qualtrics is IG approved by (ScHARR) for secure data collection and I will be able to obtain a licence through the School of Health and Related Research (ScHARR) as my project is funded by a

grant held in ScHARR. The survey response data will be exported in SPSS file format as SPSS will be used for data analysis. The data analysed using SPSS will be stored in .SAV file format. The desired amount of returned surveys is 314. No more than 5Gb of storage will be required for surveys and analysis.

Qualitative data

Interviews will be audio recorded using an IG approved encrypted recording device. Data generated from the interviews will be stored in MP3 audio files. The recordings will be transcribed into separate word documents (.docx). Quirkos software will be used to analyse the qualitative data as I am familiar with the software due to using it within my literature review. I anticipate no more than 30 interviews lasting approximately an hour over a period of six months. The estimated volume of data for audio MP3 files is 1,800Mb. The average transcript (.docx) will be approximately 140,000 bites, which means the volume of data for 30 transcripts will be 4.2Mb. Including analysis, no more than 5Gb of data storage will be required.

Data collection / generation

How will the data be collected / generated?

Describe briefly how the data will be collected or generated bearing in mind that you may be dealing with several types of data. Where appropriate include details of controls and standards that you will use.

Quantitative data

An online self-administered survey will be developed using Qualtrics software, which will be used to generate the quantitative data.

Qualitative data

Face-to-face individual audio-recorded interviews will be conducted to generate qualitative data. An Interview guide created in a word document (.docx) will be used to guide the interview through the relevant topics of discussion and prompt responses.
COVID contingency

In the case that face-to-face contact is not permitted at the time of data collection qualitative data will be collected via telephone interviews instead. Data will be managed in the same way described for face-to-face interviews.

How will it be organised / curated at the time of collection / generation?

Indicate how the data will be organised during the project, mentioning for example, naming conventions, version control and folder structures.

Two main folders will be created and named after the two NHS trusts (The two research sites), these folders will be encrypted and located on a university network file store (X: Drive). Within the two main folders, additional folders will be created for each clinical setting within the two research sites. I will create a README.txt file which will include a brief introduction of the project themes of the researchers involved in the project and a list of the files with a description of what they contain. This will help to keep the files organised and make accessing the information easier.

Quantitative data
Individual survey responses will be saved into the relevant folder. File names for individual surveys will include participant initials, Trust in which the participant works, a descriptive identifier (survey), version number (V1, V2 etc), and a date in international format

(YYYYMMDD).
Qualitative data
Individual audio MP3 files and word documents will be saved into the relevant folder. Individual audio MP3 files and word documents (.docx) will be saved using participant initials, Trust in which the participant works, a descriptive identifier (interview or transcript), version number (V1, V2 etc), and a date in international format (YYYYMMDD) as file names.

Data management / documentation

Over the course of your doctoral studies? Hard data Electronic data

Photographs of consent forms will be taken and uploaded to the university network file store (X:Drive). The original paper copies will then be shredded. The university network file store is backed up automatically by IT services.
When working remotely I will connect my Mac to the virtual private network (VPN) to securely access university services and X: Drive. My Mac is password protected and encrypted through FireVault which secures data by encrypting its contents automatically.
Quantitative data

Online surveys including personal and sensitive data will be stored in encrypted folders on a university network file store during the course of my studies.

Qualitative data

Immediately after interviews the audio-recordings will be saved to the university network file store and the recordings will be deleted from the encrypted recording device. The audio recordings (MP3) and transcripts (.docx) will be stored in the encrypted folders in the university network file store during the course of my studies.

Following completion of your doctoral studies? Hard data Electronic data

Upon completion of my studies all anonymised survey data will be uploaded to the University of Sheffield's data repository ORDA (Online research data) and preserved for a minimum of 10 years. It will be made clear to the participants where their data will be preserved and how long for in the consent forms and participant information sheets. Participants email addresses and audio files will be kept in a restricted access file in ORDA until publication to be able to demonstrate the integrity of the research if required. Only myself and my two supervisors will have access to this file. After publication I will request that IT services permanently delete the file containing the email addresses and audio files.

Photographs of consent forms will be kept for at least 5 years and will not be deleted before publication so that I will be able to demonstrate the integrity of the research if required. Participants will be given the opportunity to redact the transcripts or consent to disclosure of the texts. If participants consent the transcripts will be anonymised using pseudonyms and stored in ORDA for a minimum of 10 years.

Data sharing
Apart from your supervisors, with whom do you share your data?

At the same time as gaining consent to take part in this study, I will also seek consent from the participants for their anonymised data to be used by other researchers in the future. Survey responses will be anonymised and shared.
Participants will be given the opportunity to redact their transcripts (or parts of their transcript) or consent to data sharing.

My completed thesis will be uploaded to the White Rose Research Online (WRRO) repository and made public.

Email addresses obtained through the survey and audio files are sensitive data and will only be accessible to myself and my supervisors until they are deleted after publication.

How have you planned to share your data with your supervisors a) over the course of your doctoral studies?

My supervisors will be able to access all of the data on the X:Drive. They will be given the passwords for the encrypted folders.

How have you planned to share your data with your supervisors a) following completion of your doctoral studies?

All anonymised data will be accessible through ORDA and my supervisors will be given the password for the restricted access file containing the email addresses and audio files.

Appendix K – Minor amendment approval letter 1

Health
Sciences
School

4th March 2021

Rosie Adams
Health Sciences School
Division of Nursing and Midwifery
Barber House Annese
3a Clarkehouse Road
Sheffield
S10 2LA

Dean
Professor Tracey Moore
Health Sciences School
Division of Nursing and Midwifery
Barber House Annexe
3a Clarkehouse Road
Sheffield
S10 2LA

Telephone: +44 (0) 114 222 207+=6
Email: hesdenreshub@sheffield.ac.uk

Dear Rosie

Project Title: A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce
Appn. No: 036316

I am writing to confirm approval of your request for minor amendments to your ethics submission Number 036316 detailed in the Notice of Amendments Form submitted on 3rd March 2021.

