Community nursing middle management: 'dealing with different people in different time zones on both sides'

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ABSTRACT

Aim: The overall aim of the investigation was to redress a knowledge gap by exploring community nursing middle managers' (CNMMs') experiences of role enactment through change within Community Health Partnerships (CHPs) in Scotland—now further evolved into Health and Social Care Partnerships (HSCPs).

Background: HSCPs play a key role in shifting care from the acute to the primary care community setting. However, literature review demonstrated there has been very little research into the role of **CNMMs** within the changing primary care context. This concept was considered important in understanding how CNMMs enacted their roles to implement service change.

Design and methodology: A qualitative longitudinal interpretative phenomenological analysis (IPA) (Smith, 1996) study was conducted in four distinct phases, comprising the reflexive, foundational, recursive and expansive, from 2008–2011. Some **35** semi-structured interviews were conducted with **26** participants.

Main findings: CNMMs perceived that their responsibilities had increased, become more complex and wider ranging. Maintaining an implicit connection with service users was a primary motivation for CNMMs. They were proud to be members of the nursing profession aligning their identity with their career history. A small but significant proportion resigned during the study and some were considering leaving the NHS.

Conclusion: The study addresses a gap in literature, contributes to the understanding of NHS community nursing, middle management, role, change and gives a voice to CNMMs in Scotland. They are the lynchpins in taking change forward and maintaining quality services. Much more attention needs to be paid to the needs, constitution and sustenance of middle managers in Scottish community nursing—which has policy, practice, education, and research and retention implications.

KEY WORDS

◆ community nursing ◆ middle management ◆ role ◆ change ◆ primary care ◆ community health partnership ◆ health and social care partnerships ◆ Scotland

Primary care refers to services provided by health professionals in the community, where around 90% of patient contact occurs (Robson, 2011). Community nursing is the "cornerstone" of community care (Kennedy et al, 2008) "carrying a major responsibility for delivering change and growth in the Primary Care Sector" (Royal College of Nursing (RCN), 2009:36). All community nurses and community nurse middle managers (CNMMs) function and carry out their role within Health and Social Care Partnerships (HSCPs) across Scotland, which requires skillful management. However, there is a dearth of literature specifically focusing on CNMMs and their partnership work in HSCPs, which have evolved from Community Health Partnerships (CHPs) in Scotland.

Background

Community Nurse Middle Managers (CNMMs)

Although middle management has been examined in health care, studies have mainly concentrated on the acute sector (Pappas et al, 2004). Wall (1999) asserts that NHS organisations cannot do without them. An RCN publication (2009) reviewed the UK nursing labour market and highlighted that, due to the policy focus of shifting resource and care away from the acute to the primary care sector, development issues relating to this phenomenon have received insufficient attention. This has important implications for the management of change in community nursing and for middle managers in particular. The literature reviewed demonstrated that while there has been interest in middle management, there has been little progress in the understanding of the HSCP middle manager and CNMM role in particular.

Middle managers both experience and have a critical role in facilitating change in health care (Hill, 2003; Iacono, 2006; Ferguson and Day, 2007), yet their own role is poorly

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understood (Hewison, 2003a; 2003b). Their environment is not static, continually responding to key issues affecting primary care services (*Table 1*).

These issues have influenced community service delivery in Scotland, increasing partnership working through organisational and structural transformation.

Table 1. Key issues affecting primary care

Demographic changes, including an ageing population, with the associated health needs and the impact on the working population
Increased longer-term disorders and complex conditions
Evolving patient/user expectations, partnerships and empowerment for users; users as co-producers of care
Reorientation of health and social care recently, with the rapid shift towards community care
Evolving staff skill mix, for example, assistant practitioners
Emphasis on the evidence/research-base
Interprofessional and interagency working
Emphasis on governance, accountability, standards
Ethical issues relating to healthcare advances, scientific and technological developments
Focus on health promotion, public health and tackling inequalities, staying healthy, prevention of ill health and self-management

How Scottish Health and Social Care Partnerships have evolved

Regional Health Boards in Scotland are charged with implementing NHS policies and plan the delivery of local health services including community health services in partnership with their local authority partners. Historically, CHPs evolved from Local Healthcare Co-operatives (LHCCs). Hopton and Hill's (2001) positive evaluation of LHCCs supported the advancement of CHPs, which have evolved into the present HSCPs. Collectively, they aim to ensure that health and social care services are integrated and seamless for service users (www.chp.scot.nhs.uk/index.php/about). The rationale and driver for this change has been successful financial performance (Scottish Government, 2007). In Scotland, the vast majority of health care is delivered by primary care through HSCPs, guided by key interlinked Scottish Government (SG) frameworks and directives that identify priority areas, including health improvement. This affects health care structure, culture and service delivery, which is constantly changing.

