Evaluation of Careers Clinics and Transfer Schemes in NHS Trusts in London

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Executive Summary

Nurse retention remains a priority in London and for CapitalNurse. Career Clinics and career counselling or coaching schemes, often coupled with Transfer Schemes that facilitate moves within an employer represent one approach to improving retention.

In 2018 CapitalNurse undertook a survey of London NHS trusts asking about the implementation of such schemes. Ten employers in the capital responded and 9 of these said that they ran such a scheme. Eight of these trusts participated in this evaluation of their schemes. This evaluation combined a survey of nurses who had engaged with these schemes (n=88) with 9 interviews with the leads of the schemes in these trusts. The interview part of the study included participants from trusts in Southeast, Southwest, Northwest and North Central London. Most were acute trusts but some were integrated or specialist trusts. The sample included inner London teaching hospitals and outer London trusts. We did not have representation from a mental health trust.

Regarding our survey of scheme participants, the largest group of respondents to the survey was Band 5 nurses who had been with their current employer for between 1 and 5 years. Nearly 60 (68%) had engaged with a transfer scheme and 47 (53%) of these identified being able to move to another area without going through lengthy application processes as one of the main attractions of the scheme. The approachability of scheme leads was the second most frequently identified. Fifty-five respondents (63%) reported successfully moving within their trust though 6 (7%) said that they were prevented from moving. Some 57 (80%) said that their job satisfaction had improved as a result of the scheme while for 3 (3.4%) individuals it had decreased. Fifty-five participants (63%) reported that they were more likely to stay with their present employer. Some 38 (43%) participants provided short comments. Of these, 26 (68% of commenters) comments described positive experiences though 7 (18%) described being blocked in their transfer by clinical staff or managers or unexpectedly having to go through a job interview.

The interview findings suggest that all of the schemes are similar though scheme leads can be drawn from different parts of an organisation e.g. workforce development, recruitment and retention or education. Careers clinic and transfer schemes tended to be run by different individuals bringing different and often complementary perspectives to the work and were publicised by a mixture of on-line

and paper-based promotions. Trusts appeared to vary in the level of resourcing for the schemes and whether the schemes were strategic—based on trust-wide values such as a strengths based approach—or more pragmatic—led by internal vacancy rates. Some scheme leads spoke of a lack of administrative support hampering follow-up and evaluation. Scheme leads varied in the amount of preparation e.g. coaching training that they had received. Some schemes were open to all nurses and support workers while some were focussed on particular bands. Most schemes featured a two-stage process where nurses could express an interest and received brief advice at a large event and could then go on to make an appointment for a more in-depth conversation. The principles of confidentiality and the creation of a 'neutral' space for conversation were emphasised by a number of scheme leads.

Recommendations

A varied approach to publicising the schemes within trusts direct to all potential participants would avoid failures in cascading information

Participants value being able to move to another area without going through lengthy application processes: the process should be made clear to all involved so that there are no surprises for participants

Leads need to be visible, approachable, and knowledgeable about opportunities and have an understanding that confidentiality matters to scheme participants

Adequate resourcing and reporting at senior or board level allows schemes to be programmatic and strategic

Pragmatism and flexibility in delivery can mitigate problems of access for nurses in busy settings but are no substitute for a programmatic approach

An underlying approach, such as the strengths based approach, can provide a unifying structure to a scheme and ultimately be more useful for individual nurses and the organisation

An identified specialist nurse with organisational responsibility for retention—in same way an audit nurse facilitator exists—could raise the profile of such a role and facilitate networking across the Capital

Schemes that include nurses and Health Care Assistants in all stages of their careers would allow organisations to establish their needs and where their strengths lie across the whole nursing and support workforce

Career clinics and Internal Transfer window initiatives could be more strategically / opportunistically sequenced with key life events such as empty nest/approaching retirement/health concerns to yield maximum benefit for both nurse and organisation

Introduction

This document from the Centre for Critical Research in Nursing and Midwifery at Middlesex University reports on an evaluation, undertaken for CapitalNurse, of Career Clinics and Transfer Schemes in a number of NHS organisations in London.

Background

NHS employers in the Capital face well-known challenges regarding recruitment to and retention of their nursing workforce. Initiatives implemented to address these challenges include those that encourage and facilitate nurses, at various career stages, to consider their strengths and contribution to nursing, and career planning including, but not limited to, 'sideways' moves within their current employer in order to gain a variety of experience. Career Clinics and career counselling or coaching arrangements, often coupled with Transfer Schemes that facilitate moves within an employer represent one such approach.

In 2018 CapitalNurse undertook a survey of London NHS trusts asking about the implementation of such schemes. Ten employers in the capital responded and 9 of these said that they ran such a scheme. Seven indicated willingness to be involved in a further evaluation. Some have been subject to internal evaluations. All respondents to that survey stated that their schemes aimed to increase retention within their trusts and to increase awareness of internal development opportunities. One respondent said that aims included facilitating movement to clinical areas most 'in need'. Schemes were run from 3 times a year, through bi-monthly to weekly. They could be based on careers fairs, providing specific access to computers to search for opportunities, or individual counselling and guidance from specially trained individuals. Internal transfer included guidance about availability and simplified processes. Some schemes were only open to qualified nurses and some specifically for Band 5 nurses. Others also reported the involvement of staff across Bands 1 – 3. Two respondents reported members of staff stating that the scheme had kept them from leaving the organisation. See Appendix 1 for a summary of findings.

The present evaluation is intended to take a broad view of these schemes providing insight into the variety of approaches, perceived barriers and their impact, where

known, on nurse retention. Its sampling was initially based upon the scheme leads from the 2018 survey who had volunteered to contribute to a further evaluation and then expanded to other trusts where personnel subsequently expressed an interest in contributing. The sampling can therefore best be described as convenience. The interview part of the study included participants from trusts in Southeast, Southwest, Northwest and North Central London. Most were acute trusts but some were integrated or specialist trusts. The sample included inner London teaching hospitals and outer London trusts as well as specialist trusts. Unfortunately we did not have representation from a mental health trust.

Aims of the evaluation

The aims of the evaluation are to:

1. Undertake a scoping exercise of current Career Clinic and Transfer Schemes in the capital and categorise these by the model of scheme adopted

2. Quantify and describe user engagement with the various schemes

3. Identify impact on nurse retention by i) collating data from all existing available evaluations and:
   ii) requesting new data (where available) from those leading the schemes

4. To gauge the impact of the schemes on job satisfaction and career intention of participants as well as their experience of involvement in the scheme

5. To compare the impact of schemes operating under different models if appropriate

Evaluation methods

We collected both quantitative and qualitative data in order to address the evaluation aims. The evaluation was given ethical approval by Middlesex University Health and Social Care ethics committee.

Methods of data collection

In order to address aims 1 and 2 we undertook structured interviews with volunteering scheme leads of the currently running schemes. These were designed to elicit descriptions of schemes and their perceived strengths, weaknesses, opportunities and threats (SWOT analysis). We undertook 8 face to face interviews and 1 telephone interview.