Yours sincerely

Dr Rachel King
Ethics Lead

Appendix L – Email invitation

Subject: Mental health nurse retention study.

Calling all registered mental health nurses working in [redacted]!

My name is Rosie Adams, and I am a mental health nurse and PhD student at the University of Sheffield. I am conducting a research project in NELFT focused on the retention of registered mental health nurses currently in post and I need your help! I would really appreciate it if you would participate in the first phase of my study by completing a short survey. The survey will help to get a better understanding of currently employed nurses' intentions to leave or stay in their jobs, the NHS and nursing profession. The information that you give will contribute to the development of some direct recommendations for change to improve retention within the mental health nursing workforce in your NHS Trust.

To be able to participate in the survey you must be a registered mental health nurse currently working in a clinical role within [redacted]. You must also read the participant information sheet attached to this email before completing the survey.

If you would like to participate you can click the following link to start the survey:
https://scharr.eu.qualtrics.com/jfe/form/SV_0jFzKD9Cw7BJXJr

If you have any questions related to participation or the study, you can contact me via email.

Thank you for your time.

Rosie Adams, BSc, MSc, RMN.
PhD Student at the University of Sheffield.
Registered mental health nurse ([redacted]
Raadams1@sheffield.ac.uk.

Appendix M – Recruitment strategies

Table 2.2 - Recruitment strategies

Recruitment strategy	*Commentary*
Trust 1 The email invitation and link to the survey was distributed to all MHNs in the Trust via the personal assistant to the executive director of nursing. Email reminders were then sent by the R&D department to those teams with indicating a response rate after X weeks. The study was promoted via nurse research champions within the Trust and on the Trust Facebook page. I personally visited settings with low response rates to promote the study and prompt responses.	Trust 1 used a pre-established email list of nurses to email all the nurses in the Trust directly which resulted in an initial spike in survey responses. Promoting the study on the Facebook page and specific team email reminders increased responses slightly. By working as a nurse in this Trust across the inpatient wards I was able to promote my study and build relationships with nurses working in these settings. The relationships I had built led to a snowball effect where they would participate and promote the study to their colleagues. This significantly increased responses from the inpatient settings which carried an overall lower response in all the Trusts compared with the community settings. It took a little longer for this Trust to reach the target than Trust 2, but they have significantly fewer nurses than the other two Trusts.
Trust 2 The head of nurse education distributed the email invitation and link to the survey directly to all MHNs in the Trust. Email reminders were then sent to the clinical settings from which a low response was obtained via the R&D team. I personally contacted the settings with low response rates by phone to promote the study and prompt responses.	Trust 2 also used a pre-established email list of all the all nurses in the Trust to distribute the survey directly to nurses which received an initial influx of responses leading this Trust to reach their recruitment target within the first few days of recruitment. Then team specific email reminders and telephone contact were used for the teams with a low response rate to increase the number of responses from these teams. This Trust were able to over recruit significantly.
Trust 3 Email invitations containing the link to survey were sent via the R&D team to the medical directors	This strategy led to a gradual increase in responses until the target was met. As a pre-established email list of all nurses in the Trust did not exist the survey could

within the Trust. The medical directors then forwarded on the email to individual service managers to ensure no service was missed. The service managers then distributed the email to all the nurses within the Trust. Members of the R&D team visited the clinical settings with low responses in person to promote the study and prompt responses.	not be distributed directly to all the nurses at once like the other two Trusts. This is partly due to the structure of the Trust being split into different localities. This increased the number of gatekeepers the email containing the survey needed to go through to reach the potential participants. With these gatekeepers being senior figures within the Trust who have busy and demanding schedules including annual leave the emails seemed to get stuck at this level resulting in no responses coming though for a long period of time. This was a difficult position as neither the R&D team nor I could prompt responses from potential participants as they had not received the email containing the link to the survey. With intense support from the R&D teams contacting these gatekeepers the email was distributed to the individual service managers who distributed it to the nurses in their teams. This led to small spikes in responses suggesting that the survey may have not reached all the nurses in all the localities and individual teams. The R&D team then personally visited some of the clinical settings armed with the email containing the link to the survey to promote the study and prompt responses which increased responses further and enabled them to reach their target but unlikely to have representative samples from all the clinical settings.

Appendix N – Survey

Consent

I have read and understood the participant information sheet for the study entitled: 'A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce', and I voluntarily consent to participate in this study.

- ○ Yes I consent
- ○ No I do not consent

Background questions

Which NHS Trust do you work for?

[redacted]

What type of service do you work in?

- ○ Acute wards for adults of working age and psychiatric intensive care units

- ◯ Long stay or rehabilitation mental health wards for working age adults
- ◯ Child and adolescent mental health wards
- ◯ Wards for older people with mental health problems
- ◯ Wards for people with a learning disability or autism
- ◯ Forensic inpatient or secure wards
- ◯ Mental health crisis services and health-based places of safety
- ◯ Community-based mental health services for adults of working age (including liaison and IAPT services)
- ◯ Community-based mental health services for older people (including liaison and IAPT services)
- ◯ Specialist community mental health services for children and young people (including liaison and IAPT services)
- ◯ Community mental health services for people with learning disabilities or autism
- ◯ Substance misuse services
- ◯ [ ] Other (please specify)

What is your staff grade?

- ◯ Band 5 (in preceptorship)
- ◯ Band 5 (not in preceptorship)
- ◯ Band 6
- ◯ Band 7
- ◯ Band 8

How long have you spent in your current job?

- ◯ Less than 1 year

- ○ 1-2 years
- ○ 2-3 years
- ○ 3-4 years
- ○ 4-5 years
- ○ 5+ years
- ○ 10+ years

How many hours do you work?

- ○ Up to 29 hours
- ○ 30 or more hours

What nursing qualification do you have?

- ○ BSc in mental health nursing
- ○ Post graduate qualification in mental health nursing
- ○ Nursing Diploma
- ○ [ ] Other

How many years' experience do you have as a registered mental health nurse?

