Degree sought: Doctor of Philosophy, Professional Education

WHAT INFLUENCES NURSES' CAREER DECISIONS?

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During the novel "*Alice's Adventures in Wonderland"* the following conversation takes place between Alice and the Cheshire cat:

"Would you tell me, please, which way I ought to go from here?"

"That depends a good deal on where you want to get to" said the cat

"I don't much care where....."

Then it doesn't much matter which way you go" said the cat.

"...so long as I get somewhere" Alice added as an explanation

"Oh, you are sure to do that" said the cat.

Lewis Carroll, 1865

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Declaration

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Abstract

Background

This inquiry explores the career stories of nurses, to establish what influences their career decisions.

The Nursing and Midwifery Council has over half a million nurses on its register, mostly employed within the National Health Service. There are increasing opportunities within this varied and extensive profession for fulfilling careers, yet many nurses leave the profession early.

Research aims

This inquiry aimed to provide evidence about the influences on nurses' career decisions. It will establish an evidence-base for those who endeavour to assist nurses' career progression.

Methods

A narrative review into existing literature concerning nursing careers was undertaken. This demonstrated careers are much researched and there is a significant theoretical basis, but careers in nursing are a novel area of research.

Ethics approval was granted for a narrative inquiry amongst twenty experienced London nurses and ex-nurses. Semi-structured interviews were conducted to elicit their career stories. Three nurse managers and three nurse educators also participated. The emerging ideas were tested with a survey, sent to all participants.

Analysis

From the transcripts of the interviews, the career stories of the nurse and ex-nurse participants were derived. These were coded and the codes grouped to form narratives. Some of these were tested using an online survey of participants.

Results

Multiple complex challenges, priorities, and fears were revealed which influence nurses' career decisions. These are presented as five narratives. The most important of these to nurses is relationships. These have been overlooked in much career research, yet this inquiry showed relationships at work, especially with other nurses, are a source of enjoyment and discourage career moves. The other narratives are job satisfaction, finding the right job, stress, and work-life balance.

Conclusion

The nursing career structure can be obscure and information difficult to obtain. Relationships at work are an important source of guidance as well as being enjoyable. This thesis concludes by proposing a graphic and two tools. The graphic depicts the five narratives and could aid nurses to visualise their sources of career fulfilment. The first tool is for nurses to reflect upon their careers and the second helps managers evaluate nursing posts and may be particularly useful if a post is likely to be difficult to fill.

Abbreviations used in the text

A&E	Accident and Emergency department, now more correctly referred to as Emergency Department (ED)
ANP	Advanced Nurse Practitioner
BME	Black and minority ethnic
BMJ	British Medical Journal
BSc\BA	Bachelor of Science \ Bachelor of Arts; a first degree
CNS	Clinical nurse specialist
COPD	chronic obstructive pulmonary disease (now described as chronic airways limitation)
CPD / CPPD	continuing professional development / continuing professional and personal development
CVA	Cardiovascular accident (popularly referred to as 'stroke')
ED	Emergency Department, often still referred to as accident and emergency (A&E)
EEA	European Economic Area
EU	European Union
HEI	Higher Education Institute
ITU \ ICU	Intensive therapy unit \ ICU Intensive care unit
MSc \ MA	Master of Science \ Master of Arts; a higher or second degree
NHS	National Health Service
NMC	Nursing and Midwifery Council
PGDip	Post graduate diploma, taught at the same level as MSc but without a dissertation
PIGD	Pre-implantation genetic diagnosis
QNI	Queens Nursing Institute
RCN	Royal College of Nursing
RN	Registered Nurse
UK	The United Kingdom
USA	The United States of America

Chapter 1: Introduction and background

This chapter introduces the thesis, placing it into a wider context and facilitating the reader to navigate the work.

This thesis reports an inquiry which explored the career stories of nurses to establish what influences nurses' career decisions and whether any coherent account can be provided of them. The impetus for the inquiry arose from the researcher's work with student nurses and registered nurses (RN's). She observed most nurses do not have career plans and have a limited understanding of their profession. They are thus in danger of not fully exploiting the opportunities therein. This seemed unsatisfactory, yet there was a dearth of evidence to use in guiding the nurses in their careers or helping their career progression.

This introductory chapter explains why this inquiry is important and the contribution it makes.

1.1 The nature of career and career decisions

Arthur (2008, page 166) defined a career as "*the evolving sequence of a person's work experience over time*". Arthur's (2008) definition is rather limited because it seems to only include paid work and for Barnes, Bassot, and Chant (2011) "career" includes every way people engage with society, including unpaid work, family life, and leisure activities. It is a life-long construction of identity. In this inquiry, the term nursing career is taken to mean the nurses' and ex-nurses' paid employment and related studies. However, as we shall see, these have significant impacts on all aspects of nurses' lives.

Career decisions can include complex issues such as which course to study; leaving a job; moving to a different location; and retirement (Indeed.com, 2019). They can include delay of gratification, prioritising, planning, and personal action (Dik, Sargent, and Steger, 2008). Career decisions are amongst the most important decisions an individual ever makes, profoundly affecting their economic

health, life satisfaction, and social contacts (Yildez, Beskese, and Bozbura, 2015). Yet workers often fail to give them the gravitas they warrant (Schwartz, 2008). Career decisions are also difficult to reverse. Gillan (2014) discussed well-established research demonstrating that once a decision has been made, it increasingly appears to be the most attractive option, which discourages further exploration. In confirmation of this, Greenbank (2014) described an "*escalation of commitment*" (page 184) amongst students; as time passes, they have contributed ever greater resources to their degree and career choices, so they become increasingly unwilling to re-visit them.

Further, the nature of these decisions has changed. Careers are now characterized by unpredictability and multiple transitions (Krieshok, Black, and McKay, 2009). Fixed structures were the norm for many 20th century workers, which saw them steadily ascend a hierarchy to attain increasing responsibility, prestige, and income. These have been replaced by a less formal and less predictable system. This increases the responsibility of the worker to find their career path (Krieshok, Black, and McKay, 2009), rather than follow a route provided for them. Many authors (for example Ajzen, 2011; and Pryor and Bright, 2011) acknowledge that career choice is the messy result of basic instincts, social or economic pressures, and unconscious mental processes. Rather than occasional events, career decisions should be a continual series of responses to the environment and a workers' changing perspective. Healthcare is no exception and current upheavals make for challenging times but also offers nurses new and possibly unexpected career opportunities and rewards. The aim of a career decision in nursing is for nurses to find their way to fulfilling work which will enable them to work to a high standard and reduce their need to leave. Yet, there is evidence that nurses themselves are not always aware of the opportunities within the profession (Lundberg et al, 2011) and this lack of information will have a deleterious effect on the quality of that decision.

1.2 The nursing workforce

Nursing is a big profession - there are over 700,000 registered nurses and midwives (Nursing and Midwifery Council, 2020) in the United Kingdom (UK), mostly working for the National Health Service

(NHS). They work in all health facilities and in a variety of roles. This variety is increasing following the publication of *Modernising Nursing Careers* (Department of Health, Social Services, and Public Safety, 2006) which fostered development to the scope of nursing practice. This document set out a vision for a highly skilled and flexible profession, with an emphasis on health promotion. It was especially influential in encouraging the evolution of nursing roles in advanced or specialist practice. These developed to provide a flexible and responsive service and to address the problems created by the European Working Time Directive, which effectively restricted the number of hours worked by junior doctors (McCloughen, O'Brien, and Jackson, 2009). The title of these posts makes them comparable to medical consultants, and indeed there are similarities. These nurses work more autonomously than other nurses and can often take on responsibilities, such as prescribing drugs, which were once the domain of medical practitioners. They provide a valuable service to clients, especially those with long-term health needs (Butler et al, 2011 and Begley et al, 2013), and from the perspective of the nurses, they offer a range of interesting and prestigious positions for them.

Nurses are central to the quality of care available (Rolewicz and Palmer, 2019), yet there is a chronic, world-wide shortage of nurses which seems to be particularly severe in London (The Royal College of Nursing, quoted by Kleebauer, 2016). A shortage of nursing staff was described by the King's Fund as "the last straw" (Meadows, Levenson, and Baeza, 2000, title page) for a healthcare system already tottering under the influence of financial constraints, increased expectations, and an ageing population. This puts a strain on the remaining staff, increasing the chances of further staff leaving. This renders the workforce crisis in the NHS as severe as the financial one (Rolewicz and Palmer, 2019). Nursing shortages are likely to become more serious because the nursing workforce is ageing (Leifer, 2005).

The shortage of nurses, then, needs to be urgently addressed but there are only a few means of reversing it. One is to increase the number of recruits to student nursing programmes (discussed by, for example, Raymond et al, 2018). Another is to recruit internationally (discussed by, for example,

Larsen et al, 2005; and Adhikari and Melia, 2015) or to replace RNs with new nursing roles, such as assistant practitioners (Waters, 2011). These methods of increasing nursing availability are all outside the scope of this inquiry, but two further means are relevant. The first is to reduce attrition, which is high in nursing and is becoming increasingly serious. Between 2012 and 2018 the number of nurses leaving the NHS went from 27,100 per annum to 34,100 per annum, an increase of 25% (Leader, 2019). Attrition from nursing is not set to improve because an international study (DeCola and Riggins, 2010) found only 52% of practising nurses envisioned themselves still in the profession after another 5 years, which is a serious waste of a valuable resource (Booth, 2011). There are probably multiple and complex reasons for nurses leaving and this inquiry will contribute to understanding some of them. The second, related, means is to ensure the nursing workforce is deployed effectively and each nurse is in the correct role for them at the time. As well as staying in post, it seems likely nurses who are content and fulfil appropriate roles will also work to a higher standard (Argyle, 1989 and Aholaakko, 2011).

Unhappiness at work and attrition from the nursing profession is also a problem for nurses themselves because most entered the profession seeking a long-term career (McCloughen, O'Brien, and Jackson, 2009) and nurses are often highly committed to caring for their clients (McCabe, Thomas, and Thomas, 2008). Therefore, the high numbers leaving the profession mid-career suggests nurses enter the profession with high hopes but are disappointed with their careers. What are they disappointed about? Chandra (2003) proposed a few potential reasons, including low pay, high levels of stress, and an unfavourable shift pattern. These are all potential causes of nurses leaving, yet Chandra (2003) provided no evidence for any of them. Murrells, Robinson, and Griffiths (2008) found nurses were consistently and increasingly dissatisfied with their pay, which was particularly noticeable amongst London nurses but Meadows, Levenson, and Baeza (2000) found pay was a relatively minor factor. However, this is mostly theoretical, and little is known about why nurses leave (Jones-Berry, 2017). Indeed, we know remarkably little about any career decisions in nursing. Perhaps, for some, the work environment is key to occupational happiness. Or maybe the most

important factors are outside work, such as the nature of their journey to work – does a satisfying role warrant a difficult journey and how are they to balance their professional and personal lives? Or maybe the educational opportunities are important. Or perhaps they want to travel. Whatever the reasons for career disappointment, the effects are severe because the importance of paid work to most individuals is as great as ever (Wee, 2014). Failing to meet one's career expectations can have long-term negative consequences for the individual's well-being (Bertoni and Corazzini, 2018). In contrast, there is considerable evidence that satisfaction in this major aspect of life leads to a positive assessment of all aspects of one's life (Masdonati, Massoudi, and Rossier, 2009) an effect evident even after retirement (Stevens-Ratchford, 2011).

Finally, nurses leaving the profession should also concern universities (Higher Education Institutes, or HEIs). These have a responsibility to promote the careers of their graduates and in recognition of this HEIs are now ranked partly on the destinations of their graduates (Office for Students, 2019). Yet we know little about how nurses choose their first posts and less about how they decide to move on from there. Consequently, HEIs do not know how to help their student nurses' career progression. The inquiry reported here will provide evidence of influences on career decisions in nursing and may illuminate means of enhancing career decisions.

1.3 Objectives of the inquiry

Since we do not know how nurses build their careers nor what they aspire to, we cannot address the issues of attrition from the profession nor how to ensure the most suitable nurse fills each of the wide variety of posts available. This inquiry aims to provide an evidence-base for explaining nursing career decisions. This should guide nurses considering their careers, and those who seek to assist them, with information on what they should consider for their careers and what could impact their career decisions.

The following objectives were identified:

- Conduct a narrative review of the literature and appraise current research into nursing career decisions to identify any gaps in the literature and to help shape the interpretive lens used for this inquiry (chapter 2).
- Formulate a research question to start to address gaps in our knowledge (section 2.7).
- Explore a range of potential methodologies and identify the most suitable to address the question (chapter 3).
- Present the data (narratives) on how nurses make career decisions and what influences these (chapter 4).
- Present an analysis of the narratives and explore these in relation to the existing literature (chapter 5).
- Examine the data generated for this inquiry and analyse whether existing theories can adequately explain career decisions in nursing or whether a new approach is required. Explore new insights arising from this inquiry and whether they can contribute to our understanding of nurse attrition (chapter 6).
- Make recommendations for nursing management, education, and practice, and future research (chapter 6).

1.4 Conclusion to chapter 1

This chapter has explored a contradiction. On the one hand, people enter the nursing profession highly motivated and seeking a long-term career and, indeed, nursing offers an increasing variety of interesting careers with a range of opportunities for career advancement. On the other hand, nurses are leaving their profession early in droves. This must mean the nurses themselves are disappointed and it certainly has a deleterious effect on healthcare and on the ranking of their universities. However, much of the discussion in this chapter was speculative because little is known about career decisions in nursing.

This inquiry will provide evidence about the influences on nurses' career decisions. This will guide nurses themselves in being proactive in their careers. It will provide an evidence-base for those who endeavour to assist nurses' career progression, whether they are HEI's, managers, career guidance professionals and, importantly to nurses, friends and colleagues.

The next chapter will present a review of existing research into nursing careers to establish what is already known and to identify gaps in our knowledge. This will lead to a formulation of the research question.