Change

Change is not an entity (Pettigrew, 1987; 1990a, 1990b), but rather a process taking place against a background of history, culture, politics and economics within and outwith the NHS. The NHS has been in a state of permanent revolution, having gone through at least five major structural reorganisations with numerous policy initiatives (Hunter, 2005). This plethora of change over the years has included the application of market philosophies to the NHS, the shift from acute to primary care in the community, competing priorities from imposed government-driven targets, and an expectation that these changes are attainable through partnership working. In this context, health care delivery is as much a managerial as it is a clinical challenge (Shortell, 2004).

Based on the gaps in the literature, six research questions were formulated to guide the enquiry. These were:

- What are CNMMs' perceptions of their role within CHPs?
- What are CNMMs' experiences and views of negotiating and managing change within CHPs?
- How do CNMMs understand the impact on themselves and others?
- What sense do they make of this?
- What does this mean in the context of wider understandings from the literature in Scotland and the UK?
- What implications are there for community nursing policy, practice, education and research?

Qualitative inquiry

The research questions focused on the understandings and meanings CNMMs attach to their social world, with particular reference to the concepts of role enactment in managing change within NHS CHPs.

These phenomena are subjective and not measurable in the quantitative sense (Rowlands, 2005). Therefore, the exploration was most amenable to qualitative research (Holloway, 1997).

Phenomenology and interpretative phenomenological analysis (IPA)

The need to understand and interpret CNMMs' perceptions of their lived experiences led to the use of phenomenology as the underpinning methodology. Coming from the humanistic disciplines, phenomenology captures the ideas and reasoning of the participants (Denscombe, 2007). Drawing primarily on the work of Smith et al (2009), IPA offered a methodology that tries to link theoretical underpinnings with practical method.

Sampling

Specifying the study population was complicated by the variation of community nursing middle managerial roles; however, the roles were comparable. Agenda for Change (AfC) (HMSO, 2004) was used as a base for classifying the population. AfC Band 8 defined the collective population investigated. Purposive sampling is particularly suited to IPA and provided insight into the particular CNMM experiences that were under investigation (Smith et al, 2009). All participants self-selected.

Interviewing

Individual interview is a mainstay of IPA method. Qualitative interviewing sought to capture complex experiences, understandings, behaviours, and attitudes. Semi-structured interviews were used, with the schedule minimal and flexible and the questions prepared ahead of time.

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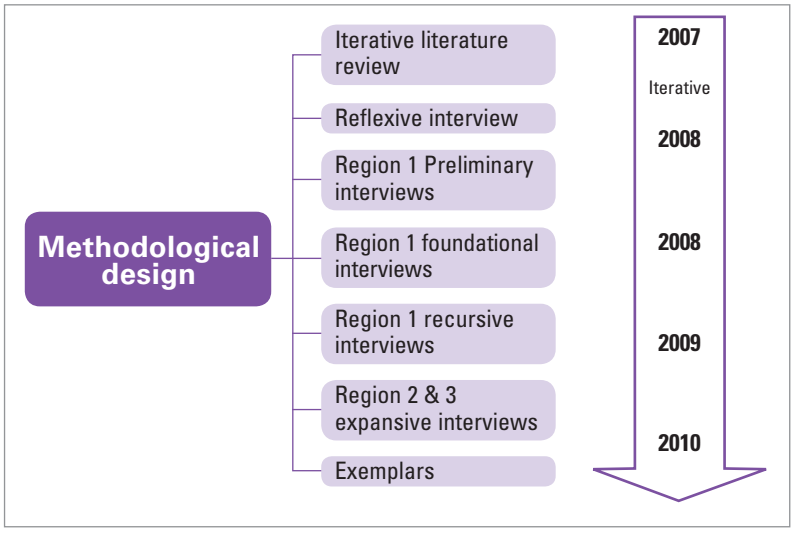

Figure 1. Methodological design

Design of the study

The design of the study was iterative, developing in the light of progress and findings. Analysis of the foundational interviews indicated value in carrying out a recursive interview phase. Following on from this, an expansive phase was identified as being important to include two additional regions of Scotland. This facilitated exploration of the phenomenon under study from multiple perspectives, obtaining 'a more detailed and multi-faceted account of the phenomenon' (Smith et al, 2009:52) over a timeline.