We addressed aim 3 by requesting, from scheme leads, retention data, from before and after the introduction of Career Clinics and Transfer schemes, however, we only received this data from two of the leads.

Aim 4 was addressed by means of an on-line survey of nurses who had taken part either in careers clinics or transfer schemes or both. Career Clinic attendees and Transfer users (or those who considered transfer but did not continue) were invited via an email from us forwarded by the Scheme Leads to participate in our survey.

We intended to address aim 5 by analysis of the data collected above and comparisons across sites, however we only received data from two organisations so we were not able to address this aim.

Findings

Survey findings

Because of data protection restrictions we did not approach careers clinic and transfer scheme participants directly but asked the scheme leads to send out an email invitation to participate on our behalf. The invitation also included the text of our Participant Information Sheet. We sent this request on January 22nd and followed up with a reminder on 29th January. We closed the survey at the end of business on Friday 7th February. We asked the leads to record the number of people who were invited so that we could calculate a response rate for the survey but we only received this information from two leads so are unable to report this. Our respondents, however, are likely to represent a small proportion of all nurses who have engaged with these schemes and one particular trust is overrepresented in our sample.

We received a total of 88 responses. Not all participants answered every question. Some 81 of these told us where they were currently employed. See Table 1.

Table 1. Current place of work

#	Workplace	%	Count
7	Croydon University Hospital	0.00%	0
9	Great Ormond Street Hospital	0.00%	0
10	Guy's Hospital	1.23%	1
12	Harefield Hospital	1.23%	1
13	Hillingdon Hospital	0.00%	0
14	Homerton University Hospital	0.00%	0
15	King George's Hospital	1.23%	1
16	King's College Hospital	4.94%	4
21	North Middlesex University Hospital NHS Trust	0.00%	0
23	Princess Royal University Hospital	0.00%	0
27	Royal Brompton Hospital	0.00%	0
29	University College London Hospital	75.31%	61
31	Royal Marsden Hospital	0.00%	0
32	Royal National Orthopaedic Hospital	7.41%	6
33	St George's Hospital	0.00%	0
34	St Helier Hospital	0.00%	0
36	St Thomas' Hospital	3.70%	3
39	Whittington Hospital	0.00%	0
40	NONE OF THESE	4.94%	4
	Total	100%	81

It is clear that we did not get participation from all of the trusts included in our sample of scheme leads. Some workplaces in London where there was no expected participation are not included in the above table for the sake of brevity. There does not appear to be any participation by nurses employed in community settings or in mental health trusts.

The largest group of survey participants were Band 5 nurses who had been with their current employer for between 1 and 5 years. See Figures 1 and 2.

Figure 1. Banding of participants

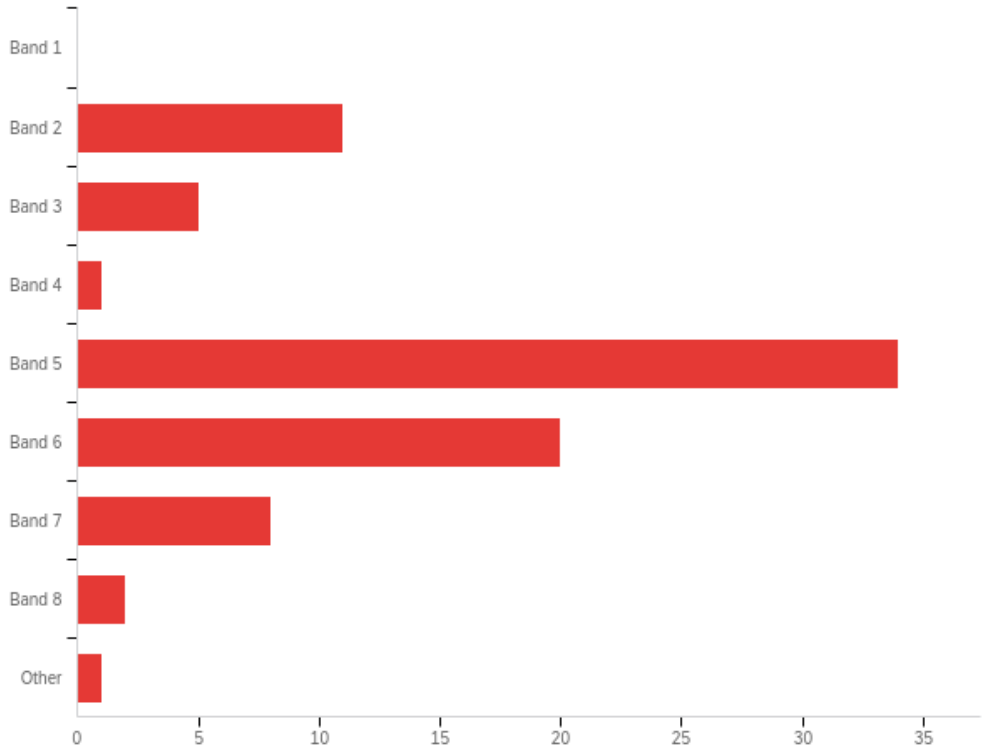
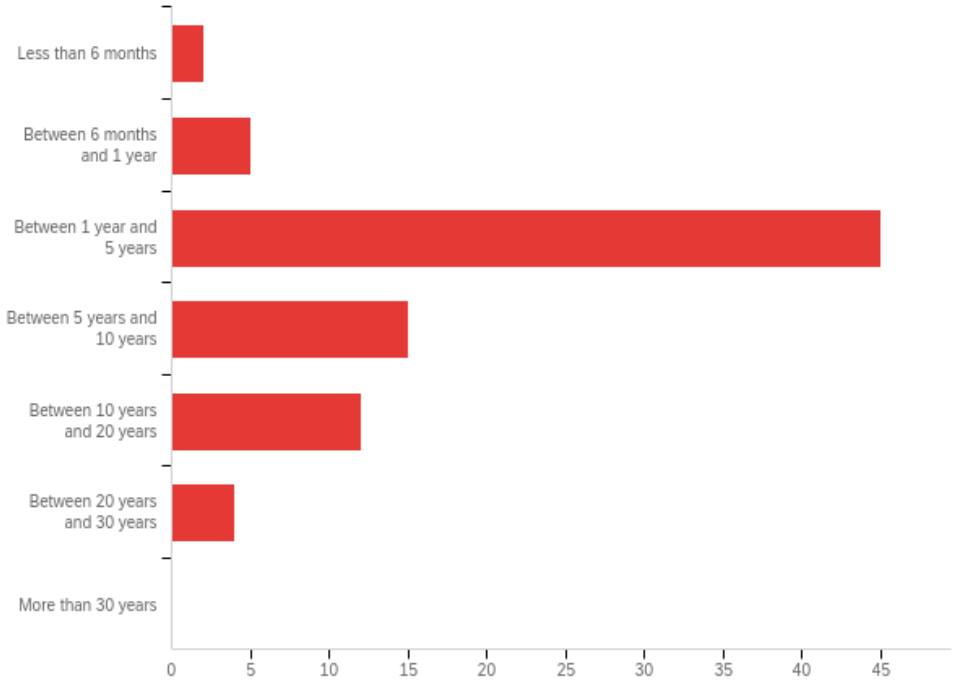
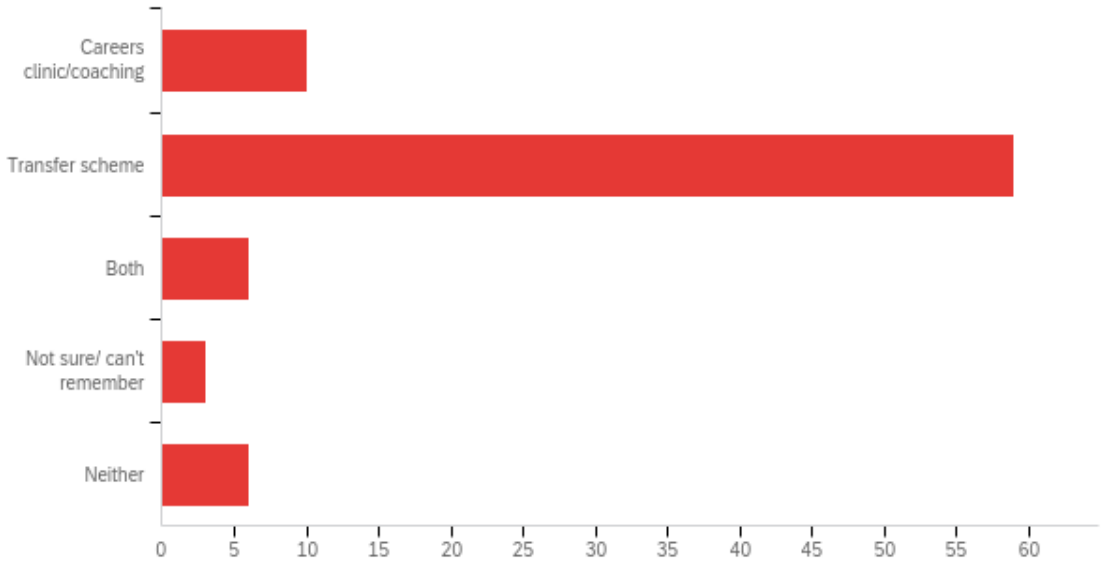