Chapter 2: Review of the literature

This inquiry starts with a narrative review of the existing literature. This is in common with almost all theses, because literature reviews set out the broad territory the work sits within (MacIntosh, 2009). In narrative inquiry, work undertaken by previous researchers can suggest the manner in which new data can be examined. This assists the researcher to hone their approach and start to compile an interpretative lens. This means the stories generated by this inquiry will be interpreted in the light of established theoretical approaches. The researcher will examine the stories and assess whether they support or refute existing interpretations. From this, the researcher provides a robust analysis to refine an existing theory or offer a new theoretical approach. This chapter will justify the methods for identifying and appraising the quality of the literature. This was complex because the research was from a variety of disciplines, including psychology, health, education, and human resources. This is reflected in the wide range of methodologies employed by research included in this review. This chapter explains how and why many potential research papers were excluded and two charts show the reason and at what stage this happened. This demonstrates the search was conducted in a replicable and auditable manner. The chapter goes on to explain how the identified research was analysed to derive themes. These themes are then presented to start to examine career decisions in nursing.

2.1 Review of the literature

The “gold standard” for reviews of the literature are often seen as systematic reviews. These take place when multiple sources are combined. They aim to furnish one outcome and they are best established in medicine where the search is typically for the one, best treatment. This approach was not appropriate here because this was not a search for one answer but rather, a search for a picture of our existing knowledge. Further, this knowledge could be in any form, including qualitative and quantitative sources. Therefore, a narrative approach was adopted. A narrative review uses established and systematic methods to identify the sources used and to assess their quality but, due

to the wide range of sources included, uses a less structured approach to the analysis (Popey et al, 2006). The analysis brings together all the included research to make conclusions based upon evidence. One reason for conducting a narrative review is to allow heterogeneous sources, which can render a systematic review meaningless.

2.2 Method for identifying and analysing the literature

Searching the literature starts with the formulation of a research question, which must be relevant and answerable (Popey et al, 2006). The question for this review was kept open to include as much as we know about nursing careers and was "*how do nurses make career decisions*?".

The search of the literature started with an electronic search of online databases. The review included literature from January 2006 until October 2019. The start date was chosen because *Modernising Nursing Careers* (Department of Health, Social Services and Public Safety, 2006) was expected to impact the nursing profession by increasing the opportunities available. This makes 2006 a critical point in the development of the nursing profession.

The platform used was EBSCOhost which includes databases from the humanities and health. The databases used for this review were:

- Academic Search Complete; a large database, which is intended mainly for scholars and academic institutions so it may not include all the professional journals.
- CINAHL Complete; this database is mainly concerned with nursing texts.
- Medline Complete: a comprehensive coverage of medical journals, but also other health-related sources.

The search terms were chosen to include any influences on the career decisions of RNs. The search terms and how they were combined are shown in table 2.1 below.

Search term	Boolean operator	Search term
Nurse* (in the title)	AND	Career decision (in the abstract)
OR		
Nurse* (in the title)	AND	Career choice (in the abstract)
OR		
Nurse* (in the title)	AND	Career development (in the abstract)

Table 2.1: The search of databases

The star wild card (*) ensured all the derivatives of the terms would have been included. For example, “nursing”, “nurse”, “nurses” and “nurses’” would all have been identified. Restricting this term to the title meant only those articles principally about nursing were included. The term “career” was sought in the abstract so articles discussing any aspect of career would be identified, but requiring this to be associated with “decision”, “choice”, or “development” ensured they were concerned with the nurses’ career decisions. Limiters were applied to omit non-scholarly magazines and news. Other limiters were the full article was available in English and was published in a peer-reviewed journal.

This yielded 723 articles or 540 after the exact duplicates had been removed by the platform. To this was added two additional articles identified from the references of the articles themselves.

2.2.1 Inclusion and exclusion criteria

It was not possible to do justice to so much research and this was unnecessary because, as expected, the electronic search had yielded many spurious results. Therefore, inclusion and exclusion criteria were developed to identify only those useful for answering the research question. Table 2.2 summarises the inclusion and exclusion criteria, with a rationale and table 2.3 shows how this impacted the number of articles excluded at different stages. This is summarised in the PRISMA diagram (table 2.3). The final number of articles included in the analysis was fifty-three. These are listed in Table ap 2.1, in appendix 2. This table identifies the salient features of each research article

and the key findings relating to this inquiry. It should be read in conjunction with table ap 2.2 and table ap 2.3 (both in appendix 2) which indicates the quality of the research.

The aspect of the article	Inclusion criteria	Exclusion criteria	Rationale
Nature of research	Original, empirical research. Any methodology was considered for inclusion.	Opinion and advice pieces or literature reviews. Papers proposing theoretical models, but without empirical evidence.	Whilst opinion and other papers showed nursing careers were a matter of interest, such pieces were unlikely to contribute to the scholarly approach required for this thesis. All methodologies were included the articles had an eclectic approach with no one methodology dominating and it was not possible to identify one or more approach as more appropriate than another.
Geography and language	Research from the UK and Ireland along with some international research, but only from the European Union (EU); the European Economic Area (EEA); North America; and Australasia.	Research from Africa, Asia, the Middle East and South America.	At the time of writing, there was free movement of workers around the EU and EEA, only restricted by language requirements. The English language facilitated workers moving between the USA, Canada, New Zealand and Australia. This had the effect of removing studies based in cultures very different from the UK, thus limiting these confounding variables. Research, where the full article was not available in English, was likewise omitted.
Perspective	Considered career decisions from the decider's perspective,	Only concerned with the fulfilling of service requirements.	This inquiry is about the deciders' perspective and not the effect of their career decisions upon the service.
Student experience	Articles contributing to an understanding of career decisions whilst still students but which impact once they were RNs,	Articles about the wider student nurse experience, or reducing student nurse attrition.	The focus of this inquiry is the careers of RNs, but early decisions may be taken whilst still students.
Recruitment	Articles about attracting RNs to a specialism or geographical area.	Articles considering entry to the profession and efforts to make this more attractive, including work with children	The emphasis of this inquiry is career decisions by RNs. The decision to enter nursing is not included but decisions to move within the profession are.
Personal challenges		The plight of nurses with challenges such as mental health problems or dyslexia.	This is a specialised aspect of career guidance, beyond the scope of this inquiry.
Participants	Nurses registered in adult, child, mental health, or learning difficulty nursing.	Unregistered nurses and non-nurses. Midwives who are not also nurses	Although this inquiry only concerns adult nurses, previously in the UK and currently in Europe and elsewhere, many students embark upon a generalist nursing course and only choose their field after registration

Table 2.2 Inclusion and exclusion criteria

Grounds	The stage at which the article was excluded from the review (after remaining exact duplicates had been removed)			Total for each exclusion criteria
	Title	Abstract or article details	Upon reading the full article	
Nature of research	23	170	0	193
Geography or language	91	44	0	135
Perspective	0	60	1	61
Student experience & attrition	7	47	2	56
Recruitment into profession	23	0	0	23
Personal challenges of nurses	0	9	0	9
Participants involved	5	1	0	6
Total for each stage	149	331	3	483

Table 2.3 To show impact of inclusion and exclusion criteria.

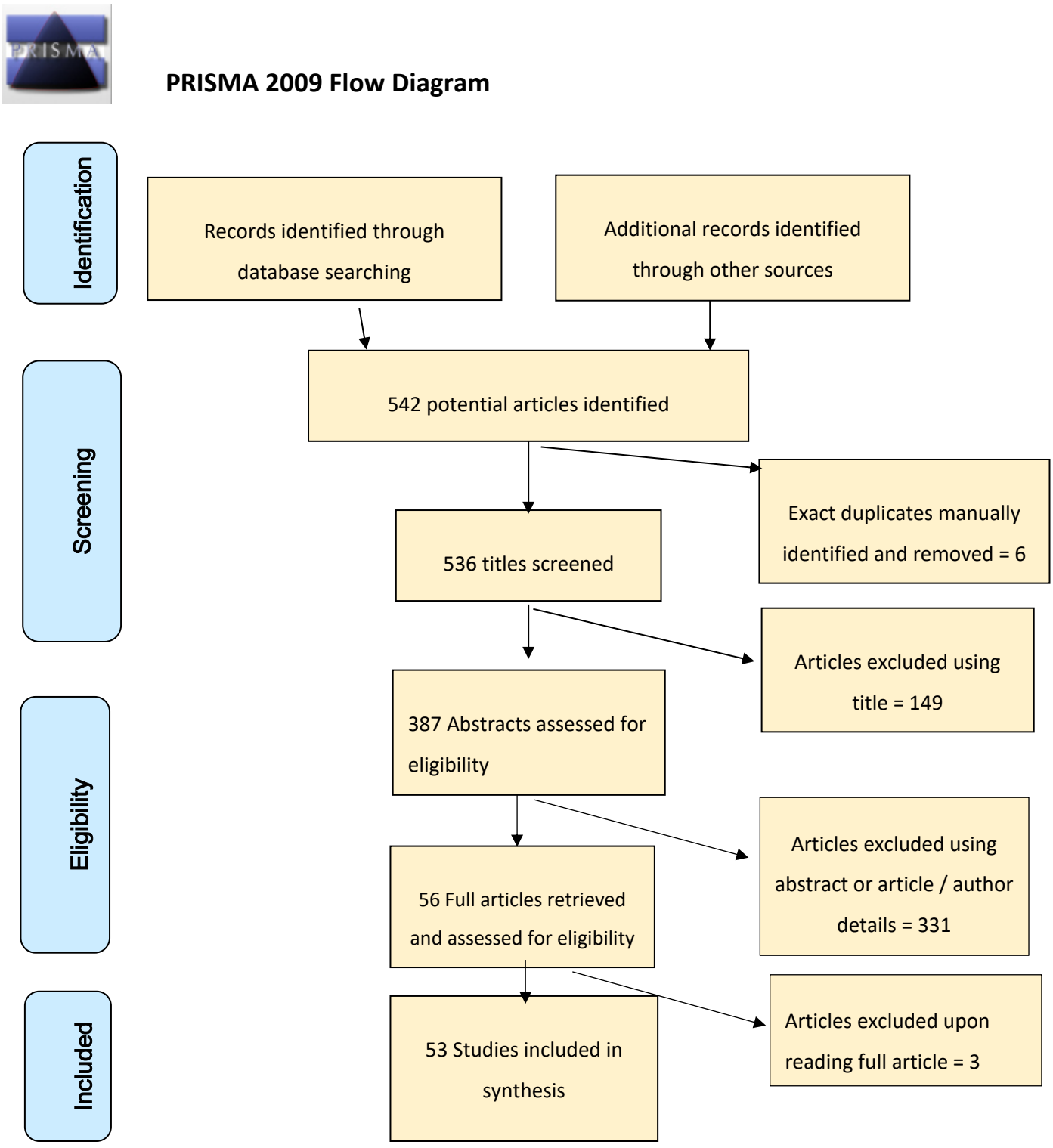

Table 2.4: Prisma diagram showing a progressive reduction in articles

2.3 Appraisal of the quality of the literature

After identifying suitable research articles, their quality was assessed. The robustness of a review relies upon both the quality of the original articles as well as the effectiveness of the reviewer (Popey et al, 2006). This assessment informed the value to attach to each piece of research. Due to the varied types of research involved, two instruments were required. All the qualitative research papers were assessed using the CASP framework for qualitative research https://casp-uk.net/casp-tools-checklists/). The framework is a checklist for verifying the quality of research. Table ap2.2 in appendix 2 shows the questions posed by the framework and the outcomes for each piece of research assessed using it. Ideally, another CASP tool would have been used for the quantitative research, but most of these articles used questionnaires or surveys and CASP does not offer a suitable tool. However, the *British Medical Journal (BMJ)* does offer a comparable tool, (https://www.bmj.com/content/suppl/2004/05/27/328.7451.1312.DC1) and this was used. This also asks a series of questions (shown in table ap 2.3, in appendix 2). Table ap 2.4 shows the outcomes of the quality appraisal for each piece of research used here. The questions asked in the CASP tool generally require a simple yes/no response, with some scope for written comments. The *BMJ* tool tends to ask open questions but to make the two tools comparable this has been responded to as a single word answers with additional comments. The BMJ tool includes questions about the findings, but the CASP tool only questions their reliability and validity. In this inquiry the results, for both types of articles, have been added to the data extraction table (table 2.1 in appendix 2) and so is less prominent in the quality assessment tools. Some research was difficult to assign to a tool. This was resolved as follows. Brown et al (2008) used mixed methods and was assessed using the CASP tool. One of the three articles by Waddell et al (2015, part 1) was described by the authors as a randomised controlled trial – a CASP checklist is available for these. However, their three research articles taken together (Waddell et al, 2015, parts 1, 2, and 3) form a long-term project that could be more accurately described as action research, so all three articles have been appraised as qualitative research. Notably, both tools were originally intended to appraise the quality of clinical articles in

medical literature, because it is healthcare which has most established the appraisal of research quality (Vassallo, 2018). This shared background and emphasis also helps make the two tools comparable.

2.3.1 Outcomes of the quality appraisal

There were several problems encountered when using these checklists. First, it was not possible to comment upon several of the questions. For example, the process of the qualitative analysis was often not fully described, probably due to the word limits imposed by publishers of journals. Similarly, the CASP tool asked about the distribution and administration of the survey, but few articles described this. The *BMJ* tool asked how the security of the data was ensured, and it was rarely possible to identify this. Further, it asked about the format of the questionnaire, for instance, whether non-threatening questions were put first and whether the title of the questionnaire and the instructions for participants were helpful. Few articles provided sufficient details to answer these and none provided the research tool in full. Some of the questions in the BMJ tool may not be relevant here. For instance, the tool asks whether the questionnaires were suitable for all participants; this would be a consideration if the participants were frail or vulnerable clients, but since the participants were nurses (or student nurses) this may be less critical for the research studies used in this review.