The design and timeline of the study is outlined (*Figure 1*).

Ethical considerations

Ethics committee approval was obtained from university and NHS research committees. Participants were informed of the NHS and Queen's Nursing Institute Scotland (QNIS) sponsors via a letter of invitation to participate. The recruitment approach comprised purposive selection of an identified target population (Groenewald, 2004), and subsequent voluntary self-selection. Taken together, the above processes ensured a basis for informed consent. Participating CHPs were identified by nurse directors and general managers self-selecting.

Data analysis

The use of IPA involves a two-stage interpretation process to describe and interpret the perspective of the participant (Bogdan and Biklen, 2007) and then interpret how the participant makes sense of their experience (Pringle et al, 2011). Reid et al (2005) provide an overall outline of the key elements of IPA. An approach was formulated based predominantly on the work of Smith and Osborn (2003) and adapted from Kempster and Cope (2011).

Findings

Participant profile information

The study focused on in-depth perceptions of CNMMs who had middle management experience, having been recruited to their posts from within the NHS. The participants were mainly women in their middle years, with long backgrounds and present foregrounds in community nursing in the NHS. Many had limited leadership/management training, having learned their craft mostly 'on the job'.

CNMM titles and role types were relatively diverse, but comparable. A total of six broadly distinguishable roles were identified. They fell into the following types, lead nurse, region wide manager, service manager, generic manager, wide generic manager, and nurse consultant (*Table 2*).

Some 35 semi-structured interviews were conducted with 26 participants. All participants had been recruited from within the NHS. The vast majority of participants were female, two were male and the majority were middle-aged (between 45 and 55 years). The number of years CNMM participants had been in post varied between 3 and 22 years, with the majority fitting into the 10-15 year bracket. The main reasons for taking up the role and level of qualifications also varied across the phases (*Table 3*). Nine of the foundational participants participated in the recursive phase.

Findings from the foundational and recursive phases suggested that an ad hoc approach to CNMM career development and progression had been applied to CNMM recruitment, with minimal succession planning. However, it could be interpreted from the expansive phase finding that a more planned approach had been applied to the recruitment of this CNMM cohort.

Table 2. Distribution of participant role types, foundational, recursive and expansive phases

Role	Foundational phase (CHPs 1-3)	Recursive (return) phase (CHPs 1-3)	Expansive phase (CHPs 4-6)	Total participant interviews
Lead nurse (LN)	4	1	0	**5**
Service manager (SM)	3	3	0	**6**
Generic manager (GM)	11	5	2	**18**
Wide/generic manager (WGM)	0	0	4	**4**
(Nurse) consultant (NC)/lead	0	0	2	**2**
Total interviews	**18**	**9**	**8**	**35**

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Table 3. Main reasons for taking up CNMM role

Main reasons for taking up CNMM role	Foundational phase (CHPs 1–3)	Recursive phase (CHPs 1–3)	Expansive phase (CHPs 4–6)
"Fell" into role	7	5	0
Planned career progression	3	1	1
Encouraged by manager	2	0	1
Role taken up following restructuring	5	2	1
Succession planning	2	0	5

The proportion of CNMMs interviewed in the foundational and recursive phases with higher level qualifications such as honours or masters degrees was relatively lower than the proportion of CNMMs interviewed with higher degrees in the expansive phase (*Table 4*). Chang et al (2015) found that the critical thinking ability of nurses with a master's degree was significantly better than those with a bachelor's degree or a diploma, arguably essential to managing the complexity of the CNMM world.