- ○ Less than 1 year
- ○ 1-2 years
- ○ 2-3 years
- ○ 3-4 years

- ○ 4-5 years
- ○ 5+ years
- ○ 10+ years

Health and well being

During the last 12 months have you felt unwell as a result of work-related stress?

- ○ Yes
- ○ No

Below are some statements about feelings and thoughts.

Please select the answer that best describes your experience of each over the last two weeks.

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	○	○	○	○	○
I've been feeling useful	○	○	○	○	○
I've been feeling relaxed	○	○	○	○	○
I've been dealing					

with problems well	○	○	○	○	○
I've been thinking clearly	○	○	○	○	○
I've been feeling close to other people	○	○	○	○	○
I've been able to make up my own mind about things	○	○	○	○	○

Questions relating to intent to leave or stay

To what extent do you agree or disagree with these statements?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I often think about leaving this organisation	○	○	○	○	○
I will probably look for a job at a new organisation in the next 12 months	○	○	○	○	○
As soon as I can					

find another job, I will leave this organisation	○	○	○	○	○

If you are considering leaving your current job, what would be your most likely destination?

- ○ I am not considering leaving my current job
- ○ I would want to move to another job within this organisation
- ○ I would want to move to a job in a different NHS Trust/organisation
- ○ I would want to move to a job in nursing, but outside the NHS
- ○ I would want to move to a job outside nursing
- ○ I would retire or take a career break

Demographic information

What is your gender?

- ○ Male
- ○ Female
- ○ [ ] Prefer to self-describe
- ○ I would prefer not to say

What is your age?

- ○ 16-20
- ○ 21-30

- ○ 31-40
- ○ 41-50
- ○ 51-65
- ○ 65+

What is your ethnic background?

- ○ English/ Welsh/ Scottish/ Northern Irish/ British
- ○ Irish
- ○ Gypsy or Irish Traveller
- ○ [ ] Any other White background
- ○ Indian
- ○ Pakistani
- ○ Bangladeshi
- ○ Chinese
- ○ [ ] Any other Asian background
- ○ African
- ○ Caribbean
- ○ [ ] Any other Black/African/Caribbean background
- ○ White and Black Caribbean
- ○ White and Black African
- ○ White and Asian
- ○ [ ] Any other Mixed/Multiple ethnic background
- ○ Arab
- ○ [ ] Any other ethnic background (please specify)

Which of these best describes how you think of yourself?

- ◯ Heterosexual or straight
- ◯ Gay or Lesbian
- ◯ Bisexual
- ◯ [ ] Other
- ◯ I would prefer not to say

What is your marital status?

- ◯ Single
- ◯ Co-habiting
- ◯ Married
- ◯ Civil partnership
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ I would prefer not to say

What is your religion?

- ◯ No religion
- ◯ Christian
- ◯ Buddhist
- ◯ Hindu
- ◯ Jewish
- ◯ Muslim

- ◯ Sikh
- ◯ _____ Any other religion (please specify
- ◯ I would prefer not to say

Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

- ◯ Yes
- ◯ No
- ◯ I would prefer not to say

Has your employer made adequate adjustment(s) to enable you to carry out your work?

- ◯ Yes
- ◯ No
- ◯ No adjustment required

Do you have and children aged from 0 to 17 living at home, or who you have regular caring responsibilities for?

- ◯ Yes
- ◯ No

Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or

mental ill health/disability, or problems related to old age?

- Yes
- No

Do you consent to be contacted for an interview to talk about your responses if you are selected?

- Yes
- No

Please could you provide the email address that is best to contact you with.

- Please write your email address here

Appendix O – Example Interview guide for MHNs

You have been selected for interview on the basis of your responses to the survey. I would like to ask you a few questions about your answers to some of the questions to find out a bit about the reasons behind them.

The interview will take about 40 minutes and will be audio recorded. Have you read and understood the participant information sent to you in the email?
Do you have any questions about the information or interview?
Your interview will be anonymised so you will not be identifiable in the write up or any future publications.

I have received your signed consent, but can I just check that you still consent to the interview today?

So, the interview will begin now, you can let me know if you want me to repeat or explain things or stop the interview.

You are a band 7 nurse working within an inpatient setting. Is that correct?

Could you please describe your role in that clinical setting?

You indicated on the survey that you are not considering leaving your job. What are the aspects of your role in particular that have contributed to your intentions to stay in your current clinical setting?

You also indicated that you do not often think about leaving your Trust and have no plans to do so. What is it about your Trust that encourages you to stay working in it?

Is there anything you would like to add about what you like about working for the NHS more broadly?

So if you don't mind I would like to talk about mental health nursing as a profession. What is it about the mental health nursing profession that makes you want to stay working as a mental health nurse?

Is there anything else you would like to add?

Appendix P – Example Interview guide for Senior leaders

You have been invited to this interview because you have some knowledge on or insight into the retention of mental health nurses.

The interview will take about 40 minutes and will be audio recorded. Have you read and understood the participant information sent to you in the email?
Do you have any questions about the information or interview?
Your interview will be anonymised so you will not be identifiable in the write up or any future publications.

I have received your signed consent, but can I just check that you still consent to the interview today?

So, the interview will begin now, you can let me know if you want me to repeat or explain things or stop the interview.

What is your role within the Trust?

What are the consequences of poor retention, what does it mean for those services with poor retention?

INPATIENT

Thinking about the inpatient settings (for example acute, rehab, older adult inpatient settings) what do you think are the key factors influencing nurses' decisions to leave their inpatient setting and go to a different clinical setting?

COMMUNITY

Thinking about the community settings (for example CMHTs, HTT,) what do you think are the key factors influencing nurses' decisions to leave their community setting and go to a different clinical setting?

What do you think are the factors specific for nurses that influence their decision to leave their Trust and go to another one?

In terms of retention plans/strategies what is being done currently to address some of the issues you mentioned?

What has worked well? Do you know what worked well in the past?

What didn't work so well?