Several of the large-scale surveys used statistical tests, but the suitability of some of the more complex tests (for example, the Kruskal-Wall test, used by Thongpriwan et al, 2015) have not been verified, nor the accuracy of the arithmetic checked. Similarly, many of the authors stated the reliability and consistency of the data were verified by a statistical tool such as Cronbach's α-coefficient. These have all been accepted at face value in this inquiry.

Question 4 of the BMJ tool asks whether participants had been involved in planning the work and the three papers by Waddell et al (2015) were the only to do this. Some (for example, Stevens, Browne, and Graham, 2013) used a pre-existing or previously validated questionnaire, this is indicated as

"utilised" in response to question 2 of the BMJ tool. Most of these papers, however, used tools specially developed for the research which had not been validated, a fact made more serious because many were not even piloted. Further, few provided the full questionnaire or other tools, so the reader could not examine this for themselves. Devising and using a new tool risks confirming existing theories. The lack of pilots is also unfortunate because some of the papers (for example Berkery, Tiernan, and Morley, 2014; and Adeniran, Smith-Glasgow, and Bhattacharya, 2013) had a high rate of unusable responses, and a pilot could have illuminated these so the researchers could have adapted to tool to eliminate this issue.

Many of the quantitative research articles could not easily be generalised. This could be due to the narrow selection of participants (for example, Abrahamson, 2015; Halfer and Graf, 2006; Homburg, Heigden & Valkenburg, 2013; Koehler et al, 2016; and Pajic et al, 2018) or because only small statistical differences had been found in a small group (for example, Adeniran, Smith-Glasgow and Bhattacharya, 2013; Throngpriwas et al, 2015; and Hovey et al, 2018). Other research recruited participants from a wider area but had a poor response rate (for example, Candela, Gutierrez, and Keating, 2013; Hovey et al, 2018; and Ng, Eley and Tuckettt, 2016).

Much of the research included in this review had a rather specific focus. For instance, some research examined the impact of a single initiative (for example, Horn, Pilkington, and Hooten, 2019 and Koehler et al, 2016) or the role of nurses in a particular context (for example, Booth et al, 2006) but tended not to examine this concerning the nurses' overall career progression: how they got there, how their current work compares to other experience, and how they view their futures. Instead, much of the research discussed here explored career moves from the perspective of attracting and retaining staff. They noted the effects of initiatives but did not explore how the nurses felt about their career moves nor did they examine career decisions from the deciders' perspective. Several of these papers reviewed career intentions, often the intention to leave (for example, Mills et al, 2016). They did this by exploring the development of career plans amongst student nurses or by asking RNs about such

issues as plans to leave their jobs or the profession. However, none followed up to explore whether these feelings had been acted upon and few papers reviewed career decisions that had already taken place.

To summarise this section, much of the research had weaknesses or showed some uncertainty relating to their quality. However, none were excluded. This means all methodologies were included as well as research of variable, or uncertain, quality. This was due partly to the dearth of research into nursing careers and partly the need to develop an interpretive lens for this research. To this end, the written analysis has been supplemented by text boxes reflecting upon the contribution of the literature to the remainder of this inquiry. The included research is eclectic and involves research of nurses in a wide variety of settings and using a wide variety of approaches.

2.3.2 Analysis of the literature

This section examines what the included literature revealed to answer the question, how do nurses make career decisions?

The analysis of the literature starts with a description of the included studies and their results (Popey et al, 2006). This can be found in the data extraction table (ap2.1 in appendix 2). This shows the essentials of the research included and the key findings relating to the research question. The next element is an analysis of any relationships between the studies. Most of the included articles addressed a specific and narrow problem, which was often related to the shortage of nurses. However, there was a variety of approaches to this problem and Popey et al (2006) describe these as “clusters” or “groupings” (page 17), whereby several articles addressed similar aspect of the problem. Each of these clusters was therefore regarded as a theme for this literature review and provided its structure. Popey et al (2006) stated that, if the data does not lend itself to statistical analysis, then a thematic analysis is the most common form of analysis. This meant five themes incorporated most of the relevant material from the articles. Each of these five themes related, albeit sometimes indirectly,

to shortages of nurses, either locally or nationally. There was just one additional theme occurring in several different articles and did not necessarily relate to nursing shortages. The themes will be explained and justified now.

1. The nurses' pre-registration education programme provides students with a range of opportunities to experience different clinical placements. This influences the career decisions made on registration about where they will seek work. Of particular concern to many researchers was the high loss of newly registered nurses and much research examined role preparation and the difficulties of transitioning into RN status. This section examines the impact of pre-registration clinical experience on nurses' career choices; the preparation during nurse education; and the experience of early-career nurses.
2. Further to the discussion of different clinical placements in the first theme, there is further literature about what influences nurses to choose specific clinical specialisms or engage in specific roles. A particular concern was areas difficult to recruit to, such as elder care and mental health nursing. Other research investigated moving on to work as a consultant nurse or an advanced practitioner. These are new and often pioneering roles, so little is known about them. Research only about the provision of health services was omitted (see table 2.1), but research examining the experience of nurses in these new roles was included, along with their career paths to reach such a post.
3. The third theme focuses on what influences nurses to make a career change or leave nursing.
4. The effectiveness of post-registration nurse education was another popular theme. These often considered just one programme and how well it contributed to nurses choosing to work in a specialism.
5. A few articles examined the experience of men in nursing. Men are perceived as being especially likely to leave nursing early and some research aimed to understand and address this, so gender in nursing was the next theme.
6. One additional theme was identified, which occurred in several other articles, namely the effects of support, encouragement, and management. This was added as the final, sixth, theme and has been termed mentorship.

2.4 Exploration of the themes in the literature

This section explores the literature under the six identified themes, to examine what existing research has told us about how nurses make career decisions. These themes will provide the lens, allowing the researcher to focus on the stories and interpret them in the light of our current understanding. This means the themes will be readily identified when they occur in the stories, whilst highlighting anything new, contradictory, or unexpected. This leads to a rich analysis emphasising the contribution the inquiry can make to our understanding of nursing careers. Each section of this chapter closes with a box containing a reflexive account of the contribution of that section to the compilation of the interpretive lens.

2.4.1 Career decisions during pre-registration education, the transition to RN status, and starting work

This section first examines the influence of pre-registration education on nurses' career decisions and how it contributes to their transition to RN status.

A series of longitudinal surveys (McCann, Clark, and Lu, 2010) demonstrated students become increasingly confident about their career intentions. At the start of their first year, about half of the students had no career plans beyond registration; in their second year, this was 18% and just 3% by the third year. This was not, however, matched by increased certainty about actions to secure their desired career because Hickey, Sumsion, and Harrison (2013) interviewed graduating nurses about their job applications. They found students applied for two or more very different jobs and were readily influenced by activities of employers designed to attract them to work there. Put together, these two pieces of research suggest nurses may believe they have learnt about careers in nursing during their pre-registration education but this does not translate into action displaying career decidedness. Clinical experiences form a key feature of all UK pre-registration programmes, accounting for 50% of learning time (Nursing and Midwifery Council, 2018a). They are crucial to the formation of early career

decisions and more important than plans made before commencing their nursing programme (Mills et al, 2016; McKenna, McCall and Wray, 2010; and Schmidt and Brown, 2019). Students use clinical experiences to identify areas to either seek employment or to avoid (Wareing et al, 2017), and they frequently obtain employment within their final few placements (Mills et al, 2016). Even if they do not work directly in the same field, they will often choose a related field, where they can continue to use skills gained as a student (Schmidt and Brown, 2019). In addition to programmed clinical experiences, career decisions are influenced by experiences gained whilst undertaking paid work, perhaps casual work with a nursing agency before or during their studies (Hickey, Sumsion, and Harrison, 2013).

A recurring theme is how to attract newly qualified nurses into the less popular fields. The most-discussed unpopular specialisms are elder care and care of the mentally unwell. Authors (for example Stevens, Brown, and Graham, 2013; and Hovey et al, 2018) make pleas to include positive experiences of these in pre-registration education. Such pleas are based on a belief that exposure encourages newly registered nurses to opt to work in these areas. Edward et al (2015) and Alexander, Diefenbeck, and Brown (2015) did indeed find nurses more likely to consider mental health nursing if they had personal experience of mental ill-health, causing some nurses to aspire to help others who were suffering as they – or someone close to them - had done. Encouragingly, student nurses do not need to experience mental ill-health themselves because they can learn of the positive impact nursing can make from classroom teaching or clinical experience (Thongpriwan et al, 2015). Some of Alexander, Diefenbeck, and Brown's (2015) student participants reported choosing mental health nursing following encouraging encounters during their clinical experience, such as helping a reticent client to open up. Likewise, McCann, Clark, and Lu (2010) found good quality clinical experiences and theoretical teaching in mental health nursing helped their students to consider working there. Indeed, this was so successful that mental health nursing became increasingly popular during their studies and by the third year it was the second most popular choice, after adult acute care. Stevens, Brown, and Graham (2013) may have demonstrated the influence of experience within the specialism and the nurses' growing maturity when they asked students how

long they had worked on mental health wards during their pre-registration education, and those who stated they had more time there were also more inclined to choose it.

Elder care is another area student nurses may wish to avoid but can learn to view more positively. Koehler et al (2016) measured student nurses' attitudes to elder care before and after a course putting elder care in a positive light; for instance, the students met older adults who lived independently. Koehler et al (2016) found a small but important shift in favour of elder care after the course. Nurses working in elder care are aware of their responsibility to encourage students to enter the specialism (Carlson et al, 2014). It is possible clinical placements can help overcome fear and prejudice and illuminate a potentially fulfilling career, but Thongpriwan et al (2015) and Edward et al (2015) claimed this will only happen if student nurses are carefully prepared for, and supported during, more demanding placements. Koskinen et al (2012) reported exposure to elder care did not increase student nurses' interest in working there. However, they also stated student nurses were more positive about elder care if they had attended a programme with a high amount of teaching in elder care. This contradiction may be explained by their method because Koskinen et al (2012) asked nurses about their interest after the experience, so they gauged changes retrospectively. In contrast, Edward et al (2015) found classroom teaching in mental health made little difference to career choices; instead, their personal experience (including placements during nurse education) was influential. This suggests classroom teaching cannot offset negative clinical experiences.

Not everyone agreed that experience increases student nurses' interest in working in less popular areas. Brown et al (2008) went so far as to claim experiences in elder care may decrease student nurses' interest in working there, because of exposure to the "impoverished environment" (page 1221), characteristic of many elder care institutions. This unpleasant working environment may have been demonstrated by Tummers, Groeneveld, and Lankhaar (2013), who asked RNs working in elder care about their intentions to leave their employer. Those who were pondering leaving reported dissatisfaction with professional and career development opportunities, a poor atmosphere at work,

and inadequate leadership. This suggested it is not the nature of the work itself, but the way it is organised, that is the problem. Nevertheless, this could be overstated because most of Tummers, Groeneveld, and Lankhaar's (2013) participants were not planning to leave. Stevens (2011) may have provided additional evidence for problems in the environment by asking students to rank their choices of specialism each year. Like Brown et al (2008), Stevens (2011) found elder care became increasingly unpopular during training, but for different reasons; in their first-year students disliked elder care because older people themselves were perceived as dull. By the third year, however, student nurses believed elder care would interfere with career plans because it would not help them hone their skills and lacked a clear hierarchy for them to climb. This is similar to the Chinese students surveyed by Xiao, Shen, and Paterson (2013) who had extensive experience of older adults because Chinese society has a tradition of living in multi-generation households. Therefore, the students liked the elders themselves yet still did not perceive elder care as a good career choice because it was not apparent to the students how they could progress their careers if they worked there. Xiao, Shen, and Paterson (2013) contrast these Chinese students with Australian student nurses who were "uncomfortable" (page 412) with older adults. They explained this was because they had been socialised to interact with people their own age and felt they did not have anything in common with elders. In examining the small differences between the two groups, however, Xiao, Shen, and Paterson (2013) appear to have overlooked the similarities; neither group favoured a career with elders and both felt this work was exhausting, demoralising, and unlikely to contribute to career progression.

Lea et al (2018) have provided further evidence students perceive elder care has little to offer them. They made intriguing use of a readily available source of insight into student nurses' feelings about clinical areas by analysing their written requests relating to clinical placements. These suggested students may believe a single placement in elder care is sufficient and, once they have completed that, they have nothing more to learn there. Some of these were requests to not go to elderly residential care, usually because they had pre-existing experience there, and several expressed

concern about the narrow range of learning opportunities available. Lea et al (2018) acknowledged the negative comments were only a small proportion of all the requests lodged and were partially offset by nurses requesting residential placements, often because they had not yet experienced such a placement. Unfortunately, Lea et al (2018) do not examine whether students similarly feel a single acute placement is sufficient to learn all there is to be learnt, but it seems unlikely.

However, the situation is different in the UK compared to countries where much of this research is based. In the UK, nurses must choose whether to study for registration as an adult nurse or as a mental health nurse when they apply for their pre-registration education. Student nurses in the UK who are preparing for registration as adult nurses will gain experience in mental health nursing, but they will not normally be expected to choose to work there as an RN. In contrast, many other countries prepare nurses on a "comprehensive" programme and will require some to choose to work in mental health nursing as an RN. Much of the research included here was concerned with encouraging nurses graduating from a comprehensive programme to choose to work in mental health. However, other research included was concerned with the choice of choosing to work in elder care, and this is relevant in the UK, and to this inquiry, since this is part of the adult branch of nursing.