Having outlined the general characteristics of the population, how CNMMs experienced their role is now outlined using definitions of aspects of role (MacDuff, 2007):

- **Role content** – activities undertaken
- **Role set** – nature and scope of relations with colleagues, those managed and managing and associate expectations in terms of function status and power
- **Role form** – professional domain(s) identity and associated cultural meanings

These are now applied to provide structure to the discussion of findings that follows:

Role content: shifting ground

The majority of CNMMs perceived the role as ambiguous, adjustable, fluid and involving complex shifting to accommodate changes, correlating with O'Gorman et al's (2005) study of middle managers in general. The character of the middle management role was not clear cut, connected to job titles or to job descriptions (Checkland et al, 2011):

"… there is a focus on how we do things more efficiently and we reduce waste and we improve safety, compared to also looking at all the other things around care and involvement, staff involvement and staff wellbeing. All of these things that we need to do and how you manage all of that has probably added a greater complexity to the role". Diane E, CL, CHP 5

"… I've got so many hats people are totally confused about what I do, because I haven't even got a title that reflects my role". Isla R, LN, CHP 3

This was associated with change, both political and financial, which influenced job descriptions. CNMMs felt that they facilitated teams to change and to implement change directives. Over the course of the study, the rate of change to accommodate efficiency gains endured, creating tensions and compounding the challenge of CNMM role enactment, leading to change fatigue and resignation:

"…The NHS is never stable; it depends who's in power at the time, and the same is happening in England. I just see disaster ahead, because people are ill-advised and ill-informed". Isla R, LN, CHP 3

"I think with any change process as well that's within nursing, with any change process … you've got to focus on key, em, benefits if you're focusing around quality of patient care, then that's when you'll get staff attention". Iona F, SM, CHP 2

Table 4. Qualification variation

Qualification variation	Foundational phase	Recursive phase	Expansive phase
Basic registration	18	9	8
Diploma	10	2	0
BA	5	4	1
BA Hons	2	1	2
Masters	1	1	5
PhD	0	0	0

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"I think there is a tension. Patients are almost the commodity and I don't want that … do you know what I mean? … it's all become financially driven, where instead it used to be patient-driven. Um, and that's essentially hard." Marie R, RW

"It got to the point where I felt that all my cylinders containing motivation and whatever else you need to do the job – you know, I was really feeling that I was running on empty. All these little cylinders were empty by the time I left." Mary R, SM, CHP 1

Role set: the view from the middle position

The principles underpinning changes at the time of the study were identified by CNMMs as a drive to shift acute services into the community through cost-effectiveness. The CNMM role was viewed as expanding and fluid, with widening spans of control across multi professionals within the partnership. The context of their position was considered to be driven by policy and reorganisation within the health care setting perceived to stifle CNMM power and creating risk:

"I've got school nursing, district nursing, health visiting, and I manage the integrated response team, which is a multidisciplinary team; there's social work, rehab care assistants, there's social work involved and health, so there's physio, OT and there's 12 rehab care assistants in the team, and their purpose is to support early discharge, or prevent admission. I also manage a community rehab, which is a health team, that's physio, OT, district nurse and level 3 carer …" Laura E, WGM, CHP 5

"I have to say over the past six months I have noticed that colleagues and myself, our workload has catapulted, exponentially, because other people's roles when they leave and retire aren't getting filled, so then the roles get divvied up". Jill E, GM, CHP 6

"…power, it's concentrated at the top of the structure, but also within its policies. From the government? … Yes … and our own policies and there's very few people that actually have that full power." Jill E, GM, CHP 6

"… before, I wouldn't have had to escalate that risk; I'd have dealt with it, because I had the financial resources there to deal with it and the means of doing it, but now I've got to jump through hoops to do that, so the risk is left there longer." Rosie R, SM, CHP 1

An additional consequence of financial constraints and organisational cutbacks was restructuring and delayering (Litter et al, 2003). CNMMs perceived that this had resulted in reduced senior nurse management posts to lead and support them.