Minor Amendment approval letter 2

Health
Sciences
School

18th January 2022

Rosie Adams
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Dean
Professor Tracey Moore
Health Sciences School
Division of Nursing and Midwifery
Barber House Annexe
3a Clarkehouse Road
Sheffield
S10 2LA

Telephone: +44 (0) 114 222 2076
Email: hesdenreshub@sheffield.ac.uk

Dear Rosie

Project Title: A workforce in crisis: understanding the factors that affect retention within the mental health nursing workforce

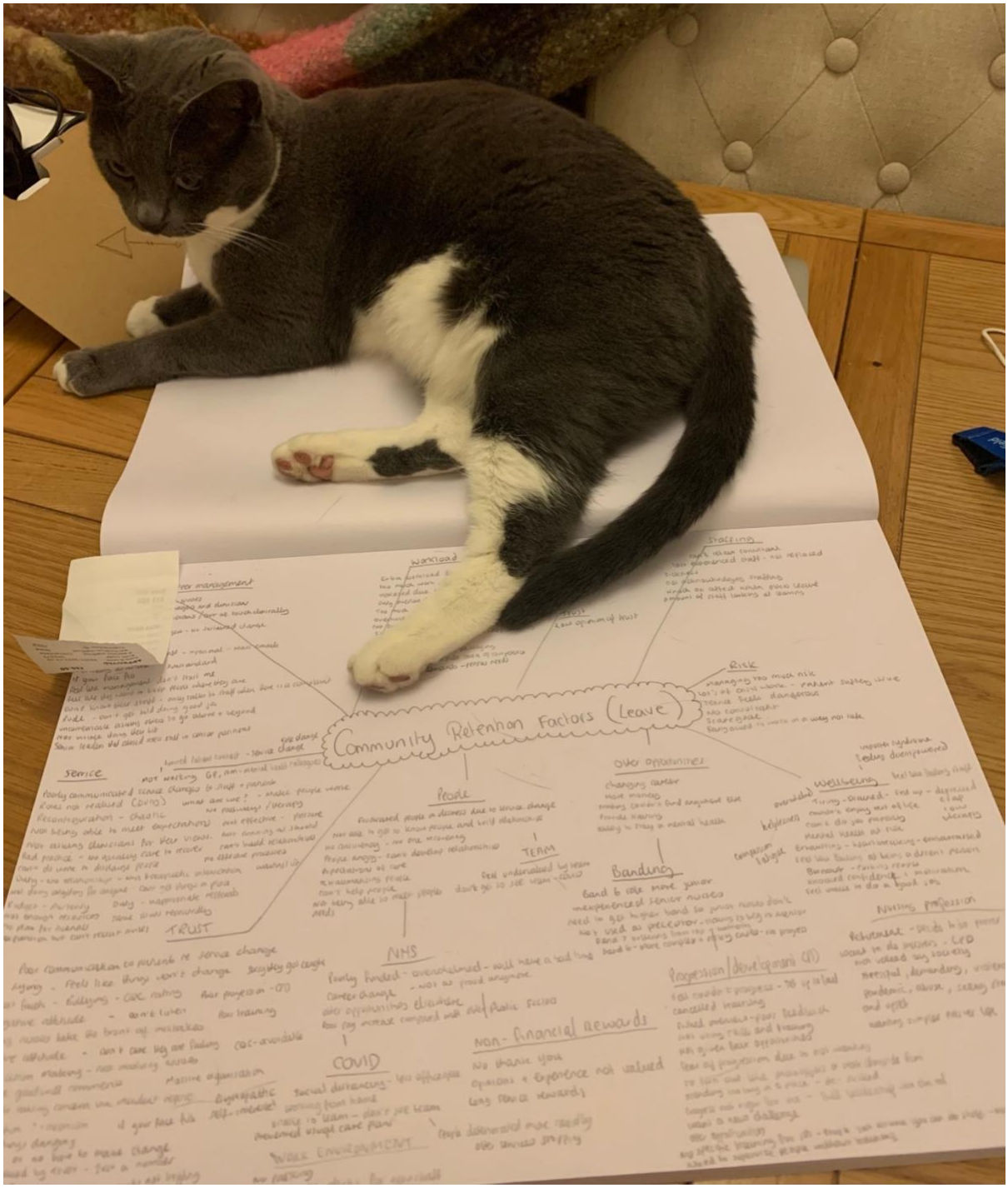
Application number: 036316

I am writing to confirm approval of your request for minor amendment(s) to your ethics submission Number 036316, detailed in the Notice of Amendments Form submitted on 17th January 2022.