Waddell et al (2015, parts 1, 2, and 3) investigated whether classroom activities could build students' career self-efficacy. Bandura's (1997) self-efficacy theory is part of social cognitive theory and explores how the individual relates to the wider world. Concerning careers, it seeks to explain why some people achieve success and happiness whilst others are apparently the subject of repeated misfortune. Self-efficacy is the ability to own one's destiny and respond to challenges in the environment (Lent, 2013) and leads to career decidedness. Whilst acknowledging the importance of context (Hagemeier, Murawski and Popovich 2013), self-efficacy theory claims the successful worker does not allow themselves to be unduly influenced by other people and the circumstances surrounding them (Peterson, 2009), as they fulfil their ambitions. Workers with high self-efficacy believe they, themselves, can succeed, and so tend to persist in the face of difficulty. They are often

the most satisfied with their career and their work-life balance (Peterson, 2009) and demonstrate superior academic and vocational performance. This approach can be criticised (for example. Blustein et al, 2010) because there is a danger of over-emphasising the power of the individual and minimising the importance of their environment and social disadvantage.

Waddell et al (2015, parts 1, 2, and 3) conducted a randomised controlled trial of a series of workshops during a four-year Bachelor of Nursing degree. Activities for the intervention group occurred in years two, three, and four, amounting to an additional eighteen hours and were designed to increase career self-efficacy. At the end of the programme, the intervention group demonstrated greater career confidence; entertained an enhanced self-assessment; and demonstrated greater career decidedness and increased self-efficacy. Pajic et al (2018) confirmed high self-efficacy is indeed associated with rapid career progression but the studies by Waddell et al (2015, part 3) did not continue to long enough to demonstrate an influence of these activities on career decisions. Further, Waddell et al (2015, part 3) identified that academic staff were not ready to help student nurses' career decisions, instead, they tended to rely on their own experience. This meant they tended to give advice, rather than adopting a student-centred approach which facilitated the development of self-efficacy, although this improved with training.

No matter how carefully the new RNs have been prepared, transitioning to RN status is widely regarded as a stressful time (Flinkman and Salanterä, 2015; Wareing et al, 2017). Even though newly registered nurses usually enjoy their work, they can still feel overwhelmed by the multiple and complex needs of clients and unsure of their ability to meet them (Halfer and Graf, 2006). This leaves them scared, vulnerable and at risk of leaving (Flinkman and Salanterä, 2015). They seek their "niche" (Mills et al, 2016, page 3) but often fail to identify it. These stresses even impact their health (Hasson, Linford, and Gussatsson, 2010) which deteriorates over the first year. Read and Laschinger (2017) compared the experience of graduates from accelerated programmes (available to candidates with an existing higher education degree) with those from traditional programmes. They were disappointed to

find the graduates from accelerated programmes were rather more critical of the support offered to them by their universities and employers. Read and Laschinger (2017) had expected the more mature graduates from the accelerated schemes to display greater self-efficacy, instead, they confirmed that all nurses, regardless of their background, require extra support at this time. Adequate support is often not available and this is a time of high attrition; up to 60% of nurses change jobs (Halfer and Graf, 2006) and about 17% leave the profession altogether within a year of graduation (Mauro, Escalier, and Rosario-Sim, 2016). One irony is the fast-paced areas nurses aspire to are also often the most stressful (Wareing et al, 2017), contributing to the feelings of inadequacy, and ultimately fuelling the high attrition early in nursing careers.

The research in this literature review included some attempts to ease the transition. Waddell et al (2015, part 2) claimed some pre-registration classroom activities help newly qualified nurses to build reciprocal relationships and to proactively seek career opportunities. This part of their study, however, only offered qualitative results and finished a year after graduation, with no job changes discussed, so there was no opportunity to investigate whether the intervention group made different career decisions. A toolkit designed by Mauro, Escalier, and Rosario-Sim (2016) consisted of 6 written articles, case studies, and online resources. These covered: job-hunting; education opportunities; leadership; and potential career paths. This was intended to help nurses establish themselves in their careers and feedback from a small number of graduates was positive, but the authors do not state how they expected it to help nor were the participants asked how they had used the toolkit, not even whether they had read all or part of it. It is likely to have required a lengthy period of study at a time when nurses are especially stressed. The authors (Mauro, Escalier, and Rosario-Sim, 2016) stated this resource is available online, but the link did not work when it was investigated for this review.

This inquiry concerns nurses' career decisions, but many nurses feel they have little choice over their first post upon graduation, which they resent (Mills et al, 2016). They are often obliged to work in less popular areas for several months, particularly elder care (Koskinen et al, 2012). This could contribute

to the high attrition of newly registered nurses. Those remaining, however, settle into their role, become more confident in their clinical skills and interested in their role as leaders (Halfer and Graf, 2006). After the first post they do, perhaps for the first time as RNs, have career decisions to make, and this is explored next.

Nurses have only the vaguest idea about careers in nursing as they commence their nurse education. These develop during their educational programme and clinical placements are of paramount importance – more important than classroom teaching. Pre-registration clinical placements may cause students to consider less popular fields, but this is dependent upon the quality of that experience. It is likely the participants will mention their clinical placements, because they appear to have a significant influence upon career decisions and so will be prominent in the analysis.

Nurses may not have a genuine choice of their first post but, rather, are allocated to one, often in a less popular area. This could hinder them as they seek their "niche". Yet, career self-efficacy can promote career satisfaction. It is possible to conduct activities designed to promote this, but there is no evidence of their effectiveness. Assessing nurses' career self-efficacy could be an important component of the answer to the research question. However, it could be difficult to measure. Nurses may be unlikely to use the term "self-efficacy". Instead, they could be asked about the extent to which they are free to make their own decisions or are constrained by other factors. Even so, if they are greatly influenced by their circumstances, they may not perceive that or, if they do, may be reluctant to discuss it.

Box 2.1: Reflexive commentary on pre-registration experiences, the transition to RN status, and starting work

2.4.2 Choice of clinical specialism

This section will assess what nurses' choice of specialism tells us about their career decisions. This research continues to be dominated by a perceived need to attract nurses to work in areas where nurse shortages are particularly severe. As discussed above, unpopular areas include long-term care, especially of elders, or nursing the mentally ill (McCann, Clark, and Lu, 2010; and McKenna, McCall, and Wray, 2010).

2.4.2.1 Long-term care

For some nurses, an influence on career decisions is the respect afforded to them by their clients and wider society (Barron, West, and Reeves, 2007; and Wilson et al, 2008). Nurses often regard work in acute, physical care to be more prestigious than work with elderly clients or those affected by long-term illnesses (Mackintosh, 2007; and Koskinen et al, 2012). In this, they may simply reflect the ignorance and prejudices of wider society (McCann, Clark, and Lu, 2010). Depressingly, Brown et al (2008) argued nurses do not necessarily enter nursing with a negative view of elder care; it develops during their nurse education. Even if nurses go on to learn that elder care is important and skilled, with adequate career prospects, they nevertheless worry about the lack of prestige from working there (Koskinen et al, 2012). The survey by Xiao, Shen, and Paterson (2013, discussed in section 2.5.2.) seems to contradict this, however, because the Chinese and Australian students both disliked elder care, even though the Chinese students were in a culture where elders are respected, almost revered.

Another influence on career decisions is nurses want their work to be of direct benefit to clients. For young students this may mean they choose areas caring for adults who have a single health problem and a chance of this resolving (Mills et al, 2016). Nurses may regard mental ill-health as not amenable to nursing interventions (Thongpriwan et al, 2015) because they are ignorant of the variety and effectiveness of therapeutic interventions nursing can offer. Abrahamson (2015) found nurses displaying a high score in altruism were not more likely to enter the less popular fields of elder care or mental health nursing. This is surprising, given the obvious needs of these clients, but it may be caused by the knowledge that these clients are unlikely to make a complete or rapid recovery.

Nurses also seek work which will build their skills and confidence and for this, yet again, they perceive the best work is in acute, fast-paced environments such as surgical nursing and intensive care (Mills et al, 2016). Student nurses tend to underestimate the skills and knowledge required to care for elders or those with mental health problems (Abrahamson, 2015). However, acute care tends to be

dominated by the medical profession and nurses fail to appreciate the high level of creativity clients with long-term conditions require and the potential for nurses to have great impact (Stevens, 2011). Some nurses do, however, learn to appreciate providing holistic, complex, care of clients with chronic or multiple problems (Abrahamson, 2015).

Carlson et al (2014) adopted a qualitative approach to establish what nurses working in long-term care of elders felt about their work. All the participants had worked there for at least eighteen months and so this should have represented a positive choice. These nurses' career decisions were influenced by the deep, long-lasting, and respectful relationships with their clients, which contrast with the brief and superficial relationships within acute care. They felt their skills and holistic care stretched beyond technical procedures and was profoundly rewarding. They could observe for themselves their work contributing to the quality of life of these vulnerable clients. They could also offer support to the families of clients, especially during times of crisis such as when the health of their loved-one deteriorates. Contrary to many students, they felt their work was highly skilled and complex, and required prior experience in an acute setting. As well as the initial choice to enter mental health nursing, (section 2.5.1) Alexander, Diefenbeck, and Brown (2015) were interested in why nurses stayed there, and found positive team dynamics helped them to remain hopeful, even in the face of challenging clients.

2.4.2.2 Advanced practice

Many nurses' career decisions are influenced by the wish to have a direct impact upon client welfare, without close medical supervision (Burton, Bennett, and Gibbon, 2009) and they may find such work in advanced practice or consultant practitioner posts. The development of these posts was encouraged by Modernising Nursing Careers (Department of Health, Social Services and Public Safety, 2006, introduced in section 1.2). However, they were not formally recognised in England at the time of this inquiry, although they were well established in Wales and Scotland. Booth et al (2006) found, even in Scotland, there were still inconsistencies and the roles were poorly defined and highly

variable in their emphasis and also in their pay and conditions. Perhaps because they were new, the career paths were unclear, thus making it difficult for nurses to plan a route from their post to advanced practice. This was also identified by Luck, Wilkes, and O'Baugh (2015), who interviewed nurses working as advanced practitioners in Australia. Their participants had varied accounts of how they obtained their post and most attributed their career success to serendipity. Some acknowledged they had been encouraged to apply by their peers or manager, but continued to identify this as good fortune. Some had been seconded from other posts, which was viewed as particularly haphazard: "right time, right place" (Luck, Wilkes, and O'Baugh, 2015, page 54). These nurses reported their careers had been shaped by political, institutional, and financial factors, which were all outside the control of the nurses. This suggests self-efficacy can have limitations (see section 2.5.1), because Luck, Wilkes, and O'Baugh (2015) explained these nurses were particularly self-motivated and argued nursing should become better organised at developing the careers of its practitioners.

Burton, Bennett, and Gibbon (2009) recruited participants from a formal network of stroke (cerebrovascular accident) non-medical consultants to investigate their career paths. Most of these were nurses, but they also included physiotherapists and speech and language therapists. Like Luck, Wilkes, and O'Baugh (2015), Burton, Bennett, and Gibbon (2009) expressed concern about the haphazard arrangements for appraisal and professional development. Nevertheless, Burton, Bennett, and Gibbon (2009) still recommended that preparation for the role should continue to be flexible and resisted moves for a formal, fixed pathway. They valued the opportunities for nurses to respond to the needs in their local area and for existing consultants to take responsibility for succession planning, in a manner best suited to their clients' needs and those of the putative consultant.

These senior practitioners want to work in innovative and creative ways and find the right combination of autonomy and professional mentoring facilitates this (Burton, Bennett, and Gibbon, 2009; and Booth et al, 2006). Autonomy becomes increasingly important to nurses as they become more senior (Wilson et al, 2008) and a lack of autonomy can trigger nurses to ponder leaving their jobs, or even

the profession altogether (Tummers, Groeneveld, and Lankhaar, 2013). Hickey and Harrison (2013) in Australia reported rural advanced practitioners enjoyed autonomy, which they had not anticipated as students. This is interesting since it suggests some nurses find their careers more rewarding than expected and contrasts with many other discussions on disillusionments. Nurses who work in clients' own homes similarly described enjoying autonomy and took much pride in their role as the "lynchpin" (De Groot, Maurits, and Francke, 2018, page e97), with themselves and the client at the centre of a network of care arrangements. This caused them to feel their work was guided by the needs of their clients, rather than the rules of an organisation.

So far, this chapter has shown nurses' values and aspirations can develop during their careers. In examining the choice of clinical specialism, this chapter has explored some aspects of what nurses are seeking at work and will now examine dissatisfaction at work and moving jobs.

Acute clinical care is often perceived as more prestigious and providing superior career advantage. This work can also appear more skilled and offer the reward of clients making a complete recovery. Nevertheless, some nurses do come to appreciate the profound rewards in long-term care as they develop and grow in maturity. This inquiry will give voice to mature nurses who may reflect on the way in which their perception of worthwhile or rewarding work has developed.
Advanced practice may provide the opportunity to directly impact client outcomes, but routes into advanced practice appear haphazard, as are the arrangements for terms of service, appraisal, and professional development. It is new in London, so little is known about career progression into, or beyond, advanced practice. This inquiry could make a valuable contribution, exploring the participants' routes into advanced practice and possible progression beyond.
Some senior nurses achieve significant autonomy. It is interesting this is important to them yet as junior nurses they had not anticipated it. This suggests participants in this inquiry may have gained more autonomy than they expected, and it will be valuable to explore with them how they feel about autonomy and whether seeking it impacts their career decisions.

Box 2.2: Reflexive commentary on choice of clinical specialism

2.4.3 What influences nurses to move jobs or leave nursing?

Much of the research reported here was concerned with preventing nurse attrition. Satisfaction at work is important because it is increasingly needed to provide an overall sense of fulfilment, identity,

and social contacts (Wilson et al, 2008; and Barron, West, and Reeves, 2007). However, Homburg, Heigden, and Volkenburgh (2013) found no evidence of nurses planning moves to enhance their careers or seeking different sources of satisfaction. Instead, they and others (for example, Dawson et al, 2014) reported nurses' career moves are triggered by negative influences and moving away from problems. Dawson et al (2014) found a major cause of leaving was inadequate staffing, which was exacerbated by poor management. This leads to a downward spiral, described by Meadows, Levenson, and Baeza (2000), because as more nurses leave, this causes the workload to become increasingly intolerable.