Figure 2. Years with current employer



The largest group told us that they had been involved in a transfer scheme. It is possible that some participants were involved in both types of scheme but understood their experience of careers coaching to be part of a transfer process.

Figure 3. Schemes engaged with



Reflecting the predominance of survey participants who had engaged with a transfer scheme, the most frequently identified attractive feature of the scheme was the ability to move area relatively simply. See Table 2. Participants were able to select more than one response.

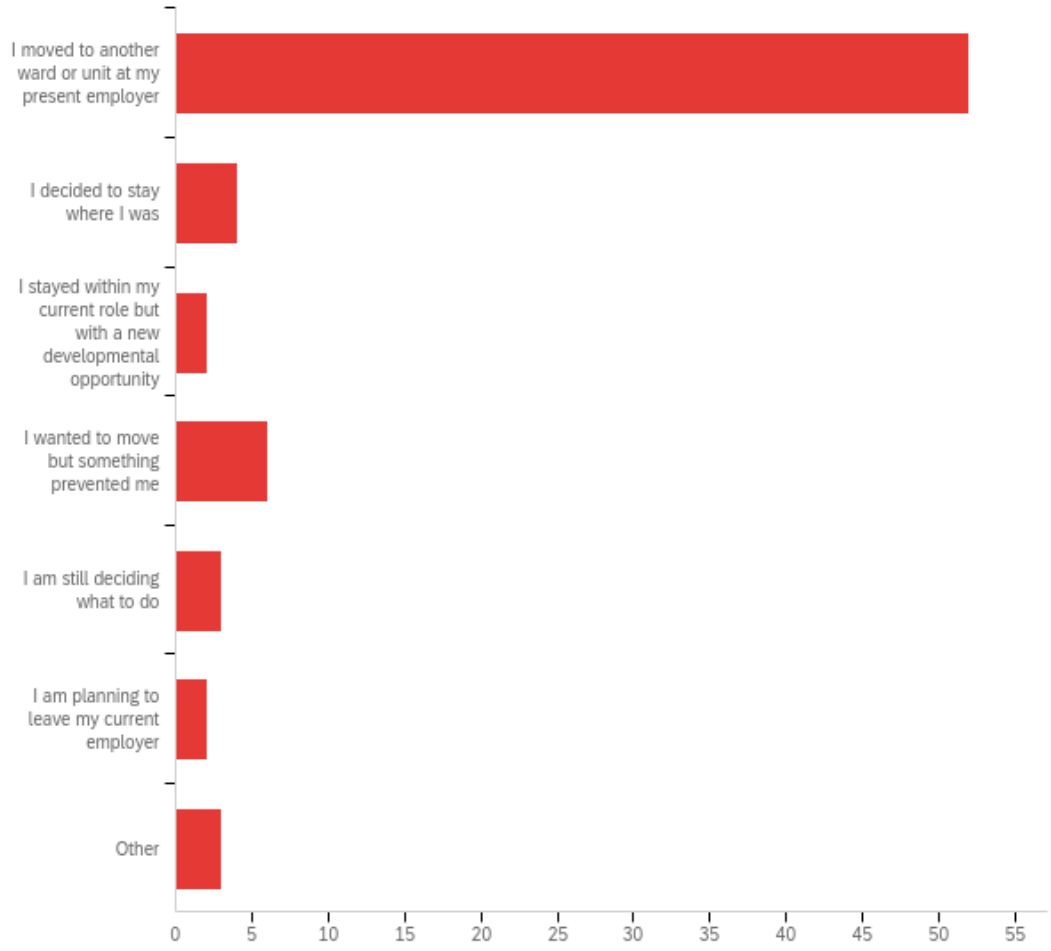
Table 2. Most attractive features of the scheme

		%	Count
1	No appointment was necessary to attend	2.78%	6
2	The person running the scheme is approachable	16.67%	36
3	The person running the scheme is knowledgeable and experienced	11.11%	24
4	It was held at a time convenient for me	6.94%	15
5	It was held at a location convenient to me	7.87%	17
6	I can get to know about vacancies and opportunities in my trust in one place	11.57%	25
7	I can move to another area without going through lengthy application processes	21.76%	47
8	Getting general careers advice/ counselling	5.56%	12

9	I was helped to self-appraise my strengths and contribution to nursing	3.70%	8
10	I could talk to someone in confidence	12.04%	26
	Total	100%	216

The most frequently identified outcome of engagement was that participants completed a transfer, however 12 did not move, 6 of these saying that something prevented them (see summary of comments added to the survey).