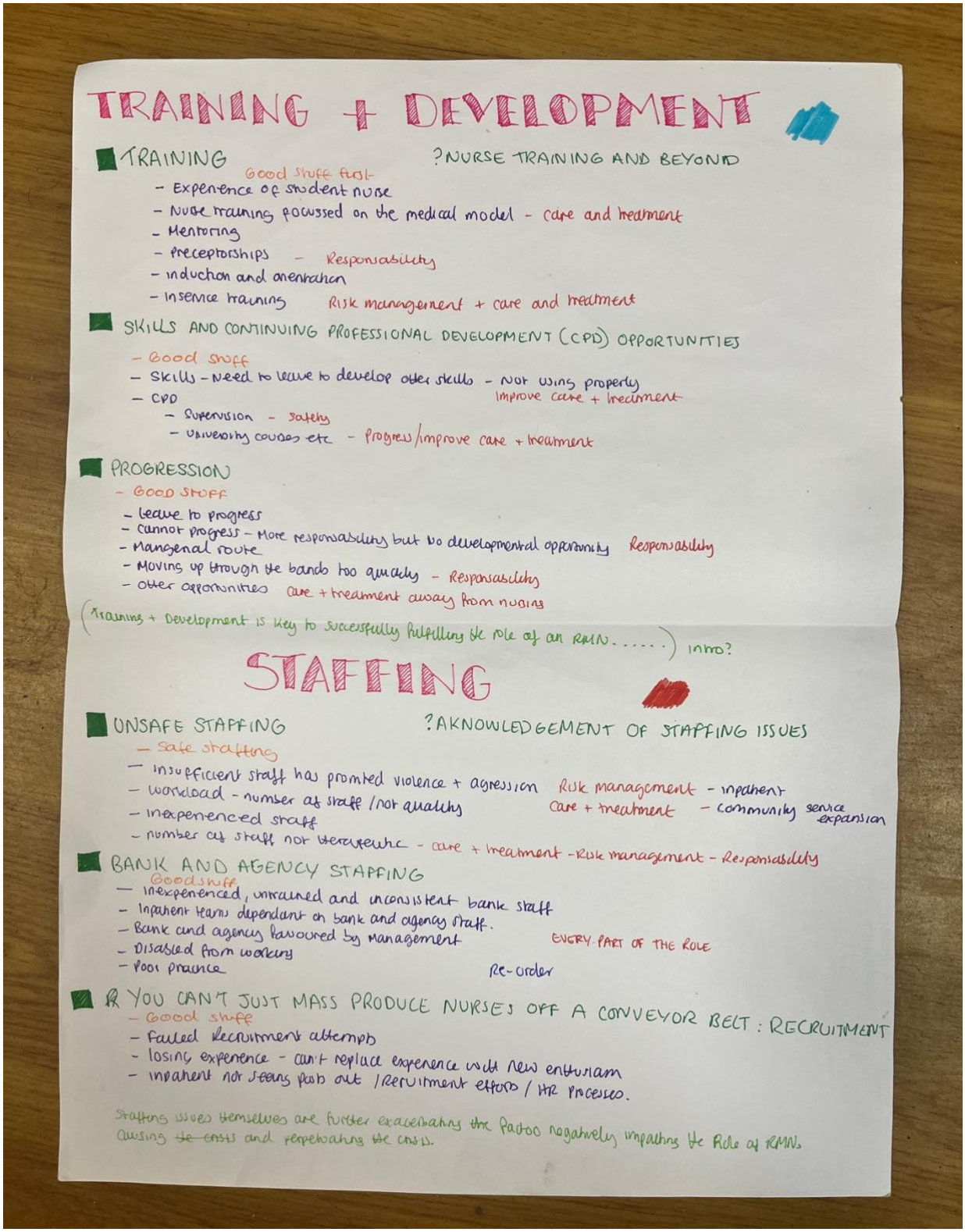
Yours sincerely

Dr Jane McKeown & Dr Rachel King
Ethics Lead

Appendix Q – Familiarisation process



Appendix R – Thematic mapping



TRAINING + DEVELOPMENT

TRAINING — ?NURSE TRAINING AND BEYOND

Good stuff first

- Experience of student nurse
- Nurse training focussed on the medical model - care and treatment
- Mentoring
- Preceptorships - Responsability
- Induction and orientation
- Inservice training — Risk management + care and treatment

SKILLS AND CONTINUING PROFESSIONAL DEVELOPMENT (CPD) OPPORTUNITIES

- Good stuff
- Skills - Need to leave to develop other skills - Not using properly — Improve care + treatment
- CPD
  - Supervision - safety
  - University courses etc - Progress/improve care + treatment

PROGRESSION

- Good stuff
- Leave to progress
- Cannot progress - More responsability but no developmental opportunity — Responsability
- Managerial route
- Moving up through the bands too quickly - Responsability
- Other opportunities — Care + treatment away from nursing

(Training + Development is key to successfully fulfilling the role of an RMN.....) into?

STAFFING

UNSAFE STAFFING — ?AKNOWLEDGEMENT OF STAFFING ISSUES

- Safe staffing
- Insufficient staff has promted violence + agression — Risk management - inpatient
- Workload - number of staff / not quality — Care + treatment - community service expansion
- Inexperienced staff
- number of staff not therapeutic - care + treatment - Risk management - Responsability

BANK AND AGENCY STAFFING

Goods stuff

- Inexperienced, untrained and inconsistent bank staff
- Inpatient teams dependant on bank and agency staff.
- Bank and agency favoured by management — EVERY PART OF THE ROLE
- Disabled from working
- Poor practice — Re-order

YOU CAN'T JUST MASS PRODUCE NURSES OFF A CONVEYOR BELT : RECRUITMENT

- Good stuff
- Failed Recruitment attempts
- losing experience - can't replace experience with new enthusiasm
- Inpatient not teams push out /Recruitment efforts / HR processes.

Staffing issues themselves are further exacerbating the factor negatively impacting the Role of RMNs causing ~~the crisis~~ and perpetuating the crisis.

Appendix S – Summary of Findings

Quantitative Findings – 392 survey responses across three NHS Trusts	
Nurses across the three Trusts who are considering leaving	**Percentage**
Nurses who indicated that they are considering leaving their job	68.2%
Nurses who indicated that they often think about leaving their organisation	49%
Nurses who indicated that they are considering leaving nursing altogether	28.6%
- Would like to retire or take a career break	13.8%
- Would like to move to a job out of nursing	14.8%

Demographic factors significantly associated with nurses' intention to leave

Demographic factor	Statements related to nurses' intent to leave their organisation	*p*	Proportions that differ significantly from one another identified through post-hoc z-test (Bonferroni Method)	Cramer's V
Gender	I will probably look for a new job at a new organisation in the next 12 months	.042	Males (42.3%) **vs** Females (27.7%)	.111
	Nurses most likely destination - Move to another job within the same organisation -Move to a job outside of nursing	.049	 Females (18.6%) **vs** Males (8.2%) Males (22.7%) **vs** Females (12.6%)	.152
Age	I will probably look for a new job at a new organisation in the next 12 months	0.43	21-30 (41%) 31-40 (34.5%) 41-50 (38.1%) **vs** 50-65 (22.1%)	.143
	Nurses most likely destination -Move to a job within the same organisation -Move to a job in a different NHS organisation -Move to a nursing job outside the NHS -Move to a job outside nursing	<.001	 21-30 (21.3%) 41-50 (21.9%) **vs** 51-65 (9.9%) 21-30 (26.2%) **vs** 51-65 (9.2%) 31-40 (9.2%) **vs** 21-30 (0%) 41-50 (1.9%) 51-65 (2.3%) 21-30 (13.1%) 31-40 (21.8%) 41-50 (22.9%) **vs** 51-65 (4.6%)	.280