"… I still firmly believe that there should be nursing leadership. Um, and I know that they've subsumed us into different posts. But without a leader again, for nursing it doesn't send out the best signals for nursing. Um, you know, I'm sure that there's another … a doctor or a medical person that they would replace that person because a medical doctor would seem important". Marie R, RW

Wulf (2012) presents evidence to support the notion of disempowerment. She asserts that flattening structures leads to the opposite of what it promises to do by pushing decisions up the hierarchy and, rather than facilitating autonomy, creating disengagement:

"I am leaving at the end of the year. I am sort of disengaged from that … I think … if I am being honest". Mary F, SM, CHP 1

However, there was a feeling of having inadequate influence over the formation of policy and strategy at Government level, along with a perception that they had negligible authority in developing centrally driven targets. They alluded to the 'tricky' position they inhabited between strategic intent and operational service delivery, while at the same time dealing with different people at different stages in the change timeline:

"I sometimes think that the middle is a difficult place to be, because above is decreeing what should be happening and expect you to make it happen and the other bit is getting an understood and acceptable message across by being supportive and that's a challenge … and we are in the middle with the pace of change and different people are in different time zones on both sides … so … between a rock and a hard place!" Jill E, GM, CHP 6

The CNMM experience for all participants was strongly associated with inhabiting the middle position. Paradoxically, although CNMMs could be seen as being surrounded by colleagues in the course of their work, the majority of participants referred to feelings of isolation. Many CNMMs referred to the reduction of middle management numbers by delayering to contain costs, thus diminishing their opportunities for support and networking:

"I was on a leadership course a couple of years ago and they kept going on about how important the middle was, that it needs to be recognised as being the kind of conduit to making change happen, because the middle is the place that's in contact with the above, strategic bit, and, and … the other operational bit and has to get the two to connect together for action to happen." Angela E, GM, CHP 6

"It is quite an isolated role, uhm, but certainly when I first came into a nurse management role it was very, very isolated." Jill E, GM, CHP 6

Fears of job loss in the current financial downturn was seen as further impacting on feelings of isolation as CNMMs felt vulnerable inhabiting the middle layer, perceived as being the

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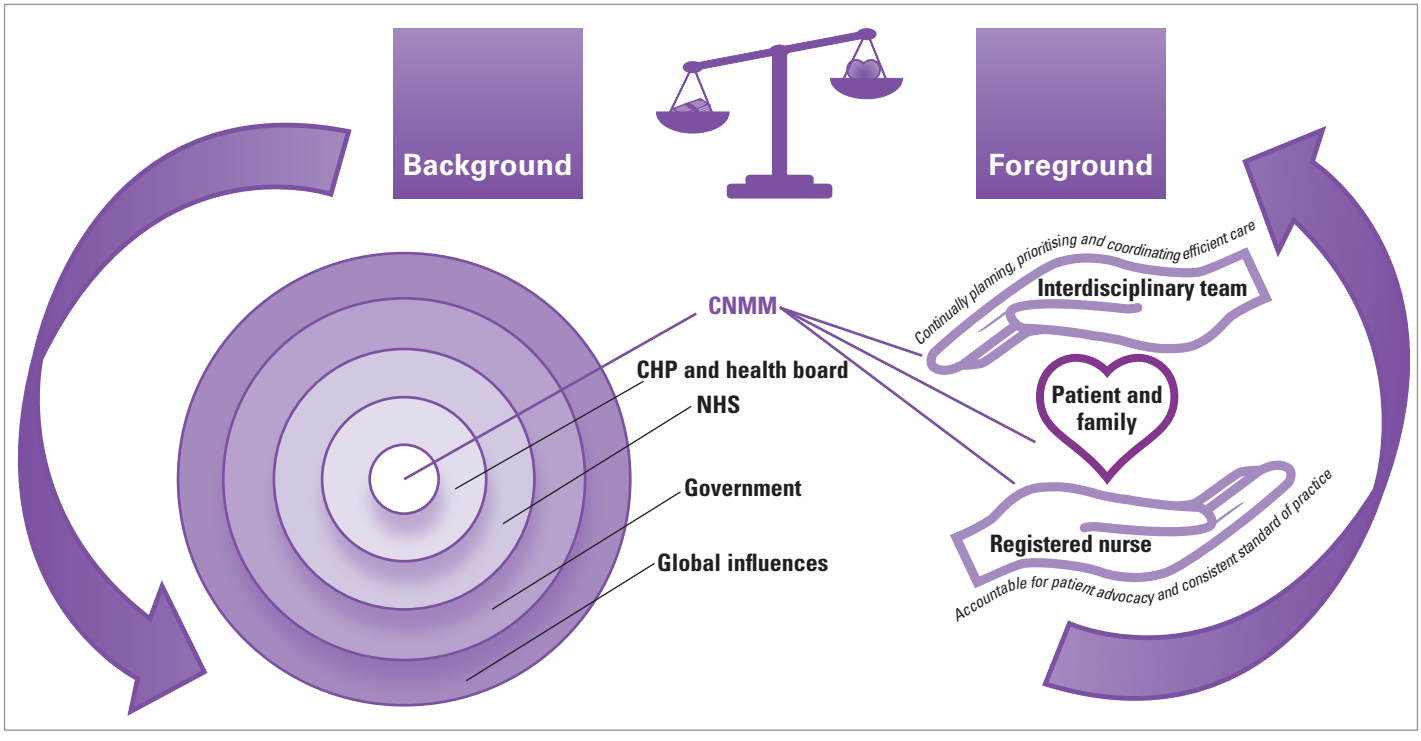