Figure 4. Outcome of engagement with the schemes



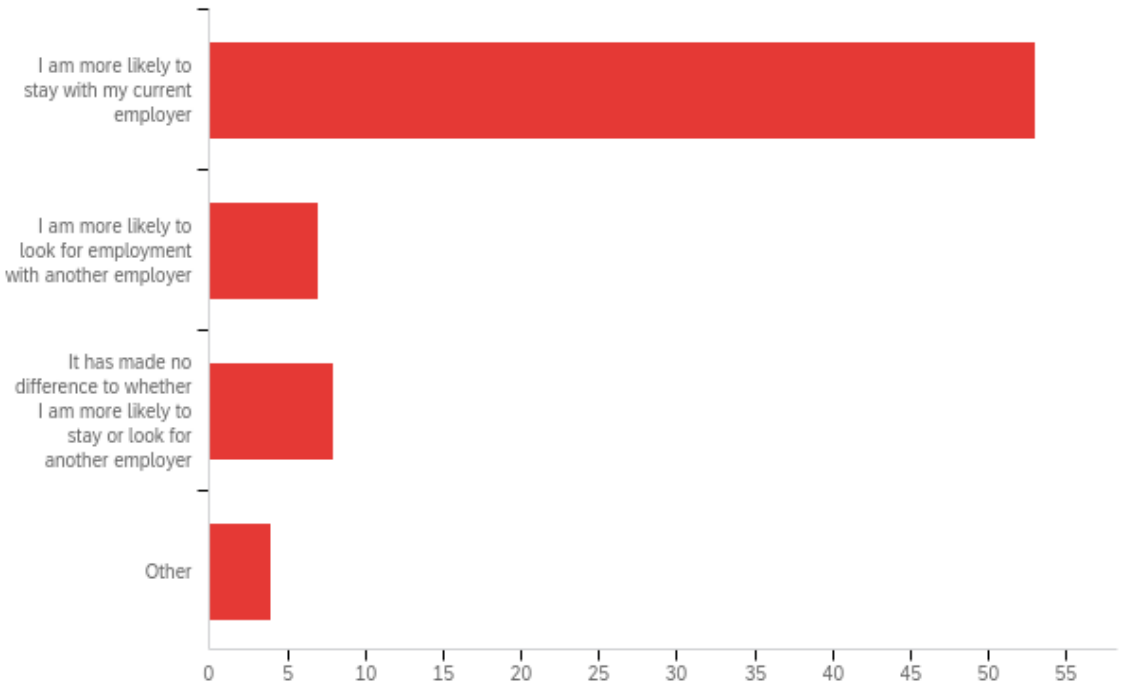
One of the aims of the career clinics and transfer schemes is to improve the job satisfaction of the workforce. We asked participants to tell us the overall impact that engagement had had on their job satisfaction. The most frequent response was that job satisfaction had improved, though 3 said that it had reduced and 8 said that there had been no change. See Table 3.

Table 3. Overall impact on job satisfaction of engagement with the schemes

#		%	Count
1	My job satisfaction has increased	79.17%	57
2	My job satisfaction has decreased	4.17%	3
3	There has been no change in my job satisfaction	11.11%	8
4	Other	5.56%	4
	Total	100%	72

Perhaps even more important than maintaining or improving job satisfaction, though linked of course, the schemes aimed at improving retention. Nearly all of our interview participants referred to this priority. From the survey, it appears that overall the schemes have succeeded in this aim. See Figure 5.

Figure 5. Overall impact on employment intentions



We invited survey participants to add a comment about their experience of careers clinics and transfer schemes. Some 38 provided short comments. Of these, 26 comments were positive. The following comment is typical, combining appreciation of the process as well as of the interaction with those who run the scheme:

> The transfer scheme is one of the most fast and convenient approach when changing career role or job. The person in charge of the transfer scheme is very approachable and supportive. He is very knowledgeable and provides you with a wide range of career opportunities which could help you enhance your career.

However, seven participants were critical of their experience in some way. The overall description of dissatisfaction included an acknowledgement that the scheme itself had potential and those delivering it were effective but that individuals had encountered resistance from clinical staff when attempting to effect a transfer:

> The transfer scheme was very accessible and the staff at the administration end were fantastic but I encountered MANY problems with clinical staff accepting my wish to transfer.

Three participants told us that they experienced unexpected complications:

> [I am] disappointed with the scheme. it was not clear that not all departments accept this. They would still require the staff to go through the whole application process and I was sent to coaching without my knowledge. I thought it was a meeting with a manager for job interview, apparently it was job coaching. I'm still here in my unit...totally disappointed. and when I email, it took weeks before I get a reply. today I decided if ever I apply for a new job I will not use the scheme at all.

We end this summary of the survey findings with a positive comment which shows the potential of these schemes to improve both work and life satisfaction:

> It's made a great difference to my life as I moved from a ward to an outpatient unit for better work life balance as I wanted to desperately stop working night shifts but I loved the Trust and didn't want to work elsewhere. Now I am able to continue working for the same employer and in a place where I can end my shifts and still get home to put my young kids to bed. I am truly satisfied and grateful, more so I am on a specialist unit and benefiting from new learning opportunities. The internal transfer scheme has made a tremendous impact to my life. I feel satisfied and grateful for this opportunity.

Findings of interviews with scheme leads

We carried out 9 interviews with trust leads for these schemes between December 2019 and February 2020. Despite attempts, we were unable to either arrange an interview or make any contact with two of the leads who had been identified by the 2018 CapitalNurse survey. In three trusts we interviewed two leads, either together or separately. This resulted in interview data from 8 trusts. The interview part of the study included participants from trusts in Southeast, Southwest, Northwest and North Central London. Most were acute trusts but some were integrated trusts. The sample included inner London teaching hospitals and outer London trusts as well as a specialist trust. We did not have representation from a mental health trust. As stated above, this approach to sampling also shaped the sampling for the survey.

The interviews lasted between 26 and 48 minutes. These were audio recorded and transcribed in full. One of the interviews was carried out by telephone; the others were done in person in site visits. Participants were sent an Information Sheet in advance and signed a consent form for their participation in the evaluation. We asked questions about the design of the schemes, about the organisational location of those who lead the schemes and about their impressions of the nurses who have attended and of the overall effect of the schemes. We derived a summary of different models of design and delivery from the interview data. See Appendix 2. The quotations included below are anonymous.