	-Retire or take a career break		51-65 (33.9%) 65+ (37.5%) **vs** 21-30 (1.6%) 31-40 (3.2%) 41-50 (1%)	
Ethnic background	I often think about leaving this organisation	.011	White (51.7%) **vs** Non-white (36.2%)	.151
	Nurses most likely destination -Move to a job in a different NHS organisation -Move to a nursing job outside the NHS -Move to a job outside nursing	.001	 Non-white (23.2%) **vs** White (13%) Non-white (7.2%) **vs** (2.5%) White (17.6%) **vs** Non-white (1.4%)	.227
Marital status	As soon as I can find another job, I will leave this organisation	.010	Single (28.8%) Married/Civil partnership (24.3%) **vs** Other (9.8%)	.146
Religion	I often think about leaving this organisation	.008	Other (64.1%) **vs** Christian (42.4%)	.133
	I will probably look for a new job at a new organisation in the next 12 months	.032	Other (53.8%) **vs** No religion (31.3%) Christian (27.2%)	.116
	Nurses most likely destination -Move to a nursing job outside the NHS -Move to a job outside nursing -Retire or take a career break	.002	 Other (10.3%) Christian (4.4%) **vs** No religion (1%) Other (20.5%) No religion (19%) **vs** Christian (8.2%) Christian (19.6%) **vs** No religion (9.2%)	.189

Background factors significantly associated with nurses' intention to leave

Background factor	**Statements related to nurses' intent to leave their organisation**	***p***	**Proportions that differ significantly from one another identified through post-hoc z-test (Bonferroni Method)**	**Cramer's V**
Staff grade	I often think about leaving this organisation	<.001	Band 5 (69.1%) **vs** Preceptorship (17.4%) Band 6 (52.7%) Band 7 (41.6%) Band 8 (32.4%) Band 6 (52.7%) **vs** Preceptorship (17.4%) Band 8 (32.4%) Band 7 (41.6%) **vs** Preceptorship (17.4%)	.198
	I will probably look for a new job at a new organisation in the next 12 months	.003	Band 5 (45.5%) **vs** Band 7 (22.1%) Band 8 (20.6%)	.173
	As soon as I can find another job, I will leave this organisation	<.001	Preceptorship (30.4%) Band 5 (30.9%) Band 6 (25.6%) **vs** Band 7 (11.7%) Band 5 (30.9%) **vs** Band 8 (11.8%)	.186
	Nurses most likely destination - Move to a job outside nursing	.005	 Band 5 (29.1%) **vs** Preceptorship (0%)	.161
Time spent in current job	Nurses most likely destination -Retire or take a career break	<.001	 10+ years (36%) **vs** 2-3 years (7.5%) 1-2 years (2.5%) Less than 1 year (8.4%)	.204
Working hours	Nurses most likely destination -Retire or take a career break	.047	 Up to 29 hours (24.5%) **vs** 30 hours or more (12.1%)	.169
Nurse qualification	Nurses most likely destination -Retire or take a career break	.007		.164

			Other (40%) **vs** Diploma (15.6%) Post-graduate (14.3%) Batchelor's (7.6%)	
Nursing experience	Nurses most likely destination - Move to a job in a different NHS organisation - Retire or take a career break	<.001	 1-2years (40%) **vs** 10+years (10.1%) 10+years **vs** 5+years (3.2%)	.197
Caring responsibilities (children)	Nurses most likely destination - Retire or take a career break	.039	 No children (18.1%) **vs** Children (6.8%)	.173
Caring responsibilities (Other)	Nurses most likely destination - Move to a nursing job outside the NHS - Move to a job outside nursing - Retire or take a career break	.005	 Caring responsibilities (5.8%) **vs** No caring responsibilities (1.7%) No caring responsibilities (18.1%) **vs** Caring responsibilities (9.7%) Caring responsibilities (19.5%) **vs** No caring responsibilities (10.1%)	.206
Work-related stress and Wellbeing factors significantly associated with nurses' intention to leave				
Work-related stress and wellbeing	**Statements related to nurses' intent to leave their organisation**	***p***	**Proportions that differ significantly from one another identified through post-hoc z-test (Bonferroni Method)**	**Cramer's V**
Work-related stress	I often think about leaving this organisation	<.001	Yes (62.8%) **vs** No (26.7%)	.354
	I will probably look for a new job at a new organisation in the next 12 months	<.001	Yes (41.3%) **vs** No (16.7%)	.325
	As soon as I can find another job, I will leave this organisation	<.001	Yes (30.2%) **vs** No (10.7%)	.305
	Nurses most likely destination - Move to a job within the same organisation - Move to a job in a different NHS organisation - Move to a nursing job outside the NHS - Move to a job outside nursing	<.001	 Yes (19.4%) **vs** No (10.7%) Yes (17.8%) **vs** No (10%) Yes (5%) **vs** No (0.7%) Yes (20.7%) **vs** No (2.3%)	.372
Mental Wellbeing	I often think about leaving this organisation	<.001	Probable depression or anxiety (86.8%) **vs** Possible depression or anxiety (57.7%) Average mental wellbeing (38.6%) High mental wellbeing (21.4%) Possible depression or anxiety (57.7%) **vs** Average mental wellbeing (38.6%) High mental wellbeing (21.4%)	.234
	I will probably look for a new job at a new organisation in the next 12 months	<.001	Probable depression or anxiety (71.7%) **vs** Possible depression or anxiety (32.3%) Average mental wellbeing (26.2%) High mental wellbeing (7.1%)	.234
	As soon as I can find another job, I will leave this organisation	<.001	Probable depression or anxiety (60.5%) **vs** Possible depression or anxiety (23.1%) Average mental wellbeing (16.7%) High mental wellbeing (7.1%)	.261