Figure 2. Balancing the 'force fields' influencing CNMM role enactment through change

first to be cut in times of financial constraint. Moreover, several felt the role was perceived as unpopular by the public in general, and highlighted negative perceptions they had experienced from members of the team and GPs in particular. Preston and Loan-Clarke (2000) reported similar findings. Hyde et al (2011) suggested that middle managers have become the lost tribe of health service. Indeed, the King's Fund observed that 'whenever politicians talk about management, it is almost invariably a pejorative term and often equated sneeringly, with bureaucracy' (King's Fund, 2011:1):

> *"… when you hear about all these cuts in the press and the media, it's always that we have to get rid of these middle managers". Iona R, SM, CHP 1*

Many CNMMs indicated that strong professional leadership was required through change. However, leadership cannot necessarily overcome the detrimental effects of wide spans of control, even under the most positive of conditions (Shirey, 2009). Employees become victims of job overload when they are given extensive portfolios (Channuwong and Kantatian, 2012), again perceived as creating risk:

> *"Senior managers and politicians have to remember that if you put too much food on a plate or too many books on a bookshelf, things are bound to fall off; it's the risk that that creates." Rosie F, SM, CHP 1*

Reflecting on their position, many CNMMs acknowledged the ripple effect that their role expansion had for teams whom they believed had a similar experience:

> *"I think that making sure they (teams) are not … overburdened is close to my heart and I think that's because I was a nurse". Matt F, SM, CHP 2*

However, there was CNMM intention to maintain and improve quality for service users:

> *"I want to make sure patients are being cared for. I think there's a lot of goodwill." Marie R, RW*

Role form: how CNMMs navigated change through professional identity

The vast majority of participants espoused commitment to the caring aspect of the NHS, basing their management philosophy primarily on their nursing value base. Workplace identity appeared to give CNMMs a sense of meaning and purpose (Walsh and Gordon, 2008), centring on what it meant to them to be a nurse (Avis, 2005; Bessant, 2004; Weiss and Welbourne, 2008). This helped make their identity and culture definable and recognisable, (Bloor and Dawson, 1994; Morgan and Ogbonna, 2008):

> *"… we're all in the job because we've got a patient. And although we might not touch them and deal with them in the same way as the clinical teams, that's why we're here, and I think that is my entire one hundred percent focus" Joyce R, SM, CHP 2*

> *"One of my main aims is that people don't see me too far removed from being a nurse and, as I say, when I go and speak to people, I still think I'm nursing, by the long stretch of the arm … it is my identity. It's completely who I am. I've always*

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Table 5. Comparing the cases