Design of the schemes

Trusts tend to offer a two-stage career conversation process. The first stage tended to take the form of a careers fair or walk-in clinic open to nurses in the trust without appointment. These can be part of larger trust events. These events provided the opportunity for nurses to engage with a second stage by making an appointment for more in-depth discussion with designated senior nurses who could help them to consider their career intentions and personal strengths and provide more information. There were variations to this approach (see next section).:

> …the careers clinic is like initial advice, and then [nurses] can book on to have [further career coaching] – that's where they complete the online booking request form about what are they looking for and with the times that are best for them. And they're all with career coaches, that would be paired up with a career coach in their selection pool of career coaches would potentially be the best fit for what they are looking for. (Trust 4)

In some trusts it appeared that the two schemes ran in parallel but at a slight distance, particularly perhaps where the schemes were run by different individuals situated in different parts of the organisation. By contrast, in other trusts our informants spoke of the schemes as more integrated, for example:

> The transfer is part of the Careers Service and it is a route that some people might take, but it is definitely not the driver of the service – I think it may have been historically, but it is one option as a result of the careers conversations. (Trust 9)

Facilitating attendance

The challenge of nurses being able to leave clinical areas to attend careers clinics is tackled in different ways in different organisations. One lead saw this at least as partly the responsibility of individual nurses:

> nurses …leaving the ward areas to go and pitch for half an hour and have a career conversation is something that's not in the culture of nursing. Some of the ideas that have come out of HR [about careers clinics], they're brilliant but they're generated from a corporate world – [but] nurses won't leave the ward areas; it's hard enough getting them to have a break, let alone trying to have half an hour to discuss their career opportunities. So it's trying to have a happy balance… it's a challenge to get everybody's priorities to align exactly the same way. (Trust 4)

Other leads incorporated a partially or totally peripatetic element to their work to engage nurses and overcome this problem. One lead took a trolley loaded with information leaflets to visit wards on a rotational basis while another (see quotation from Trust 10 below) undertook her role entirely by visiting nurses and by attending and speaking about careers at preceptorship, Band 7 progression and other trust courses. Although it is difficult to compare trusts and the numbers engaged in these schemes, this particular nurse, using this approach, told us that she had completed 43 careers interviews with nurses in the first four months of her post, working on the scheme for one day a week.

Schemes focussed on all nurses or only some Bands

Organisations were split between those who made the schemes available to all nurses and those who focused these initiatives at particular bands of nurse and healthcare support worker. (See Appendix 2 for the table of models). Of the latter,

scheme leads in one trust discussed one rationale for an approach that excluded working with more senior bands of nurse:

> [management] felt they wanted to have more of a formal interview selection process for people who are at Band 6, Band 7 and 8as. Often for senior roles there's an assessment of some description, either a presentation or there's some scenarios or 'values based recruitment'. What we would try to drive quite strongly for the 7s and the 8s is values based recruitment. And if you're bypassing that are you selecting the right people for those Band 7 roles and 6 roles? …from a trust viewpoint they are such pivotal roles. …so having somebody transfer into those roles unless you really have the knowledge of the skillset they've got you don't necessarily know they are the right person for the job. (Trust 8)

As detailed below, while some schemes were aimed at a particular group, for example Band 5 nurses, scheme leads had agreed to work with nurses outside the specified target bands.

Who mainly attends

We asked the scheme leads if they could characterise the situations and motivations of the main groups of nurses who make use of careers clinics and transfer schemes. The responses were surprisingly varied. In one trust more experienced nurses tended to engage with the scheme:

> There is a mixture of people who are very ambitious and who want support to achieve their career, but I think generally this is a service that is destined for people who maybe have reached a glass ceiling or have been maybe, their career has progressed with very little direction from themselves, but support from other people. Often it's people who want to find a better work-life balance. I have seen people who have resigned, ready to leave, who just think it's their last chance of staying there. So there's a broad range of people, which is why, not only do I have a hand-out with different support services on there, but I refer, I've got a very good relationship with staff psychological services and welfare, so I refer people there if they need emotional support, which happens quite frequently. (Trust 9)

It was not unusual for leads to tell us that newly qualified nurses were not their priority because often these nurses were engaged with rotation schemes of various types. Some leads also told us that, while their trust's scheme might be aimed at certain bands of qualified nurse, many individuals in the support workforce (Bands 2

and 4 were mentioned by some) had approached them for advice which they had been willing to provide.

The schemes can reveal unpopular or problematic work areas

Careers clinics and careers conversations can reveal areas in parts of an organisation that appear to have problems in need of intervention. Leads try to distinguish between those nurses who are trying to get away from a problem area and those who 'genuinely' want to further their career. It may well be that these two drivers become combined.

> So I do think there probably needs to be more of a conversation with the individuals from a management point of view about why they are wanting to move – is it because you want to have another opportunity or is it because you are unhappy – what can we do to retain people in the one ward area? I'm not necessarily sure that those conversations are going on. (Trust 4)

> What we don't want it to be used for is for people to be moving for things that should be dealt with by HR, for example. (Trust 1)

Many that we interviewed spoke about additional work that they may do when apparently unpopular or problematic areas appeared to emerge from the process:

> I think one of the things that we are conscious of is, if there are multiple requests for a transfer or a change in an area, there's something that signals that perhaps there's some difficulty in an area. Then, because you do have a relationship with the ward leaders, you often find a way to explore that a little bit. Because [without that] you just place somebody else into that same scenario. (Trust 9)

One scheme appeared to be orientated toward trust needs and the lead used organisational data to prioritise particular areas for attention:

> So what I initially did was I did a project plan and then I actually visited 3 identified wards with a higher rate of staff turnover for starters. So what I do is, I go to the ward, I introduce myself and I give out my leaflet with my contact details – the plan being that then people can come forward. So normally, I have a brief conversation with staff members - so they just tell me where there are, what they're planning to do – some know, some don't know – and then I also briefly tell them what we have to offer. (Trust 10)

Schemes have to balance two priorities

Related to the above, it seemed that in the running of these schemes two priorities could conflict: the individual nurse's and the organisation's – the former in terms of maximising job satisfaction and the latter in terms of maintaining stability and even trying to fill hard to recruit to areas. Some leads at times appeared to acknowledge the organisation's requirements for stability in staffing in addition to the needs and aspirations of the individual nurse:

> I don't know if anyone's left because they couldn't have the transfer they wanted, but I do know that, at times, it's been – critical care's a very popular area to get into; they have to have a vacancy, and there tends to be a waiting list – and I know, at times, some of the elderly medicine wards have had to say no to people moving, because they've had a lot of requests for staff to rotate out of their areas. So in that way, they've had to say no, we can't move another one. But I don't know if that actually resulted in people leaving. (Trust 4)

> Quite a number of our internationally educated nurses have been allocated medical wards and they've got a background in a speciality, intensive care maybe, so they want to transfer on to a specialist area. Obviously if a group of nurses decide to do that at one time, that's not going to be safe so then it becomes a waiting game in terms of this person will go this time and next time around the next and making sure they've still got development for them while they are there and sort of managing expectations. (Trust 8)

> I think they need to be more flexible with the internal transfer scheme, but I'm not a ward manager, and a lot of the restrictions have been put on by ward managers because they are really struggling – (Trust 4)

In one trust nurses were not allowed to transfer for the first 6 months of an appointment while for internationally educated nurses, this period was 12 months.