Nurses are altruistic and want to help people (Edward et al, 2015), "to make a difference" (Wareing et al, 2017, page 231) and the perception for a nurse that their caring is insufficient is profoundly de-motivating and a cause for them to ponder leaving (Flinkman and Salanterä, 2015), feeling betrayed and disillusioned (Dawson et al, 2014). Other sources of unhappiness include dissatisfaction with management, lack of staff or other resources leading to poor care (Walker, Clendon, and Willis, 2018), and bullying, harassment, or experiencing verbal abuse from clients and their families (Dawson et al, 2014). These all lead to feeling undervalued by their managers or the wider society; and feeling ignored by management with little opportunity to influence policy and care decisions (Clearly et al, 2011). Some young nurses can also feel the work is too "one-sided" (Flinkman and Salanterä, 2015; page 1053) with nurses constantly expected to give of themselves, with little in return.

Wilkes et al (2017) examined how different aspects of nursing added to or detracted from nurses' enjoyment of work and showed nurses vary greatly. For instance, the factor of "a busy workload" was liked and disliked by a similar number of nurses (45% and 38% respectively). Indeed, all the factors listed were both liked and disliked by at least one participant. The most damaging factors were angry staff (90% rated this negatively) and the presence of bullying and harassment. In contrast, there were nine factors nurses felt had positive impacts. These were: educating others (92% positively rated this); connecting with others; variety; working with others, and supporting others. Dissatisfaction with

pay is another potential influence on career decisions. UK nurses unhappy with their pay are likely to plan to leave the profession altogether, rather than move to another nursing post (Wilson et al, 2008). This is probably because national pay arrangements mean they are unlikely to receive more pay elsewhere for a similar post (Barron, West, and Reeves, 2007). Nevertheless, intentions to leave can be related to pay, such as feeling that they have too much to do or if they work unpaid overtime (Flinkman and Salantera, 2015).

The emphasis on being enabled to do their work was seen amongst nurse faculty members (usually referred to as academic staff in the UK) in all HEIs in America. Candela, Gutierrez, and Keating (2013) surveyed academic nurses and reported that being enabled to teach to a high standard was more important than expectations of promotion; workload; a conflict between educational and research demands; and the culture within the university. Although the quality appraisal (see table ap 2.4, appendix 2) suggests their results may not be generalisable, it nevertheless does suggest one specific group of nurses share a phenomenon found amongst other nurses, namely being able to work to a high standard is important and not being able to is more likely to trigger a career move than other attributes, such as expectations of promotion or pay.

The negative influences may become even more prominent because some researchers (for example, Wilson et al, 2008 and Price et al, 2018) claimed to provide evidence that successive generations of nurses are less satisfied with most aspects of their work compared to older nurses, and this was apparent even when different methodologies are used. These analyses were based upon allocating nurses to different generations according to their year of birth, although this can appear random and these researchers were inconsistent in their definitions of generations. Price et al (2018) found older nurses wanted to be involved in management decisions and resented having these simply handed down to them. Wilson et al (2008) found successive generations of nurses were increasingly less satisfied. They conducted a statistical analysis of nurses' feelings about seven aspects of their work and found younger nurses were less satisfied in five of them, which were pay, rostering, career

opportunities, praise and recognition, and autonomy. There were no differences in the generations' feelings about friendships and socialising at work. However, these differences were not pronounced, and it is possible these studies merely showed up differences between workers of different ages. Both studies were cross-sectional, so they could not indicate whether these feelings were a characteristic of the generation into which they were born or whether this reflects the current age of the nurses and their seniority. Indeed, it seems likely these feeling change as nurses mature and theorists such as Super (1975) claim younger workers engage in more career moves whilst exploring, before settling to one or just a few employers. Cross-sectional research, such as these, could give the impression that more recent generations are less patient and satisfied at work. However, the reality could be that younger workers are always likely to be more restless and critical and this is all Wilson et al (2008) and Price et al (2018) identified.

Walker, Clendon, and Willis (2018) examined why nurses choose to retire early. This research had the potential to be revealing because it included nurses who had left, rather than the more typical research which reports pondering leaving. They found such decisions are not taken lightly and follow months or years of thinking, planning, and taking advice but, like decisions to change jobs, the decision to retire early is often the result of negative pressures. The most common reasons are work-place concerns: these included high workload and inadequate staffing, insufficient time, bullying and violence, out-of-touch management, and unsafe environments. The second group of reasons are problems such as stress or ill-health. The third group of reasons is the lack of professional recognition, loss of confidence and a lack of opportunities to develop. The last reason is personal issues such as family commitments. This research is important because it suggests many mature nurses are not choosing to leave nursing for positive reasons but, rather, are being driven away by an unacceptable environment there.

Most career decisions made by nurses are for negative reasons, moving away from problems, rather than positive reasons such as career advancement. Nurses vary in what they like or dislike, but a high workload, staffing shortages, or other forces negatively impacting the quality of care provided seem to be a major trigger for career moves. Other negative influences include the perception of poor management or bullying. Further, nurses want to feel appreciated and respected. This inquiry will investigate the triggers for leaving nursing jobs and will seek to confirm the participants were mostly influenced by negative reasons, and what these are.
Pay is much discussed, but different researchers do not agree on how important it is to nurses. In view of the prominence given to pay in the research, it is likely to feature in the stories, which should contribute to the debate about its influence on career decisions.
The same negative reasons causing younger nurses to leave the profession can cause older nurses to ponder retirement. Such a move is considered well before they leave and nurses have other options since retirement has become more flexible, with the abolition of the default retirement age and the opportunity to reduce hours towards the end of a working life. These nurses will all be relatively mature, and it will be interesting to explore their feelings about retirement.

Box 2.3: Reflexive commentary upon moving jobs or leaving nursing

2.4.4 Post-registration education

The section above discussed student nurses' thoughts about their careers. However, education of nurses continues after they have registered and is referred to as post-registration education. This is greatly valued by nurses (Halfer and Graf, 2006; and Wilson et al, 2008). It is seen as an encouragement to stay in a role and as a route to career progression. Indeed, some posts, such as advanced nurse practitioner, are not available without a higher degree (or working towards one). Yet, Cleary et al (2011) found nurses complained about a lack of support for education and they often did not receive study leave or they found the courses they sought were too inflexible to meet their working or travel requirements. A perceived shortage of post-registration education opportunities will cause nurses to ponder leaving their employment (Flinkman and Salanterä, 2015; Tummers, Groeneveld, and Lankhaar, 2013; and Cleary et al, 2011).

Why is it so highly valued? Horn, Pilkington, and Hooten (2019) found the most important reason is improving client care and personal fulfilment, whilst increased salary and promotion opportunities are least important to them. Cleary et al (2011) found mental health nurses favoured locally, targeted, educational opportunities which were specific to their clients' needs. Ng, Eley, and Tuckett (2016) confirmed that postgraduate qualifications in their specialist field increased nurses' confidence in their skills, and was the reason most of them gave for embarking upon post-registration education. Most also stated it increased their career satisfaction and career prospects. Yet, over half of Ng, Eley, and Tuckett's (2016) specialist nurses did not have a higher qualification nor were undertaking one. The uptake of higher education was explored by Brand et al (2016) amongst neonatal nurses, one of the many areas in nursing currently experiencing shortages; they complained many nurses wish to become practitioners, yet few commence training for this. Those commencing specialist training had gone through a sequence of events and some would-be trainees would drop out at each stage. The sequence started with the nurses' decision that neonatal intensive care was their medium- or long-term career choice, accompanied by the discovery of the practitioner role, perhaps through observing practitioners at work. This needs to be followed by readiness, which could be delayed until they have both the time and the money to study. Once they have decided to embark upon a post-registration

Nurses value further education, seeing it as a route to personal fulfilment and enabling them to provide enhanced care, rather than a route to promotion. More nurses aspire to higher education than actually embark upon it because of a series of obstacles they must overcome to start a programme of study. This means some posts, such as advanced practice, are unobtainable for some nurses without significant support from managers and others.

The participants in this inquiry will all have experienced pre-registration education and are likely to have extensive experience of post-registration education. Indeed, nursing degrees were unusual until recently and so some participants may have gained their nursing registration with an academic qualification at certificate or diploma level and graduated whilst working as a nurse. Their stories should be examined to assess the influence of such education upon their career decisions.

Box 2.4: Reflexive commentary upon post-registration education

2.4.5 Gender and nursing

The impact of gender is much researched in career literature. Some theorists claim children learn very young of the expectations related to gender. For example, Gottfredson (1981) showed that from just six to eight years children are orientated to sex roles and learn certain roles are only suitable for one gender, rendering several potential roles apparently unsuitable for them. For instance, a young child may be exposed to books and television shows which depict women in caring, nurturing roles and decide nursing is only suitable for women. In more recent work, Wee (2014) found this gender stereotyping is still pervasive, because she asked young adults to make hypothetical career choices and found evidence to support Gottfredson's (1981) assertion that if they are forced to compromise, workers sacrifice other aspects of their ideal job before they sacrifice gender stereotyping. This leads to difficulties in combining a career with parenting and homemaking responsibilities. These duties fall disproportionally upon women and can mean family responsibilities stop women nursing whilst their children are young (Homburg, Heigden, and Valkenberg, 2013); postpone their entry into specialist training (Ng, Eley, and Tuckett, 2016); or mean they cannot make advantageous career moves (Luck, Wilkes, and O'Baugh, 2015).

Yet, in other ways, it may be men who are disadvantaged, particularly at the outset of their careers. Less than 10% of adult nurses are men, and this has persisted despite developments towards gender-equal numbers in other professions (Sayman, 2015). Men may be discouraged from entering the profession in the first instance (Weaver et al, 2014; and O'Connor, 2015) which means those that do are often highly motivated to forge a career in nursing. Even so, men struggle to establish an identity and professional relationships in nursing and are at increased risk of leaving (Sayman, 2015). Male nurses described to Sayman (2015) facing derogatory comments on an almost daily basis and it may be men are particularly influenced by the bullying environment some authors have noted (Wilkes et al, 2017; Dawson et al, 2014; and Walker, Clendon, and Willis, 2018). Several related feeling they

had to perform better than their female counterparts; they had to be the “go-to guy” (Sayman, 2015, page 14). Despite this, many experienced career frustrations and not being able to progress.

However, the situation may be reversed in later career; at leadership levels in the profession it may be the women who face discrimination. According to Burton, Bennett, and Gibbon (2009), hands-on care is less significant to consultant nurses, who instead stress the importance of leadership and service development. Yet Berkery, Tiernan, and Morley (2014) found male nurses and midwives - but not female nurses or midwives - tend to expect men to demonstrate superior leadership capabilities compared to women. Berkery, Tiernan, and Morley (2014) do not examine where these expectations arise, or whether they are simply based on society’s norms, but they express concern about the profession becoming “two-tier” (page 717). This is because men rise more rapidly within the profession, which reinforces the gender stereotyping but would be de-motivating to female nurses. Berkery, Tiernan, and Morley (2014) note this gender stereotyping is well-established throughout society and survives even in a profession dominated by women. They take some comfort, however, from finding students seem to adhere less to gender stereotyping.

The research literature almost universally acknowledged being a woman is a disadvantage to career progression. It will be interesting to collect the participants’ stories related to gender and evaluate whether, even in a profession dominated by women, these disadvantages continue to apply. For men in nursing, the situation is complex. They start off with a disadvantage and need to be quite resilient to see it through, but the rewards, in terms of career progression, for those who persist, are potentially attractive.
This inquiry must include men. Ideally, the proportion should reflect the gender balance of London nurses. They cannot be asked pointed questions about discrimination or career advantage (since any such questions need to also be asked of the women participants), but it will be interesting to examine their stories to identify any such material.

Box 2.5: Reflexive commentary on gender in nursing

2.4.6 The role of managers and mentors in career decisions

Much of the research mentioned these in other contexts and they have been gathered here to form the final theme. Price et al (2018) found student nurses and newly qualified RNs wanted a supportive

environment in which to build their careers. Newly registered RNs looked to their manager to provide a clear structure in which to work, strong leadership, guidance, feedback, reassurance, and support with professional development; but they were often disappointed. Most complained to Price et al (2018) their manager was largely invisible and merely required ever-increasing administrative work from them. Flinkman and Salanterä (2015) similarly found a lack of support in their new role may contribute to RN's leaving the profession. Experienced nurses reported that for most of their careers they had been "on their own" (Price et al, 2018, page 639) which made them feel unappreciated. Price et al (2018) and Flinkman and Salanterä (2015) all noted the few nurses who found posts offering good support tended to remain there for longer than otherwise.

In UK nursing, preceptorship is a requirement of the Nursing and Midwifery Council, or NMC (Nursing and Midwifery Council, 2011) for the first year following registration. Much literature on support and encouragement for new RNs is simply concerned with the passing on of skills and attitudes to junior nurses and help with practical aspects such as rostering (Wilson et al, 2008). Yet, good mentoring can be much more. Adeniran, Smith-Glasgow, and Bhattacharya (2013) stated receiving mentorship is essential for professional growth and helps them find their niche (Mills et al, 2016). However, mentoring such as this is often absent (Mills et al, 2016). Adeniran, Smith-Glasgow, and Bhattacharya (2013) noted internationally educated nurses tend to make slow career progress compared to indigenous nurses and suggested this was because international nurses are less likely to receive career mentoring.

Philippou (2015) asked nurses to rate the degree of responsibility managers and nurses had for different aspects of career development. They presented a straight-forward structure: managers are responsible for short-term development, through the provision of developmental activities and courses; the manager and the nurse share responsibility for medium-term activities, such as identifying and addressing weaknesses and building upon strengths. The nurses and managers showed some slight disagreement about this because each stated it should mostly lie with

themselves. There was more agreement that the nurse has the long-term responsibility of building a career path and consistent with this, senior staff were more willing than junior to accept responsibility for their career development. Philippou (2015) did not explore whether this rather neat arrangement is what happened but did note both managers and nurses tend to perceive ideally, the employer would take more responsibility than they did.