Exemplar 1. 'Mary' Foundational and recursive phase cohorts	Exemplar 2. 'Laura' Additional phase cohort
A perceived lack of focus by senior/executive management on CNMM wellbeing, led to Mary feeling that she was not being listened to, supported or valued, resulting in feelings of disempowerment. She perceived that there was weak leadership due to the turbulence of constant change, lack of clarity regarding role amendment and disappearing CN structural support mechanisms; through loss of posts; and she was less able to balance resultant tensions. **Had a weakened sense of coherence and lack of engagement—experienced burnout**	A perceived focus on CNMM role wellbeing during and following reengineering with strong senior nurse leadership. With clear links through management structures to board and community nursing structural support mechanisms maintained, it led to Laura feeling listened to, supported and valued. She experienced clarity of expectations, involvement in strategic planning and devolved authority, with freedom to act. **Had a strong sense of coherence, felt engaged and positive.**
Mary's words	**Laura's words**
'... I'm thinking now of my immediate line manager. I might have felt disempowered because perhaps I felt that sometimes she didn't listen enough to my point and how I was trying to see things ... you would sometimes pick up that people didn't appreciate what you did.' Mary R, SM, CHP 1 *'... the CHP was becoming ever bigger and more complex and the management structure within the CHP wasn't growing, because of financial constraints. So that resulted in far more work coming our way. And it didn't seem to me like we, as managers, had found a very good way of coping with that.' Mary R, SM, CHP 1* *'My strategy was to have an exit plan. I suppose I was working towards that exit plan and felt I could cope with whatever was thrown at me because I knew it wasn't going to be there for much longer.' Mary R, SM, CHP 1* *'All these little cylinders were empty by the time I left.' Mary R, SM, CHP 1*	*'I would have six weekly meetings with my manager ... there's clear guidelines, but if something comes into the CHP, it might come in to the general manager and she might bypass a locality manager and come straight to me, it depends what it is.' Laura E, WGM, CHP 5* *'... we do have a head of nursing within the CHP who's nursing background but she's not a manager, she's just for professional leadership.' Laura E, WGM, CHP 5* *'... I feel I'm given autonomy to do my job and left to do it. I feel they value what I do and they trust I get on and do it, so I don't feel undervalued in any way.' Laura E, WGM, CHP 5* *'I got to do it as I did ... I was able to put my case across and they listened to me, so I never wake up and think, oh no ... I have to go to work, so (small laugh), I'm quite happy to go into my work.' Laura E, WGM, CHP 5*
Outcome: resigned	**Outcome: remained in post**

wanted to be a nurse and I love nursing". Diane E, CL, CHP 5

It was felt that the managerial role held negative ethical connotations for the public, politicians and some colleagues. This was seen to be due to the opposing ideologies associated with managerialism and NHS caring principles:

"GPs don't like managers (laughter), because they don't see our worth, and if there's problems, staff will always go looking to GPs for their support ... when I go to the practice in a uniform they say, oh you are working today? And I will say, oh, as opposed to sitting in my office with my feet up drinking coffee, yeah? ... you know that is not aimed at me, that is aimed at manager." Emma R, SM, CHP 1

However, CNMMs reconciled the management component of the CNMM role by aligning it with altruism and caring. 'Every social group invariably couples its scale of desired ends with moral or institutional regulation of permissible and required procedures for attaining these ends' (Merton, 1938).

"... I think to be in this type of job if you weren't a nurse you wouldn't be able to empathise with what people need staff for, and why they need them. And they aren't just here leading them and really I think it would be very ... a really bad move to have somebody in this job that wasn't a nurse, actually". Marie R, RW

CNMMs attempted to balance opposing philosophies and financial constraints and maintain a strong nursing identity to support quality and advocacy for the service user, which is depicted in *Figure 2*.

Overview of exemplars

Further interpretation of CNMM experience through change demonstrated important differentials across the phases (*Table 5*). This resulted in the identification of two notable contrasting CNMM experiences selected from different CHPs and across different phases. Both individuals had spent the majority of their working life within the NHS and had been in the CNMM role for at least 10 years. The exemplars were chosen because of distinct variance between the two and the consequent learning potential they afford. Exemplar 1 outlines the negative effect of an unsupportive manager while Exemplar 2 outlines the positive effect of a supportive manager. Exemplar 1 is taken from the foundational and recursive interviews and has a longitudinal aspect. Exemplar 2 is from a different CHP and region of Scotland in the expansive phase.

Exemplar 1 highlights the experience of burn out, which resulted in resignation from the NHS. Exemplar 2 highlights how this CNMM remained in post due to perceived support and strong leadership, which contributed in helping this CNMM to deal with the complexities of the role and appeared to have avoided burnout.