The leaders of the schemes in one trust spoke about how their own approach to a transfer scheme had developed over time with growing acknowledgement of the need to encourage nurses to focus on developing a personal career plan:

> …it was really about allowing people to transfer internally without going through formal recruitment processes, but it was relatively functional. So the

> conversations weren't necessarily careers focussed; it was more around 'this is where the vacancies are and do you think your skillset or your interests might align to this other area?' Or it was employee led, so they would know that there was a vacancy in this other area and they wanted to use the transfer scheme to bypass the recruitment processes reasonably and efficiently, to go and then work in a different specialty… [but now our approach is] very nurse centric, so that nurses are at the centre of the process, rather than fitting people in gaps or moving people around or retaining people here – there's obviously a lot of pressure on department managers; there's a lot of pressure on the Trust; there's a lot of pressure on nurses on a daily basis – but it's putting the nurse at the centre of the process (Trust 9)

When trusts have attempted to measure the effectiveness of careers clinics and transfer schemes, the measures have been, of course, organisational. There have been some apparently notable successes. In one small trust that had introduced careers clinics alongside a number of initiatives aimed at the workforce, retention and vacancy rates had significantly improved over a year. Because, however, the careers clinic was among a number of initiatives, the scheme lead was unable to say with confidence that her work had been the sole cause of this improvement.

The organisational position of the lead and organisational investment in the schemes

The main responsibility area of the leads appeared to have some influence over the character of the schemes, or at least how participants talked about their work. In addition, often, where each scheme—careers clinic/coaching and transfer scheme—had its own lead, the backgrounds of each had the potential to complement each other. For example, where a lead had overall responsibility for education, careers conversations, as described by our participants appeared to include signposting toward opportunities for further study. Nurses with a retention, recruitment or workforce brief tended to see the work of careers clinics from that perspective.

The leads in one trust where the scheme was located at board level spoke of its alignment with a broader trust framework underpinning recruitment and development. Perhaps it is the location of the scheme at this level that makes this possible:

> The Trust has previously invested in strengths based recruitment and so there were strengths profiles developed for certain roles like a Ward Sister's role and so we began to look at strengths and thinking about strengths within the context of the Careers Service – so, in other words, helping

> people connect with where they are at their very best and where they find energy, drive, fulfilment. (Trust 9)

The scheme in another trust showed, perhaps, a different level of organisation commitment and had appointed a Clinical Nurse Specialist to run the scheme during one day per week. On this basis one trust lead used her limited time to deliver a flexible service that responded to and worked with (rather than attempted to change) nurses' apparently limited ability to take time out for career conversations:

> Once a week… I have to go to where they are, because trying to sit somewhere else hasn't worked. It doesn't work; people don't come, they don't have the time, and whereas because mostly it's long days, whereas there's no overlap or handover that they can come, so I have taken it upon myself to go and find people and I've asked people sometimes when their lunchbreak is, if they don't mind, I'll sit and go through it with them. (Trust 10)

Coupled with the organisational position of the scheme leads is the issue of resourcing. At least three leads told us that they had no administrative support for their role. Two of these said that it hindered them from effectively following up those nurses with whom they had had initial conversations (one critical comment added to the survey mentioned this) or who did not attend a scheduled interview while another told us that she managed the administrative work related to the role in her 'spare time'. It appeared that the smaller trusts were most challenged when it came to resourcing such schemes and the leads seemed to struggle as suggested in this extract:

> *How much time would you say you dedicate to the Career Clinics and the Internal Transfer Schemes?*
>
> It's difficult to quantify because all I try and do is prioritise which one is important because some employees might book for career clinic, not during the scheduled time. I need to be able to fit them in. And some might be just a telephone call and that they have a couple of questions… on a mobile phone if I'm not around so they know where to find me.
>
> *So do you think it's well resourced? Is there anything else you'd like to have invested in the career clinics or the transfer scheme?*

> I don't think it's well resourced. I think, like I said, there's a need for administrative support. We're such a small Trust… it can't be a one man show running retention activities and all of that – the more you get into other things that come up that you need to explore. Obviously where there is no money, you have to make do with what you have. (Trust 5)

Some organisations have provided coaching training for some of their staff involved in Careers clinics and transfer schemes, though the extent of the training varies. In one organisation it was a half-day training. In another the scheme lead had completed year-long coaching training. Another organisation had developed a 'faculty' of senior nurses along with those with training in reflection or coaching. In one trust that had developed an underpinning framework (the strengths approach) for its careers work, this enabled a certain consistency to the conversations between coaches and nurses:

> So then we had trained 14 people from – we invited or enlisted nurses from all different parts of the Trust to come forward and volunteer one to two hours per week as a Careers Facilitator – so a very peripatetic service, cause we're a very big organisation across multiple sites – so they would be trained in the strengths approach, in order to facilitate the conversations, and also that offers a degree of continuity and consistency, so, theoretically, if you were to see one person and another person, you would have a very different, unique conversation, but the underpinnings and the framework of that would be underlined. (Trust 9)

Finally, a number of informants told us that their scheme was informed by the CapitalNurse careers framework.

The importance of confidentiality

In 3 of the trusts, the scheme leads made a particular point of emphasising the importance of confidentiality regarding careers conversations.

In more than one trust, the leads used the word 'neutral' to describe either a space or a type of discussion where an individual nurse could speak freely about career intentions outside of line management structures and the possible constraints that this could impose. Confidentiality is clearly an important element of neutrality.

> The [careers] service has always intentionally not sat within recruitment- it doesn't actually sit within education either; it sits within corporate nursing, so it sits in its own space… distinct from core education and from recruitment

> and workforce, and that, I think, we'd both say has created quite a safe environment for people to come and access the service, because it's not aligned to a department that's performance related in terms of an individual's personal performance, so it sits in quite a neutral safe space which, I think, has enabled people to feel comfortable, coming forward to come and access the service; I think it's been one of the benefits. (Trust 9)

Some leads told us that they had found that many nurses were reluctant to engage with a scheme that had any association with the organisation's Human Resource department and had taken pains to separate themselves from this department. Others told us that their work included efforts to change the mind-set of some ward managers who, they believed, understood a nurse's desire to move as an expression of dissatisfaction with their management style.

Strengths, Weaknesses, Opportunities and Threats – a summary

Finally, we offer a brief 'SWOT' analysis of the schemes, based on our understanding of the interview data as a whole.