	Nurses most likely destination - Move to a job outside nursing	<.001	Probable depression or anxiety (42.1%) **vs** Possible depression or anxiety (20.8%) Average mental wellbeing (6.7%) High mental wellbeing (7.1%) Possible depression or anxiety (20.8%) **vs** Average mental wellbeing (6.7%)	.226
Adequate adjustments	I often think about leaving this organisation	.006	No (100%) **vs** Yes (36.8%) No adjustment required (41.9%)	.244
	I will probably look for a new job at a new organisation in the next 12 months	<.001	No (70%) No adjustment required (39.5%) **vs** Yes (16.2%)	.286
	As soon as I can find another job, I will leave this organisation	.002	No (60%) **vs** No adjustment required (25.6%) Yes (8.8%) No adjustment required (25.6%) vs Yes (8.8%)	.271
	Nurses most likely destination - Move to a job outside nursing	.020	No (50%) **vs** Yes (13.2%) No adjustment required (14%)	.296

Trust and clinical setting factors significantly associated with nurses' intention to leave

Trust and clinical setting	Statements related to nurses' intent to leave their organisation	*p*	Proportions that differ significantly from one another identified through post-hoc z-test (Bonferroni Method)	Cramer's V
Trust	I often think about leaving this organisation	.029	Trust 1 (61.2%) **vs** Trust 2 (42%) Trust 3 (46.2%)	.117
	I will probably look for a new job at a new organisation in the next 12 months	.002	Trust 1 (39.7%) **vs** Trust 2 (26.1%)	.148
	As soon as I can find another job, I will leave this organisation	.038	Trust 1 (28.4%) **vs** Trust 2 (16.6%)	.114
	Nurses most likely destination - Move to a job within the same organisation - Move to a job in a different NHS organisation -Move to a job outside nursing	.001	Trust 2 (19.1%) **vs** Trust 1 (8.6%) Trust 1 (19.8%) Trust 3 (18.5%) **vs** Trust 2 (8.3%) Trust 1 (24.1%) **vs** Trust 2 (12.1%) Trust 3 (9.2%)	.194
Clinical setting	I DO NOT often think about leaving this organisation	.035	Other (61.5%) **vs** Community (31.8%) Inpatient (22.6%)	.115
	I will probably look for a new job at a new organisation in the next 12 months	<.001	Inpatient (44.3%) **vs** Community (28%) Other (0%) Community (28%) **vs** Other (0%)	.168
	As soon as I can find another job, I will leave this organisation	.019	Inpatient 31.3% **vs** Community (20.1%) Other (0%)	.123
	Nurses most likely destination - Retire or take a career break	.018	Community (16.7%) **vs** Inpatient (6.1%)	.167

p = p-value
*Represents a statistically significant result
Cramer's V effect size (Cohen, 1988)
Non statistically significant associations are displayed in Chapter 4.

Qualitative Findings – 30 interviews with RMNs and 10 interviews with Senior Leaders

	Responsibility

<table>
<tr><td rowspan="6">Disillusionment with mental health nursing</td><td colspan="3"><u>Risk management</u></td></tr>
<tr><td>Leave factors</td><td>Stay factors</td><td>Potential strategies</td></tr>
<tr><td>• Solely responsible for the safety of huge caseloads**
• Responsible for the safety of acutely unwell service users and large staff teams*
• Violence and aggression
• Inappropriate cases/admissions
• Too many high-risk cases (Community)
• Inability to share risk (Community)
• Frequent emergency interventions (Inpatient)</td><td>• Ability to share risk
• Manage less risk (Community)
• Smaller caseloads (Community)
• Ability to share responsibility (Community)</td><td>• Caseload management tools
• Transforming community mental health services
• Increased managerial support
• Training
• Building an interprofessional network
• Safety huddles
• Strengthen nurses risk assessing, safety planning and crisis intervention skills
• Reducing causes of violence and aggression</td></tr>
<tr><td colspan="3"><u>Care and Treatment</u></td></tr>
<tr><td>Leave factors</td><td>Stay factors</td><td>Potential strategies</td></tr>
<tr><td>• Poorer clinical outcomes
• Lack of recognition
• Lack of therapeutic engagement
• Excessive workloads
• Medical model
• Substandard care
• Bad practice
• Premature discharges (Inpatient)
• Task orientated (Inpatient)
• Specialist community teams (Inpatient)</td><td>• Rewarding, inspiring, interesting
• Valuable input
• Meaningful recognition
• Good clinical outcomes
• Modified expectations
• Challenging, unpredictable, and varied
• Meaningful engagement with service users
• Good care and treatment options
• Good practice</td><td>• Make a difference award
• Need to help nurses find the right setting for them
• Outsource non-clinical tasks to other members of staff
• Make a difference award
• CDU
• More trauma informed care models less medically focussed.</td></tr>
<tr><td></td><td colspan="3"><u>Visible and approachable leadership</u></td></tr>
<tr><td></td><td>Leave factors</td><td>Stay factors</td><td>Potential strategies</td></tr>
</table>

Leadership and Management	• Lack of clarity • Constant changes in leadership and management • Lack of visible and approachable leadership • Poor communication • Lack of Trust	• Safe organisational culture • Well defined leadership and management structure (**Community**) • Inclusive leadership (**Community**) • Visible leadership (**Community**)	• Managers and senior leaders to work clinically • Managers must alert senior leaders if nurses are thinking of leaving • Improve communication beyond email to Trust Facebook pages, apps, and staff survey action plans for dispersing information • Improve exit interviews • Introduce stay interviews/conversations
	<u>Supportive management and leadership</u>		
	Leave factors	**Stay factors**	**Potential strategies**
	<u>Supportive management and leadership</u> • Unsupportive line-managers with clinical activity • Poor management of violence and aggression • Lack of support/debrief after serious incidents • Blame culture • Bullying • Lack of support with root causes of wellbeing • Lack of support with training and development • Ignoring risk management concerns (**Inpatient**)	<u>Supportive management and leadership</u> • Feeling valued and understood • Satisfactory wellbeing support • Trusting and empowering relationships (**Community**) • Support with development (**Community**) • Hands-on support (**Inpatient**)	<u>Supportive management and leadership</u> • Provide more support for middle managers via leadership and development programs • Promote a 'no blame culture' • Offering comprehensive wellbeing packages • Develop a robust wellbeing strategy that addresses the root causes • Introducing wellbeing conversations into appraisals • Focus on the quality of PDRs
	<u>Poorly managed services</u>		
	Leave factors	**Stay factors**	**Potential strategies**
	<u>Poorly managed services</u> • Underperforming services with poor CQC ratings • Lack of accountability • Insufficient care pathways • Poorly defined roles • Waiting lists (**Community**) • Feeling excluded from service development plans (**Community**) • Managers with a lack of clinical and managerial experience (**Inpatient**) • Over occupying wards (**Inpatient**)		<u>Poorly managed services</u> • Improve visibility and communication • Include nurses in service development and empower them to drive change forward