Advice and encouragement could be especially important for nurses who wish to follow an unconventional or unpopular career path. It was noted (section 2.5.4) embarking upon post-registration training involves several steps and would-be trainees can drop out at each step. One reason for this, according to some of Ng, Eley, and Tuckettt's (2016) participants, is they were discouraged by their peers and it took considerable confidence to go against this advice and to overcome negative stereotypes. Alexander, Diefenbeck, and Brown (2015) examined how nurses selected and remained within the unpopular field of mental health. Again, they found these nurses had to disregard unsolicited and often contradictory advice from peers. On the other hand, encouragement from a respected senior colleague, suggesting they were particularly suitable for mental health nursing, would encourage them to consider a career path most had not previously pondered. They term this "validation of potential" (Alexander, Diefenbeck, and Brown, 2015, page 449) and it involves reassuring the nurse they had the required skills with further potential to be effective. Such encouragement was particularly valuable if the advisor had witnessed them in practice.

Adeniran, Smith-Glasgow, and Bhattacharya (2013) identified most newly registered RNs were able to identify a mentor and saw them as a source of information but were less likely to see them as a role model. Those that did, however, were rewarded with increased career expectations and a clearer idea of how to progress in their careers. However, mentorship is important throughout their careers and

Booth et al (2006) found clinical nurse specialist greatly valued the support and encouragement of fellow specialist nurses.

> Mentoring is often seen as simply passing on skills, but good mentoring can be a powerful and rewarding relationship. It can encourage workers to remain longer in post but to make bolder career decisions when they do move. Yet many nurses do not receive quality mentoring. Rather, they must make their own way through their careers.
> Most of the research into mentoring (or lack of it) is from the recipients' point of view. However, this inquiry will include managers, educators, and senior nurses, and should explore with them the experience of providing mentoring.

Box 2.6: Reflexive commentary upon the influence of mentors and managers on career decisions.

2.5 Conclusion to chapter 2

This concluding section will summarise what the existing literature tells us about careers in nursing and what we still need to learn, which has been highlighted in the reflexive commentaries. From there, the research question for this inquiry will be formulated.

Students enter their nurse education with poorly developed career plans, so any plans they entertain will have developed once they are within the profession. Career ideas can grow during student placements and a good experience in challenging placements may illuminate career paths they would not have otherwise considered. Student nurses often start out believing acute, hospital-based care is the most skilled and interesting, whilst caring for clients with long-term care needs is hopeless and dull. However, some students develop insights into the impact nursing care can have and learn to appreciate the advanced skills required to care for such clients. Nevertheless, efforts to portray elder care in a positive light may be hampered by the reality of some clinical environments.

The profession has witnessed a growth in advanced and specialist practice. These posts often involve caring for clients with chronic problems, such as people who have experienced a CVA. Nurses entering these fields will have learnt of the fulfilment available in caring for such clients, because this

is not apparent to most student nurses. These advanced practitioner posts are attractive because of the degree of autonomy they offer. However, they are poorly and erratically organised and routes to them are not transparent.

Once registered, nurses want to give good care and to receive respect and recognition for their contributions. Feeling their care is insufficient, for whatever reason, is profoundly de-motivating, causing nurses to ponder leaving. Nurses at all levels report frustration with poor management and a lack of respect, as nurses are excluded from management and strategic decision-making. Many career decisions to change jobs, or even to leave nursing altogether, appear triggered by negative influences in their posts, rather than the prospect of career progression. Nevertheless, nurses are keen to receive post-registration education because they believe this will help them deliver better care. However, to embark upon formal post-registration education is a significant undertaking and nurses can be deterred by the expense or time commitments, or even by the attitudes of their peers.

The findings of this review concerning gender are complex. Career theory generally deems being a woman is disadvantageous to a career, yet the research suggests male RNs experience discrimination early in their career. However, when it comes to leadership, some nurses tend to expect men to do this more easily and men may find themselves at an advantage when they apply for senior posts. Similarly, RNs from the black and minority ethnic (BME) community may also particularly benefit from encouragement.

When mentorship is present, all nurses will strive to do their best, enjoy working, and are less likely to leave. However, too often it is not present, certainly later than one year after registration. Many nurses feel they are on their own and need to build their careers in isolation, even though they would value a mentorship relationship.

The review of the literature also informed the development of the methodology, and this is discussed at the start of the next chapter (chapter 3). Another purpose of the literature review was explained at

the start of this chapter namely, to develop the interpretive lens so the stories could be understood in the light of recent research.

Concerning the current area of interest, the literature review has provided some insight into influences on nurses to stay in their posts or consider moving, but much of this is limited to early careers. There is no literature focused on how to support nurses' career decisions. Much of this research was from the perspective of the employing organisation and their need for sufficient nurses to deliver high-quality care, few examined the nurses' perspective. Even those investigating the nurses' perspective used large-scale statistical surveys to measure attitudes, for example, Koskinen et al (2012) and Barron and West (2007). The first two sections of the BMJ appraisal tool ask whether the method is appropriate for the purpose. These have mostly been completed "yes" because this is an established research method (Bar-Anan and Nosek, 2014), but we should note its limitations. A recent critique by Kramon and Weghorst (2019) expressed concern about the validity of measuring attitudes with research tools involving lengthy lists. Several research papers used in this review did just that and claimed to report the nurses' perspective based on statistical correlations. For example, Larsen, Leir, and Fraundienst (2012) asked participants to choose between career options and Candela, Gutierrez, and Keating (2013) asked participants how much they agreed with a list of statements. Both were determined in advance and neither were piloted (see table ap2.4 in appendix 2). This meant participants only had the opportunity to comment upon aspects of the research question the researchers had already believed important. Kidd (2006) complained career research has long been dominated by psychology, which traditionally favours large-scale, quantitative studies. Such approaches can identify trends but are less valuable in understanding people's motivations, hopes, and fears. Qualitative papers are generally better at capturing participants' feelings. Several of these included in this review used focus groups. Whilst the shared experience of a supportive group can help define novel concepts (Mills et al, 2016), it is possible some deep feelings about their careers, such as failure or disappointment, may not be revealed there. Yet, the individual's experience is central to this inquiry.

An additional problem is much of the existing research examined student nurses' intentions upon registering (for example, McCann, Clark, and Lu, 2010) or RNs' intentions to leave their current employment (for example, Tummers, Groeneveld, and Lankhaar, 2013). Fewer involved nurses who had left and there may be a difference between intentions and actions. This inquiry will examine career decisions in retrospect. There are other problems with the existing research; many of these studies were from overseas: nineteen were from North America and a further thirteen were from Australasia with just five from the UK or Ireland. This means much of the research was conducted in a context where nurses train as generalists and then opt for a field. This is similar to the training many of the participants in the current inquiry would have experienced, but currently, UK nurses choose their field at the outset and moving between fields is unusual. This inquiry will contribute to our knowledge of careers within the UK.

Further, many of these studies reviewed early career decisions, addressing the well-documented problem of nurses leaving the profession shortly after registering (for example, Flinkman and Salanterä, 2015; and Wareing et al, 2017). Others were concerned with measuring student nurse intentions to enter some of the less popular fields (for example, Edward et al, 2015 and Lea et al, 2018). Another reason for concentrating upon early careers, however, may be expedience, because the researchers are likely to have details for this population and they are readily identified. Moving on from the first post is less researched, and the careers of senior practitioners (except advanced practice) are largely overlooked.

Despite considering over 500 recent research articles, we still know little about the career intentions of experienced nurses in the UK, nor how they perceive their careers. There appears to be a gap in our knowledge concerning nurses with well-established careers and we know little about how nurses build their careers in the medium- and long-term. The little we do know is often from nurses in different countries, where preparation to enter the profession is different. There is some research into advanced practice, but these tend to review the effectiveness of these new posts on improving client

outcomes. Whilst a few examined how the nurses prepared for these posts, only Luck, Wilkes, and O'Baugh (2015) examined career moves into advanced practice and none examined moves on from there.

This inquiry now goes on to consider how to address these gaps in our knowledge.

2.6 Research question

Nurses' perspectives as they make career decisions after qualification have received scant attention, particularly in the UK, and career decisions are therefore an under-researched field. Given the limited information available concerning nursing careers, the research question for the data collection part of this inquiry should be broad. The literature review addressed a very broad question to include as much data as possible. Such a question was likely to be too broad to adequately cover in a single piece of research. Chapter 1 identified the imperative of exploring why nurses leave the profession early and some of the research included in this chapter examined the intention to leave a given place of employment. However, our knowledge of nursing career decisions is not sufficient to answer specific questions. The question addressed by this research needed to be sufficiently broad to open a new area of research yet sufficiently precise to make a contribution to our understanding of nurse attrition. Further, to complement the existing research, which tends to concentrate on the perspective of the employers and healthcare providers, a question putting nurses at the centre of the inquiry was required. The research question to address these two requirements was: "what influences nurses' career decisions?".

The next chapter (chapter 3) examines how this question was addressed.

Chapter 3: Research methodology and method

This chapter evaluates how the research question was answered. Potential methodologies are reviewed, and the chosen approach explained and justified. The next section examines how the quality of this research was assured. The chapter goes on to explain the practical steps in the development of the data collection tools and how the data was managed. The chapter goes on to explain how the participants for the inquiry were identified and recruited. The crucial issues of ethics is examined. The chapter then turns to the analysis of the data and explains how the career stories were derived and analysed to yield a series of narratives and the contribution of the managers and educators. It goes on to explore how member checking increased the rigour and trustworthiness of the analysis. Finally, the chapter outlines how the research was written up.

3.1 Research question and objectives

The research question was: "what influences nurses' career decisions?". The following objectives for the data collection stage of the inquiry were identified to answer this. They were derived from the literature review and the researcher's own experience:

1. Explore what nurses seek in their careers.
2. Examine factors which impact upon nurses' career decisions.
3. Explore when and why nurses change jobs.
4. Establish whether nurses seek, receive, or provide career mentoring.
5. Explore whether nurses have plans for their careers and whether these are implemented.

3.2 Review of potential research methodologies

This inquiry explored the nurses' – or deciders' - perspective. It will help redress the imbalance identified by Kidd (2006). Consequently, it asks of nurses questions about career decisions such as: "how", "why", and "what if"? Qualitative methods are designed for answering such questions because they celebrate individual experiences and acknowledge the importance of social context. The

literature review included some examples of qualitative methods to explore career decisions. These were used to help inform the design of this inquiry and will be discussed next.

There were a few possible qualitative methodologies available. One possibility was to adopt a phenomenological approach to explore making career decisions. This would have involved participants reflecting in detail and an in unstructured manner on the decision-making process as it proceeded. Alexander, Diefenbeck, and Brown (2015) used what they described as a descriptive phenomenological approach to examine how it feels to be working in a rather unpopular field of nursing. A phenomenological approach would have explored what it feels like to make a career decision, but such an approach may not have allowed the participants to review decisions with the wisdom of hindsight. Another possible methodology would have been an ethnographic approach. Such an approach would have had the advantage of using well-established methods of observing and analysing the subject of interest. However, ethnography has anthropology as its basis (Harrison, 2018) and in its purest form involves immersive fieldwork which examines every aspect of the participants' lives, who come from a distinct and discrete culture. In contrast, although these participants shared a professional background, nursing is a diverse profession (see for example Adhikari and Melia, 2015) which is one of the profession's strengths (Phillips and Maline, 2014). Despite the shared occupational background in which the career decisions occur, they are also likely to be influenced by the nurses' family background and the expectations of their culture, which are likely to be different. This may explain why there were no examples of an ethnographic approach used in chapter 2. One way in which cultures vary, which is notably relevant to this inquiry, is in the expectations pertaining to the careers of women (Fouad et al, 2015). Therefore, ethnography, which seeks the common experience and culture (Harrison, 2018), was not deemed suitable to answer this research question.

Case-studies are ideal for exploring complexity and exploration of meaning from different perspectives and for explaining decision-making, values, and behaviour (Yin, 2003). Magnuson,

Wilcoxon, and Norem (2003) described a case-study approach to researching the careers of teachers and were surprised at the quality of the data their method yielded. The literature review chapter (chapter 2) included examples of case studies, such as Burton, Bennett, and Gibbon (2009) and Mills et al (2016). Some aspects of the current study were like case-study research because it was seeking patterns in a system and used observations to inform logical reasoning and coherent inferences (Greenbank, 2012). However, other aspects of this study were not consistent with case-study methodology. For example, case-studies usually use different types of data such as, in this instance, job specifications and employment records. This would have emphasised the context of the decisions. Whilst context is important, this study was centred upon the deciders' perspective, and there would have been a danger other data, perhaps from the employing trusts, would have come to dominate the study and detract from the nurses' perspective. Instead, the research question required keeping the focus on nurses, the cognitive processes and issues impacting their career decisions. Therefore, the only source of data was nurses themselves. The methodology needed to keep the nurse, and how they perceived their career decisions, at the forefront of the study and to analyse how they made sense of their career decisions. Narrative inquiry is a methodology centring on the experience of the participants (Cousin, 2009), and so was chosen for this study. It has been used in career research before, for instance, it formed the qualitative component of Bennett and Hennekam's (2018) study of careers in the creative industries and Price et al (2013) used narrative inquiry for researching motivations for entering the nursing profession. However, it may be a novel approach for researching the careers of RNs.

3.2.1 Philosophy of narrative inquiry

Stories are a very old way of sharing experiences and cave paintings from about 40,000 years ago show early humans were depicting stories to each other (George, 2019). Yet, the analysis of the stories is relatively new. Narrative inquiry is based on Dewey's conception of experience (discussed in Clandin, 2006). Nobody can have another's experience, but they can come to learn from it through

stories. McAdams (2012) characterised narrative inquiry as searching each unique story for the occurrence of repeated themes. In narrative inquiry, these are referred to as narratives.