Strengths (a resource or capacity the organisation can use effectively to achieve its objectives) of the schemes included: where the schemes report to the trust at a high level; where schemes are well-resourced, possibly with a broad bank of trained facilitators; schemes that have an underpinning philosophy; leads who are well-networked in the organisation (Can also be a threat if this is perceived as potentially compromising confidentiality); where scheme joint leads bring differing and complementary organisational perspectives; use of the CapitalNurse career framework which is widely known; scheme leads who are highly motivated and have had coaching training; good marketing with blend of on-line, large and small events flexibly delivered including ward and site visits; where scheme leads are visible, approachable, knowledgeable and sensitive to nurses' needs (esp. for confidentiality and a 'neutral' space); leads offer précis of discussions for nurses.
Weaknesses (characteristics of the organisation that place it at a disadvantage) comprised: where trusts are located in areas that are difficult to travel to; where trusts do not have a range of specialities on offer; trusts that cannot afford to resource the schemes adequately with leads with limited time commitment; where schemes are supportive of transfer but do not facilitate them; where managers may use the schemes to offload unsuitable staff; nurses and HCAs may not have a career plan;

leads who have no resource or time for proper recording of outcome and evaluation.
Opportunities (any favourable situation in the organisation's environment): to respond to need expressed by nurses working in the capital to stay engaged with and develop within a nursing career; to respond to nurses who wish to adapt their career to changing life circumstances; to increase overall job satisfaction; to show staff that the organisation 'cares'; to identify and provide appropriate 'taster' experiences instead of/before transfer; potential of well-designed on-line systems to mitigate problems of access; a process for providing brief cover for a nurse involved in a career conversation; timing of events to coincide with life events and milestones e.g. beginning of the school year; to identify need and refer staff to supportive services e.g. those with physical problems wanting alternative work arrangements; to welcome those near end of career who want to make adjustments.
Threats (elements in the environment that could cause trouble): Perceptions that a given scheme is related to HR functions and that career conversations would not be kept confidential; insufficient resourcing can lead to inadequate follow-up of individuals and possible disappointment; nurses unable to leave work to engage with the schemes; cascading information through ward managers may not be effective in reaching all staff; a requirement for nurses interested in transfer to first approach their own manager; referral by managers may side-step equality and diversity policies; targeting an area with high turnover may distract from investigating causes (but is also an opportunity to identify and take remedial action).

Conclusion

The schemes described by the leads we interviewed have perhaps more commonalities than differences. In terms of careers focus, all leads emphasised their interest in supporting nurses to think positively about their careers in terms of strengths and personal aspirations and many referred to the CapitalNurse Careers framework as a helpful and well-known aid for this. Though some emphasised the counselling and coaching aspects of their role, all spoke of the importance of providing information about opportunities in the trusts of which some nurses were unaware. All spoke of signposting to other services or of discussing opportunities for shadowing or further study. All of the leads described the schemes as one way that

the organisation showed its care for its nursing staff. Participants in the schemes appeared to have engaged most with transfer schemes.

In terms of process, all of the schemes featured some kind of two stage process for nurses to become involved in progressively deeper reflection on their career aspirations.

Some of the schemes were explicitly focussed on a particular staff group, usually Band 5 nurses though some were open to all, qualified nurses and those workers in support roles. Some told us that the transfer scheme would not be appropriate for more senior nursing positions. It was interesting that even where a scheme officially did not include a certain group, the leads responded to demand from individuals in that group.

Schemes appeared to vary in the amount of resource that their trust had invested. There was variety in the seniority of the nurses (or others) involved in the schemes. Relatively junior leads with little time allocation or administrative support appeared to be struggling to maximise the potential of the schemes though some of them, through a mixture of commitment, flexibility and imagination, appeared to achieve a great deal. The price may well take the form of lack of follow-up of nurses who had made inquiries or who had failed to attend appointments. Well-resourced schemes were programmatic and strategic.

Though few leads provided us with data about their activity and outcomes, all believed that the schemes were positive to the organisation and everyone we interviewed could remember an instance of a nurse who had been about to leave the organisation but who had stayed as a result of their intervention.

Though a small number of survey participants spoke of disappointment and resistance from clinical managers to their desired transfer, the majority of nurses spoke of increased job satisfaction and reported an intention to stay with their current employer as a result of using the schemes.

Recommendations

A varied approach to publicising the schemes within trusts direct to all potential participants would avoid failures in cascading information

Participants value being able to move to another area without going through lengthy application processes: the process should be made clear to all involved so that there are no surprises for participants

Leads need to be visible, approachable, and knowledgeable about opportunities and have an understanding that confidentiality matters to scheme participants

Adequate resourcing and reporting at senior or board level allows schemes to be programmatic and strategic

Pragmatism and flexibility in delivery can mitigate problems of access for nurses in busy settings but are no substitute for a programmatic approach

An underlying approach, such as the strengths based approach, can provide a unifying structure to a scheme and ultimately be more useful for individual nurses and the organisation

An identified specialist nurse with organisational responsibility for retention—in same way an audit nurse facilitator exists—could raise the profile of such a role and facilitate networking across the Capital

Schemes that include nurses and Health Care Assistants in all stages of their careers would allow organisations to establish their needs and where their strengths lie across the whole nursing and support workforce

Career clinics and Internal Transfer window initiatives could be more strategically / opportunistically sequenced with key life events such as empty nest/approaching retirement/health concerns to yield maximum benefit for both nurse and organisation

Appendix 1: CapitalNurse 2018 survey summary result - anonymised

Does your organisation have a career clinic / transfer scheme?	What is your career clinic / transfer scheme process called?	What is your model?	What is your model trying to achieve?	What impact has your model made, please include any measurable outcomes
Yes	They are 2 separate processes: 1 is called internal transfer and the other just called careers Clinic	For Careers Clinic's we have 1 session a week on Tuesday and Thursday on alternating weeks, Staff can book on to the careers clinic sessions or we have a space available in HR for staff to access a library and computer to do research or apply for vacancies, as part of careers clinic we offer advice on training and development and interview and CV support. The internal transfer scheme as evolved from being open to nurses to now being open to all staff and as long as the job criteria they are transferring to match they can do this via the internal transfer scheme	The internal transfer model is trying to achieve a reduction in vacancy rate and allow staff to experience working in different areas of the trust, Rather than losing someone we try and offer them the opportunity to move internally first	Currently the uptake on the internal transfer scheme has been minimal and therefore we do not have any measurable outcomes yet
Yes	Career Clinic and Internal Transfer Scheme	Regular monthly Careers Clinics attendees emailed prior to appointment to discover areas of interest and given link to Capital Nurse Careers Framework. Internal transfer Process- to allow easier movement for Band 5 staff nurses across our integrated Trust	By demonstrating the wide range of career opportunities within the trust aim is to achieve greater retention of staff.	We need to introduce measurable outcomes e.g. follow up 8-12weks after re any decisions taken by staff member.