This is important, as Freed and Dawson (2006) use metaphor to describe the role middle managers have in general, suggesting that they are the company's engine, as they set the pace for executing the strategic plan and focus on the organization's priorities. As mediators, CNMMs may find it difficult to negotiate a successful route between competing challenges, role conflict and ambiguity, and remaining engaged with the organisation. Therefore, supporting this group is crucial, especially as the exemplars show that strong leadership and support from CNMM management appeared to be a protective factor

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in preventing burnout and retaining experienced staff. Research indicates that both work identities, and employee engagement, improves organisational outcomes, by increasing employee motivation (May et al, 2004), yet their connection is too little discussed in research (Popova-Nowak, 2010).

This is especially important as Scotland moves towards further integration with local authorities and the third sector to deliver health (and social) care services in the community. Being in the middle of the organisation, CNMMs are in a unique position to influence the successful implementation of change (Hill, 2003; Iacono, 2006; Ferguson and Day, 2007) and through nursing leadership to maintain quality assurance. It is important to address this gap in literature, knowledge, and understanding of CNMMs' experiences in contemporary Scottish health care.

KEY POINTS

- A key gap in literature in relation to Health and Social Care Partnership Community Nurse Middle Managers in Scotland is addressed in this article.
- Interpretative Phenomenological Interpretative Analysis is identified as a methodology that links theoretical underpinnings with practical method.
- Community nurse middle managers (CNMMs) are proud to be nurses aligning their identity with their career history.
- As the CNMM role expands through change they maintain an implicit connection with service users to maintain quality.
- The style in which CNMMs are managed impacts on the retention of experienced staff.

Conclusions

Being in the middle of the organisation, CNMMs are in a unique position to influence the successful implementation of SG change. They carry out multiple roles through change, engaging and managing diverse teams and acting as conduits for vertical and horizontal communication between both the operational and strategic planes of the NHS and partner agencies. In addition, they manage budgets in a high-pressure sector, with high expectations from government. Crucially, they make decisions and judgements affecting nursing teams that can have an effect not only on the resiliency of teams, but more importantly patient safety (Ebright et al (2002), in Shirey, 2009). At a juncture in time when the NHS is about to lose highly experienced staff through retirement and to ensure that community nursing middle management roles remain attractive to community nurses, it is vitally important that the complexity of CNMM role enactment through change is understood and supported adequately. To quote two CNMM participants, acting as '*nurses by the long stretch of the arm*', they are '*dealing with different people in different time zones on both sides*'. Results show how culture and executive/senior management leadership style influences engagement and retention of this important population. This concept was a significant area to explore, given the potential challenges of change, first to the identity and role of CNMMS in the present context of further 'integration' in Scotland and second, given the age profile of middle managers, a high proportion could retire or potentially leave the workforce, leaving a concerning dearth of experienced nurses as managers. It would be useful therefore to consider the importance and advantage of having a strong HSCP community nursing middle management workforce. This could be supported by the following recommendations:

- Review present community nursing middle management structures and ensure they are fit for purpose, with a clear line of professional support throughout the system
- Apply healthy work practices, taking into account employee needs
- Review CNMMs' role to ensure realistic configuration for individuals to thrive in the workplace and deliver quality services
- Provide accurate CNMM job descriptions so that their workload is more manageable
- Involve CNMMs in power-sharing activities
- Design appropriate, affordable initiatives to contribute to the retention of staff and safe service user care
- Develop a national, structured CNMM, senior and executive manager programme to degree level and beyond, with a formal management programme designed, established, and funded, so that is tailored to need. **BJCN**

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Impact Statement: It is vitally important to understand the unique complex position of the community nurse middle managers (CNMMs) who drive Government change from the middle of the organisation by outlining the general characteristics of the population, using definitions of aspects of role (MacDuff, 2007) through:

- ***Role content** – activities undertaken*
- ***Role set** – nature and scope of relations with colleagues, those managed and managing and associate expectations in terms of function status and power*
- ***Role form** – professional domain(s) identity and associated cultural meanings*

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CPD REFLECTIVE QUESTIONS

- In what ways do you engage with professional literature, theory, research and policy to challenge and inform your thinking on your managerial/leadership practice through change?
- What leadership styles do you utilise to manage change and how and in what context do you apply them?
- How and to what extent do your values and beliefs influence how you manage change?
- Do you consider recruitment and retention in your approach to leading change management?
- How will you change or improve your practice as a result of the findings of this article?

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