	• Task orientated managers (**Inpatient**)		
Work Environment	**<u>Team dynamics</u>**		
	Leave factors	**Stay factors**	**Potential strategies**
	• Negative team dynamics • Highly valued nurses leaving • Feeling disconnected from the wider organisation • Insufficient team meetings to discuss cases (**Community**) • Lack of camaraderie (**Inpatient**) • Inadequate skill mixes (**Inpatient**) • Conflict (**Inpatient**) • Difficult relationships withing the MDT (**Inpatient**) • Unhealthy relationships between wards and other services (**Inpatient**)	• Positive team dynamics • Feeling valued by the wider MDT • Positive team dynamics • Supportive networks across the organisation (**Community**) • Camaraderie (**Inpatient**)	• Support nurses to regain collective leadership over their workloads • Full team away-days
	<u>Pay</u>		
	Leave factors	**Stay factors**	**Potential strategies**
	• Unpaid overtime • Agency pay rates • Small pay rises • Agenda for change • Living below inflation (**Community**) • Disparity in pay for similar roles across Trusts (**Community**) • Lower salaries post retirement (**Community**) • Progression leads to pay cut (**Inpatient**)	• Job security • Bank shifts • Annual leave (**Community**) • Maternity leave (**Community**) • Sick pay (**Community**) • Pension (**Community**) • Pay enhancements for unsociable hours (**Inpatient**)	• Ensuring people are on the highest pay point possible • Recruitment and retention bonuses • Paying nurse registration fees and car parking

	Working hours		
	Leave factors	**Stay factors**	**Potential strategies**
	• Overtime • Lack of flexibility • Thinking about work beyond working hours (**Community**) • Working too many unsociable hours (**Inpatient**)	• Flexible working • Office-based hours (**Community**)	• Create an organisational culture that encourages flexible working
	Physical working environment		
	Leave factors	**Stay factors**	**Potential strategies**
	• Working from home (**Community**) • Unsafe ward environments (**Inpatient**)	• Working from home (**Community**) • More autonomy over the management of their responsibilities (**Community**) • Less restrictive (**Community**) • Less interruptions (**Community**)	• Hybrid system that provides choice over where community nurses can work • Improving ward environments
Training and Development	**Training**		
	Leave factors	**Stay factors**	**Potential strategies**
	• Supervising student nurses • Inadequate preceptorships • Inadequate induction and orientation • Insufficient in-service training specific to clinical setting • Poor experience of nurse training (**Community**)	• Good in-service training • Positive experience of nurse training (**Community**) • Nurse training secondments (**Community**) • Rotational posts (**Community**)	• Super mentors • Introducing non-clinical practice facilitators • Rotational posts • Improve inductions • Reduce mandatory training
	Skills and CPD opportunities		
	Leave factors	**Stay factors**	**Potential strategies**
	• Fear of losing skills • Lack of CPD opportunities to develop and acquire new skills • Lack of regular good quality supervision	• Opportunities to learn and develop new skills • Regular quality supervision	• Regular reflective supervision • Professional nurse advocates

			• Offer more CPD opportunities such as ACPs, management and leadership courses, Shadowing, and post-graduate courses. • Improve communication around what CPD opportunities are available
	<u>Career progression</u>		
	Leave factors	**Stay factors**	**Potential strategies**
	• Fewer opportunities to progress • Lack of clinical progression pathways • Progress too quickly • Alternative job opportunities • Unfair HR processes (**Community**) • Being given responsibilities of a higher band but no progression (**Inpatient**)	• Plenty of opportunities to progress • Clear developmental pathways for individual nurses	• Last minute career progression conversations • Creating more senior posts for inpatient settings • Developing a strategic vision for nurses' career pathways • Encouraging managers to regularly discuss developmental and progression opportunities • Creating more clinical progression pathways
Staffing	**<u>Unsafe staffing</u>**		
	Leave factors	**Stay factors**	**Potential strategies**
	• Insufficient core numbers • Unsafe staffing causing dangerous and substandard care • Heightened anxiety over safety • Further increases workload leading to exhaustion and burnout • Unable to work in line with policies and procedures (**Inpatient**) • Increase in violence and aggression (**Inpatient**) • Prevents training and development (**Inpatient**) • Lack of support (**Inpatient**) • Working outside the limits of their competence (**Inpatient**) • Inadequate skill mix (**Inpatient**) • Poor staff morale and team dynamics (**Inpatient**)	• Working in teams with a full complement of staff	• Investment of £4.6 million into community settings to recruit more nurses • Mental health optimum staffing tool • Ensure more senior nurses are on shift including ward managers and matrons acting in a clinical capacity.

	Bank and agency staff		
	Leave factors	**Stay factors**	**Potential strategies**
	• Excessive use of bank and agency • Negatively affects team dynamics • Permanent staff feel they are treated unfavourably to bank and agency staff • Increase in workload causing burnout • Lack of support (**Community**) • Creates a chaotic and dangerous work environment (**Inpatient**) • Poor practice due to a lack of training and management (**Inpatient**) • Increase in risk incidents (**Inpatient**)	None described	• Emphasis on progression posts to prevent nurses leaving for agencies for higher pay • Government to increase pay for nurses