Yes	One Stop Career shop / Internal Transfer Process	One Stop Career Shop (OSCS): Bi-monthly - quarterly career fairs circulated across geographical area of Trust aimed at whole workforce. Nursing Workforce team and Education promote internal transfer, professional support and career pathways. Pop up coaching is available as is health and well being support. Directorates are encouraged to replicate this model within their own areas and support is offered for this. Internal Transfer Process provides guidance around transfer at same grade, this is promoted widely and publicised in 'transfer window' adverts.	OSCS- aiming to ensure all are aware of available support and opportunities and have a chance to discuss this with expert sources. Internal Transfer process- aid flow and opportunity, allow career mapping and planning, aim to improve retention at key pinch points particularly band 5 at 12-18 months in post.	OSCS- 3 Band 6 internal transfers within specialist areas due to information and facilitation from OSCS. All have given written thanks citing that they would have left trust had this interaction not happened. Notable increase in applications received from Band 1&2 support roles to Band 2&3 nursing assistant roles citing information given. Internal Transfer: Marked increase in activity in window period, including flow to difficult to recruit areas.
Yes	Transfer Scheme	3 times a year, areas with vacancies are released. Applicant completes a form and has to meet critieria. Can share guidelines if needed.	Retention of staff and movement to clinical areas most of need	Early days

Yes	Careers clinic for nurses and midwives	The careers clinic is available to all nurses, midwives and care support staff and runs monthly across the main hospital sites. Senior nurses and midwives from across the clinical divisions have been trained and supported to run the careers clinics and provide careers coaching. This clinic provides a range of support, including: - careers coaching - signposting to career pathways/internal vacancies/the - internal transfer scheme and other development opportunities - advice on job application best practice - developing a career action plan	The aim is to improve the retention of nurses and midwives through providing careers support, signposting internal job roles and development opportunities	The careers clinic was launched in late September and will be reviewed in January 2019. To date 20 members of staff have booked onto a careers coaching session
Yes	Internal Transfer Scheme. Career Clinic	Career Clinics are a work in progress but currently target bands 2-6. Have been introduced at 'a great place to work week'. Internal Transfer scheme is aimed at band 5s only. Nurses complete a request form and submit it to their current line manager and the line manager of the ward they want to move to. Post numbers and start dates are agreed and the form is sent to HR who action.		Retention

Yes	Internal Transfer and Nursing Career Clinic	We have an internal transfer guidance to support our employees . Nursing Career clinic is new and our first event will be held in November 2018 . We hope to provide one to one consultation as well an open forum approach	Staff Retention and development	Career clinic is new. Happy to feedback Internal Transfer- Number of staff wishing to explore internal opportunities that are available. Number of both registered and unregistered staff that have used internal transfer to move around the Trust
Yes	Careers Clinic	Action Learning Type Model	Staff retention and an awareness of the professional development opportunities to them within the Trust	Staff attending leadership programmes, conferences, secondments within the Trust
No				
Yes	Career Transfer	Based on information received from [another NHS trust] vacancy advertised and appointments made to discuss opportunities with organisation Application completed. Discussion on move and transfer takes place. The Career transfer is based on the Trust Career Nursing framework and career map	Retaining staff and allowing them to develop within the organisation rather than without	Too early in its introduction to comment

Appendix 2: Models of Careers Clinics and Transfer Schemes derived from interviews

Trust	Providing both CC and TS	How publicised	How often	Who aimed at	Model of engagement with CC	Model of TS	Role of scheme lead(s)	Attendance during work time	HR involvement	Confidentiality
1 Outer London combined trust	Yes but not one process	Flyers inviting booking go to managers + intranet	4-6 weekly	Nurses and HCAs	Booked meeting for 'signposting' not counselling or coaching	Nurse expected to approach manager in new area then line manager then paperwork	CC is Practice development and education nurse; TS matron for workforce	Yes though can be problematic	No HR support or named involvement	Not discussed
2 Inner London	Yes	FB page; staff bulletin; emails to managers to cascade	Main event 4-6 monthly; ward visits 3-4 week rota	Nurses all bands incl assistants	Trolley – visits all wards in 1 year; intranet; Initial info giving followed by individual	One stop career shop; transfer window; vacancies board; they give advice but don't formally	Recruitment	Yes – trolley to wards and clinics	Not until transfer is agreed as HR don't have capacity	Advise nurses to first talk with manager when starting transfer

Trust	Providing both CC and TS	How publicised	How often	Who aimed at	Model of engagement with CC	Model of TS	Role of scheme lead(s)	Attendance during work time	HR involvement	Confidentiality
					coaching where requested	facilitate				
4 Inner London	Yes	Intranet screensaver and paper posters	3 monthly	Band 5 nurses	Two stage: a less formal career clinic 30 min appointment then booked career coaching session	Have to speak to own manager first	Preceptorship	Yes but problematic	HR have overall responsibility for CCs and TS	Not discussed
5 Outer London specialist	Yes but separate	Posters and intranet cascade via ward managers	2 monthly career clinics	Nurses all bands plus HCAs	Nurses can book ad hoc	Application form to Div head of nursing	Retention recruitment and development	Yes	Lead refers to HR manual where needed	Not discussed

Trust	Providing both CC and TS	How publicised	How often	Who aimed at	Model of engagement with CC	Model of TS	Role of scheme lead(s)	Attendance during work time	HR involvement	Confidentiality
6 Two specialist trusts	Yes but run by different people	Cascade via senior staff; flyers	monthly	Nurses all bands	Pre-booked ½ hour slot career discussion + some ad hoc discussions; some out of duty hours	Leads find out where vacancies are	CNS and Staff development lead; less than 1 day per month	Yes in trust room but considering virtual clinic as staff release problem	Not discussed	Strong emphasis so no admin involvement. Trust in the leads is important; held in private spaces
8 Inner London	Yes run jointly by two people	'Trust channels' Intranet page 'mentioned in meetings' cascaded	Four times a year (2 on each site)	Band 2 and 5 only	Careers fairs; + career conversations with snr nurses and some trained coaches	Apply during transfer window; matrons manage	Workforce (retention) and education	yes	HR involved once transfer form is completed	Not discussed
9 Inner London	Yes run by two people. Careers Service includes	Posters and presentations at trust events; Intranet page; chief	Monthly drop ins across trust sites	Registered nurses all Bands	Drop ins and individual approaches	Nurse sends statement to scheme lead who forwards to appropriate manager who	Corporate nursing	Yes; self-referral on internet page to contact a careers coach	Only at the end	Meetings can be off site; Emphasised need to clearly separate CS from HR

Trust	Providing both CC and TS	How publicised	How often	Who aimed at	Model of engagement with CC	Model of TS	Role of scheme lead(s)	Attendance during work time	HR involvement	Confidentiality
	TS	nurse bulletin				arranges meeting				
10 Outer London	Yes one person leads	Lead visits wards with leaflets; attends preceptorship course	Weekly	Aimed at Band 5 and 6 but Bands 2 and 4 also use it	Nurses take leaflet then make appointment	Leads put nurses in touch with manager if there are vacancies	Clinical nurse specialist on 6 month secondment 1 day/week and Recruitment lead nurse	Yes – lead goes to the nurses	Recruitment lead has an HR role	Not discussed

The numbers allocated to each trust in column 1 are not continuous because they are based on the original sampling frame and not all anticipated trusts responded.

Appendix 3: Project timeline

13th September	23rd Sept	24th Sept	6th November	11th November	28th November	2nd December	9th December	22nd January	29th January	7th February
Project agreed	Project finance approved at Mdx	Ethics application lodged	Ethics approval (32 working days)	Request to CN for first email to contacts	CN send email to contacts	Research team start to make initial contact with participants	Interviews start	1st invitation to survey sent to scheme leads	Reminders sent to scheme leads	Survey closes; Report writing starts