Narrative inquiry involves the analysis of people's stories. The approach has become increasingly popular and has come to represent a wide range of approaches across many traditions (Holstein and Gubrium, 2012). It is frequently employed by educationalists because "life is education" (Clandin, Pushor, and Orr, 2007, page 21) and lives are lived according to learning. There are several reasons it is particularly suitable for researching career decisions. First, analysing stories emphasises the context and contrasts with other qualitative approaches, which often search for individual meaning in a more isolated frame of reference (Hunter, 2010) and career decisions are taken within a specific context, which is important to the research. Second, when people tell stories about themselves, they will often spontaneously stress their options and decisions (Hunter, 2010). Third, stories show how people make sense of the complex world around them and navigate their way through it (Bell, 2002). Finally, the literature review (chapter 2) has shown nurses have good insight into their careers and are able and willing to explore these.

Narrative analysis has three foundational propositions (McAdams, 2012).

People construct and internalise their stories to make sense of their lives. Working within careers, Savickas (2013) was surprised individuals often have greater insight into their "life path" (page 656) than even they realised.

1. These stories are sufficiently robust and important to be re-told.
2. These stories can be analysed to yield psychological, social, and cultural meaning which can be used to understand the setting and are thus of value to others.

Clandin (2006) explored the "borderlands" (page 4) of narrative inquiry which helpfully locates narrative inquiry amongst other traditions, borrowing from some methods whilst offering several distinctive characteristics which are helpful to answering the research question here. The first border

is positivists. Although positivists no longer attempt to describe provable truths, they still seek to provide an account of the reality that, like a scientific experiment, could be falsified. Their philosophy is that absolute, external truth exists. In contrast, narrative inquiry insists the person's subjective experience is paramount and is central to inquiry. Such an account cannot be deemed false because it is real to the person whose story it is. A second border is critical theory, often part of the Marxist or post-Marxist tradition. Marxists often talk about "false consciousness" (Clandin, 2006), but in narrative inquiry the individual story is central and their consciousness cannot be false. The final border is post-structuralism, which emphasises the linguistic structure of knowledge and is interested in how people represent their world. Narrative inquiry has benefitted from the recognition there may be more than one way to represent the world, but still takes the person's experience, itself, as central. This inquiry needs to examine influences on nurses' career decisions. Nurses' career stories explore their understanding and experience of their career. Stories include the actions of others, cause and effect, and how the actors feel about these. All these could be relevant to answering the research question and to illuminate and explore the influences upon career decisions.

Riessman (1993) acknowledged not all narratives are stories and delved into English literature to illuminate the features of a narrative making it a story. She agrees with Culler (1980) that narratives must have a chronology or a sequence of events. This usually includes a start and a middle, but not necessarily an end. A chronology, however, does not necessarily make a story and Riessman (1993) agreed with Burke (1945), a story must also include a plot with five elements. Most importantly, stories need a purpose, which fits with the notion of career stories. Stories also require actions or events; a scene or context; an agent or actor; and an agency, or how it was achieved. These can all be analysed and contribute to answering the research question.

Stories encapsulate how actors make sense of their world and convey it to others (Berry, 2016). Thus, how it is told is vital and allows the researcher and participant to explore the context and the underlying influences on the story. Hunter (2010) stressed the importance of using the participants'

own words. Stories are also useful for exploring marginalised groups, or those not often heard (Bell, 2002) and so maybe singularly useful for exploring nursing, which has so long been dominated by the medical profession. Career decisions by medical practitioners are much researched (recent examples include Ratelle et al, 2014; Appleton et al, 2017; and Goldenberg, Williams, and Spollen, 2017). Stories can also be helpful in exploring an area, like career decisions in nursing, not often discussed in the literature.

This methodology was entirely dependent upon the perspective of participants and there was a danger of past events being inaccurately recalled. This could lead to concerns about the veracity of the account being provided. Riessman (1993) pointed out a phenomenological approach would state the mere telling of an account would make it true, but in narrative analysis, the interpretation of the narrative is critical. Frank (2012) grappled with this when he reluctantly admitted that he had heard one specific story from several people, each claiming the story as their own. The narratives represent the junction between history, biography, and society (Hunter 2010) and it may not be necessary to trace the events to a particular person or place. Rather, the telling by several people could indicate the situation being explored was authentic. The participants' understanding of the decisions they have made is important, not the factual re-telling of events. Narrative analysis is not seeking to uncover some truth that has escaped the storyteller, but rather to act as a "witness" (Frank, 2012, page 36) to the process, in this instance of making a career decision in nursing.

The narratives need not represent some externally provable truth because stories depend upon the context (Hunter, 2010). They represent an individual's attempt to ascribe meaning to an event, situation, or life course. There is no "true" narrative or "accurate account". People construct stories to support their interpretation of themselves and will omit anything undermining that (Bell, 2002). Rather than being a problem, it is this meaning that narrative analysis seeks to examine, and the narratives derived from the stories provide order and meaning to events, which can be shared. Narrative analysis also acknowledges the role of the researcher in the co-construction of stories. The

researcher was not a passive listener, but instead was part of the context from which the participant is telling their story. The researcher does not simply record the words of the participants but encourages and assists in the telling of the story. Thus, the researcher will nod or show emotion by laughing at funny anecdotes or showing sorrow upon the recounting of sad stories. The researcher and participant jointly negotiated a co-constructed meaning through the narrative. Typically for research involving co-construction of knowledge, these ideas were mutually developed as the researcher and participant together explored something they both found interesting. This means it is not always possible to identify who said what first nor to attribute a new insight to the researcher or the participant (Crabtree, Miller and Dawsonera,1999).

So far, this chapter has explained that narrative inquiry was the chosen methodology because it allows examination of the multitude of influences upon a career from the decider's perspective. It allows the phenomenon of career decisions to be explored in the contemporary events and acknowledges the individual as an active agent who interacts with their situation in a dynamic manner, giving meaning to lived experience.

Having justified the theoretical approach, this chapter will explain how the inquiry was conducted. Before this can be commenced, however, it is necessary to examine how the reader can be assured of the quality of the data collection and analysis, because this is complex in narrative inquiry.

3.3 The assurance of quality

Research must be of high quality to be worthy of attention. Rolfe (2006) explained the major measure of quality in natural sciences is the reliability of the results – can the research be repeated with the same outcomes? Qualitative research is almost impossible to repeat and so trustworthiness is a better measure of the quality of the research than reliability. Trustworthy research is credible, transferable, dependable, and confirmable (Rolfe, 2006). The nature of these qualities, and how they were assured, will be explored next.

3.3.1 Credibility

Credible research is believable, it seems plausible to the reader. As explained above (section 3.2.1) narrative inquiry is based upon participants' interpretations and world views. The participants' account may not be "true", but it is meaningful to them. This means narrative inquiry should be judged on different criteria, even than those applied to most qualitative research methodologies (Webster and Mertova, 2007). The reliance upon participants' memories of their decision-making posed a potential problem because decisions can be made without conscious thought, and it was the task of the researcher to make some of these explicit. This again shows the active role of the researcher in helping to make sense of the participants' experiences.

A strength of narrative inquiry is the importance of reflexivity, which explores and reports on these unconscious processes. Together, the participant and the researcher examine the participant's story and how it has unfolded for them. Reflexivity in research involves the systematic analysis of the subject being examined and sharing its meaning for the researcher and the participant (Finlay, 2002). The participants' stories are paramount, but they do not stand alone. Rather, they are interpreted in the light of the researcher's pre-existing ideas along with the current research (examined in chapter 2). This helps counter the potential biases of this and of other researchers, because no one interpretation dominates, rather they all make a contribution and are used to focus upon the new stories. Some of the discussion points will be expected and will confirm pre-existing ideas, others may contradict these and still others may open up new ways of thinking not considered before. This inquiry aims to make explicit multiple thought processes going into career decisions and to emphasise the truth from the perspective of the participants (Webster and Mertova, 2007). The interviews included some discussion of future plans, such as retirement. This led to the danger some participants may fabricate ideas and potentially meant this inquiry reported cognitive processes not existing prior to the interview. This is not in itself a bad thing, because it could still reveal the background and influences against which career decisions are taking place. The researcher and participant engaged in co-

construction of knowledge. Nevertheless, the researcher needed to be vigilant against constructing fantasies and the resulting data needed to be credible, or believable.

Rolfe (2006) argued in the social sciences, context and the personal involvement of the researcher are important. In the case of narrative inquiry, the data is a series of stories, which reflect the participants experience (Hunter, 2010; and Bell, 2002) and the researcher is seeking to convey the participants' meaning and experience. As discussed above (section 3.2.1), this cannot be falsified. The inquiry must represent the participants' understanding of the phenomenon. Bell (2002) stated a good narrative inquiry not only reports the participant's stories to others but enhances the participants' understanding of their own life paths. The narrative inquiry should appear credible to the participant, researcher, and reader (Webster and Mertova, 2007). The stories represented in the research (and the narratives) should sound true because they remind them of their own experience, or they generate a new understanding of their own story or experience. This is important because the stories cannot be falsified, nor can they be demonstrated to be false by reasoning or logic. They can and should, however, demonstrate authenticity. This is achieved by the researcher providing sufficient details for the reader to be satisfied the story is true and the narratives authentic.

3.3.2 Transferability

This is more problematic, but at least some of the lessons learnt could likely be applied to other workers, especially within healthcare. The value of qualitative research lies not in its representative nature but in the extent to which it can offer insights and understandings that could help illuminate other situations (Rolfe, 2006). The reader of this inquiry will take from it whatever they consider may be relevant to the situation they are interested in. To do so they need enough details of the context of the inquiry to evaluate the transcripts and their relevance to them. This inquiry involved just one group of workers in one place (i.e., nurses with experience of London) over a short period. Their situation is explained and explored; this will facilitate the reader in assessing whether this illuminates anything of relevance to themselves.

3.3.3 Dependability

This refers to the stability or consistency of the research processes (Rolfe, 2006). Dependable research is believable because of rigorous data collection and analysis and the credibility of the researcher(s), their supervisor(s) and their HEI (Rolfe, 2006). Hence the importance of this chapter in providing an audit trail of the process. The reader should be able to appraise the quality of the research by reading the details of the research method. This emphasises the importance of a clear method which could be verified if necessary. Morse et al (2002) argued rigour lies in the conduct of the research. The researchers should verify the quality of the work as it progresses by checking their understanding of the participants' accounts during the interviews; allowing mistakes to be rectified before they are woven into the analysis. Thus, during the interviews for this inquiry, the participants and researchers discussed the early analysis, based on the current and previous participants. During the interviews, the researcher continually looked for concepts to be refined or confirmed. In narrative inquiry "accuracy" is less important, because the inquiry was about the meaning the participants gave to their narrative, rather than factual accuracy. After the interviews were completed, the participants were offered an opportunity to view the data and analysis as described in section 3.7.3, below. This invited them to correct, refine, or embellish their stories. Further, educators and managers also participated, potentially offering an objective perspective. These participants were likely to have seen many nurses making career decisions and observed some of the outcomes.

3.3.4 Confirmability

This refers to the quality of the results: are they supported by the participants? The results of this inquiry (chapter 4) are composed almost entirely of direct quotes, allowing the reader to verify or challenge the interpretation provided by the researcher in chapter 5. Thus, the participants voices directly contributed to the analysis and conclusions. Webster and Mertova (2007) term this accessibility, because the reader can see the research data and confirm for themselves the coding to generate the narratives.

Confirmability has been enhanced by employing triangulation to increase the validity of observations and interpretations. This is exceptionally useful in the narrative inquiry because the method largely precludes the traditional standards of distance and objectivity (Kim, 2016). The types of triangulations employed here were data source triangulation and investigator triangulation. Data source triangulation is where the same effect is observed at different times or with different actors. Thus, participants included a range of different types of nurses. They worked in different specialisms and in different posts and their stories formed the series of narratives. These were supported by contributions from nurse managers and nurse educators. Investigator triangulation uses different researchers to examine the same data. One of the project supervisors checked and verified the analysis at each stage. She read a sample of the original transcripts and all the career stories. This potentially leads to theory triangulation, when someone with a different perspective offers an interpretation of the same data, bringing about a complex but powerful analysis.

The literature review (chapter 2) employed two tools (see appendix 2) to assess the quality of the research used there. The tool provided by the BMJ, relating to questionnaires, and the tool provided by CASP, relating to qualitative studies, were used to ensure all issues relating to quality had been explored in this chapter. It was noted many of the published articles did not provide sufficient details of the method to assess their rigour. In a thesis such as this, there is a more generous word-limit, and the questions asked in the tools can be answered in this methods chapter, and in a similar sequence. For example, the CASP tool asked whether the participants had been selected using an appropriate means and whether the relationship between the participants and the researcher had been explored, and this chapter will explicitly examine and justify this (see section 3.5.1, below). It was noted in the quality assessment (see section 2.3) of questionnaires many had used unvalidated tools. This inquiry used a new tool, devised especially for this thesis, but the tool was verified using two pilot interviews. Further, the BMJ tool asks whether “consumers” were involved in the development of the tool, and the answer for this inquiry is “yes”, because the questions / prompts were revised following the pilots and the early interviews to reflect the stories and the emerging narratives (see section 3.4.1, below).

3.4 Conduct of the inquiry – the research method

Table 3.1: Process of the inquiry

Having justified the methodological approach, this chapter now goes on to look at the method, or the practical details of conducting a narrative inquiry. This starts with outlining the data collection tools. The data collection started with semi-structured interviews. From the interviews with the nurse participants were derived career stories. This required a special type of interview, narrative interviewing, which is specifically considered. Also considered is insider research. This section then goes on to examine the practicalities of pilot interviews, managing the interviews and transcription.

To facilitate the forthcoming discussion, it will be useful to distinguish between transcripts, stories, and narratives. The transcript was the verbatim record of each of the 26 interviews and includes all that was said and some additional, descriptive, text from the notes of the researcher. From the transcripts of the nurse participants (but not the manager or educator participants), the researcher derived stories. These were short accounts of each nurse participants career, still mostly using their words.

They are all available in appendix 3. The stories include all material from the interviews with nurse participants relating to their career decisions, how they felt about them, actions they had taken, and their consequences. Some authors refer to these as "career stories", because material not relating to the participants' careers was omitted. In this inquiry, the term "stories" has been adopted, for brevity and because it is not always possible to distinguish between career and other aspects of the participants' lives. From all the stories with nurses, narratives were derived. The narratives contrast with the actual events because each narrative is based on the perception or observation of the event (Hunter, 2010) and arise from several stories. The narratives were anything several of the nurse participants identified as influencing their career decisions. These narratives inform the discussion in chapter 5. The transcripts of the three managers and three educators were not intended to be used as stories and were not formed into stories but were examined later for additional material.

The inquiry was conducted (part-time) over a period of about eight years. An overview of the chronology and sequence is presented in Table 3.1, above.

3.4.1 Data collection tools

In Kvale's (2007) seminal work, he stated if we want to know about people's lives, we talk to them and learn about their world: "their dreams, hopes, and fears" (page 3) and several researchers cited in chapter 2 used individual interviews. Interviews are suitable for research involving members of the same profession and characterise the research of Mackintosh (2007) and O'Connor (2016). Another example was Brand et al (2016), who explored a single career decision, namely the decision to embark upon post-registration training in neonatal nursing. The number and variety of these studies shows this approach is flexible. Unfortunately, most of these papers provided minimal details of the tools or the analysis (see discussion in section 2.3), but mostly presented a completed analysis of the content of the interviews.

The participants in this inquiry included nurses at different career stages and in a variety of settings. They were asked about their career decisions and they told their stories so far; they examined what had occurred in the past, their present situation, and future possibilities. These were explored to illuminate what had influenced their career decisions. Nurse educators and managers were also interviewed because it was anticipated they could offer insights into how nurses make career decisions: they were likely to have known nurses at different stages in their careers, have witnessed the process they had gone through during career decision-making, and may have advised them. Occasionally people in these roles are not nurses but those involved in this research all were. They were not to be interviewed about their own careers and did not provide career stories. Therefore they did not need to meet the requirements of the nurse participants, but in the event, all would have fulfilled the criteria for nurse participants except some had been qualified for longer.

Two short lists of questions were prepared. One was for use with the nurse participants and was designed to illicit their stories. The other with the educator and manager participants and was designed to gather information on the nature of career decisions in nursing. These were broad, open questions designed to allow the participant and researcher to explore influences on career decisions from a variety of perspectives.

The analysis is discussed below (section 3.7) but suffice to note here that it was an iterative process because it started even as each interview was progressing, and further analysis was done in preparation for the next interview. Ideas and hypotheses were formed and checked then and in subsequent interviews. This meant sometimes the analysis of the early interviews revealed additional questions were required or some amendment of the wording of the schedule for subsequent interviews. In this way, emerging narratives were explored. For instance, one of the early participants complained retirement was rarely discussed by nurses and yet was a concern for her, so this was added to the schedule. On the other hand, it had been assumed pay would arise spontaneously in the discussion, but it did not, so this, too, was added.

Indeed, the progress of the interviews demonstrated the schedule for nurse participants required a complete re-structure. This was because at the outset it was a list of open questions, in a sequence that appeared logical during preparation; in practice, no interview followed that pattern. Instead, each was unique and demonstrated the interests and stories of the participants. This meant some questions were unnecessary and the sequence could unduly constrain the interview process. Therefore, the schedule for nurse participants was re-organised into a shorter list of prompts, which were potential issues to be explored. Analysis of the early interviews showed some pertinent issues had been raised but not examined, therefore, each of the prompts on the revised list included suggested probes, or areas to explore, if appropriate. This included such suggestions as what had initiated the decision, what they were aiming for, the thought processes they went through and any other influences upon their decisions. Appendix 3 provides the schedules. The nurses' is shown in its initial and final form. The interview schedule for managers and educators is only in one form because it did not require significant editing. This was probably because the educator and manager interviews were mostly about other people's careers – certainly, that was how they had been planned - they were not telling their own story and it may be this rather impersonal material led to fewer diversions and less complex discussion. These revisions, along with the developing skills of the researcher, meant the later interviews had a higher "coding density" than the earlier ones.

The interviews allowed the participant and the researcher to explore career decisions together in a private and comfortable environment, assured of confidentiality and anonymity. The one-to-one format was designed to allow participants to express themselves freely, including issues they may not ordinarily talk about to colleagues.

Interviews are an established means of gathering data, yet they have only been systematically studied since the 1960s, and their common-place form can deceive the researcher into under-preparing for them. Although there are few standard rules or formats (Kvale, 2007), good preparation capitalised on the wealth of the participants' experience. It is no longer acceptable to consider each

question a stimulus and the answer independently meaningful (Crabtree, Miller, and Dawsonera, 1999), and the research interview is not a normal, social conversation. In this inquiry, and typical for this type of research (e.g. Smith, 2012; and Magnuson, Wilcoxon, and Norem, 2003), the interaction was initiated by the researcher who decided in advance what areas would be discussed (see appendix 3). The participants needed to be free to express themselves, revealing novel insights and examining ideas neither researcher nor participant may have previously thought about, which can be a feature of the co-construction of knowledge. The interviews of the educators and manager participants followed a similar pattern to those of the nurse participants, but the questions were less personal and tended to ask about any nurse working in their area. There were fewer probes and the interviews tended to be shorter in duration.

3.4.1.1 Narrative interviewing

This is a special form of interview, used with the nurse participants.

In her classic text on narrative analysis, Riessman (1993) pointed out investigators do not have, nor do they require, direct access to another's experience; instead, they deal with the actors' representations of it in spoken or written accounts. In narrative inquiry, the data is people's stories, in which they describe the turning points in their past, issues in the present, and how they anticipate their futures. Riessman (1993) summarised the process of narrative analysis as one of "representation of experience" (page 9). These representations are stories, which provide meanings to events and "self." Narrative inquiry centres on how people understand themselves and what has happened to them.

Riessman (1993), Berry (2016) and others tacitly assume the narratives will be obtained through interviews. In contrast, Cousin (2009) suggested the stories could be written without even the researcher being present, or the researcher could use published biographies (Frank, 2012). Asking these participants, however, for written accounts could have been unduly onerous in terms of their time, and the need to express personal experiences in writing could have discouraged potential

participants. Nurses are often more confident in expressing themselves in speech rather than writing, since nursing is a profession based on human communication (Berry, 2016).

Narrative interviews contrast with many other qualitative interviews because they generate a story. The interviews with the nurse participants aimed to record their stories, which is a meaning-making device, rather than obtain answers to a series of questions. In this way, the participant becomes the narrator and the researcher an active listener and scribe. In telling stories, the narrator is not just relating experiences, but making sense of them. The researcher does not interview to “get a story” but rather, she enters the story with the participant (Beuthin, 2014). Therefore, the interviews were minimally structured and became less structured with each iteration of the guide as the skills of the researcher developed. One job of the researcher is to facilitate the participants to achieve narrative coherence, to provide a story that makes sense.

Reissman (1993) recommended questions should open the topic and allow participants to construct their own answers. The prompts privilege the participants’ perspective, without probing beyond what they were willing to share. Although participants often become more willing to share details as the interview progresses, the initiative for this must remain with the participant (Emerson and Frosh, 2004). Reissman (1993) stated the instinct to construct stories appears almost universal, and most participants will readily relate stories in answer to open questions. She and others (e.g. Emerson and Frosh, 2004) recommend just a few key questions or suggestions for talking, which allow the participant to explore areas important to them. This happened because each interview with the nurse participants included areas not prepared in advance.

The researcher allowed the nurse participants to drive the conversation and avoided controlling the conversation or dismissing material as irrelevant. This contrasts with most qualitative interviews, where the interviewer directs the conversation, but in these interviews, the participant directs the conversation to tell their story. One question and related probes are set out in table 3.2, below. Although the participants were telling their own story, the researcher did need to focus on aspects of

the story most pertinent to the research question, whilst being careful not to overly lead the participant (Beuthin 2014). Probes allowed the participant to provide examples, explanations or justifications.

What are you looking for in your career? • Why did you enter nursing originally? • Why did you apply for this/that particular post/type of work? • What do you enjoy most about your work? • What motivates you? • What do you feel about the pay you receive?

Table 3.2 Example of prompts and probes

The researcher actively listened and was emotionally attentive to the participant. This development of rapport, which is especially important in narrative interviews, creates a safe space for the participant to recount their story. This may be why several reports of narrative analyses include intensely personal accounts of the researcher (see, for example, Clanadin, Pushor, and Orr, 2007; and Beuthin, 2014). The role of the researcher is a complex one in narrative interviews and involves continually negotiating several balancing acts (Beuthin, 2014). These include, for example, conducting the interview in a professional, skilled manner, whilst remaining authentic and responsive; or between being warm and friendly, yet also able to end the relationship at the appropriate moment.

3.4.1.2 Online survey

During the analysis (discussed in section 3.7, below), some problems were becoming apparent. Although the codes were all mentioned by several participants, none were mentioned by all. In such a heterogeneous sample, much similarity may not be expected, and each code could still be important, but it was difficult to be sure. There was a danger of over-extrapolating from what was said and a potential need to reign in over-enthusiasm on the part of the researcher. These could lead to claims the participants would not recognise. Therefore, some new ideas were converted into a series of short statements about nursing careers, using *Survey Monkey*, https://www.surveymonkey.co.uk/. The surveys asked participants to state the amount of agreement they felt with each statement.

There were two versions of the survey, one for the nurses and one for the educators or managers. They were similar, concentrating upon the same new ideas, but the former was phrased to ask about their own career decisions, whilst that of the managers and educators asked about career decisions in nursing generally. Thus, the nurse participants were asked to respond to the survey using their own careers as a frame of reference, whilst the managers and educators were asked to respond more broadly, perhaps based on nurses they had worked with. The surveys were emailed to all the participants, with one follow-up reminder four months later. The time lapse between the two requests to complete the survey allowed for one participant - who was known to be on extended leave - to complete it on her return, which she did. The survey invited the participants to state the extent to which they agreed with each statement, using a five-point Likert-type scale. By asking them to respond to some initial ideas, the surveys provided the participants with the opportunity to contribute to the developing theory, and so were a form of investigator triangulation. The surveys also invited additional “free written” comments. Appendix 4 shows the questions from the surveys and all the raw data. Some data from the surveys is included in the result chapter (chapter 4).

3.4.2 Insider research

In this inquiry, the researcher and the participants shared a nursing background, so it was an example of insider research, which occurs when a researcher is studying their own area. This meant both were bound by the same professional code and may have meant the participants believed the researcher would understand some of the enjoyments and frustrations in professional life. This facilitated a deep exploration of complex material but could have meant the research was not objective. However, Wilkinson and Kitzinger (2013) stated complete objectivity is impossible in the social sciences and may even be unethical. In narrative analysis, the researcher must accept the story they have helped construct may be different from that which another interviewer may have compiled (Beuthin, 2014). The researcher was no longer a clinical nurse and used this to strive for some degree of objectivity.

Beuthin (2014) argued all narrative inquiries are insider research, because of the shared nature of the story-telling. Further, the shared nursing background in this inquiry informed it. The participants perceived the researcher as a fellow nurse and related to her as one; indeed, that may have been partly why they agreed to participate. This shared professional background may have influenced the researcher's analysis and interpretation of the stories, which the participants would have expected. Added to this shared background, the researcher also interprets their stories in the light of the literature (discussed in chapter 2). All this leads to a rich understanding of the context and frees the participants from feeling it necessary to always explain themselves, which could interfere with the free exploration of their story. Nevertheless, it was important the researcher's understanding of the context, and the narrative was verified, hence the importance of member checking. The shared professional background may have assisted in building an in-depth picture, but Smetherham (1978) warned against the danger of assuming others experience the phenomenon in the same way as the researcher and Smith (2012) cautioned of the dangers of allowing the insider researcher's voice to dominate. A sample of the data from this inquiry was examined by one of the research supervisors to verify this had not occurred. To add further rigour, the stories were examined in the light of the existing research. This meant the analysis can confirm the state of existing knowledge, based on the researcher's understanding honed through the literature. The analysis should also highlight areas which have not been previously discussed and are potentially new insights into the experience of making career decisions in nursing. These will be presented in the thesis and should contribute to the interpretive lens of those who follow with further research, and so on. This means the evidence base relating to nurses' careers, which is surprisingly limited considering the numbers involved in the profession, will gradually build up.

Wilkinson and Kitzinger (2013) stated insider status may facilitate gaining access to participants, who would accept them more readily and talk freely, using informal vernacular. Smith (2012) stated her insider research amongst women teachers enabled her to obtain rich data and provided additional insights into a complex situation. Similarly, Magnuson, Wilcoxon and Norem (2003) used their inside

knowledge to identify potential participants, and the interviews were a joint exploration, with mutual respect apparent. In narrative inquiry, the researcher's voice should be heard; in some other research methodologies, discovering the researcher's presence in the analysis would be grounds for suspecting the research could be biased. However, in narrative inquiry, not hearing it could be grounds for suspecting deception (Berry, 2016), because the researcher and the participant should have crafted the story together. Nevertheless, it remained important it was the participants' narrative was heard, not the researcher's (Cousin, 2009). This had the effect of offering some compensation for the imbalance of power (considered in section 3.6), which is an inevitable feature of research interviews.

Dialogues are one of the features of narrative inquiry. They distinguish it from most other methodologies, which are essentially monologues (Frank, 2012) whereby participants answer the researchers' questions. Additionally, there are the voices of other people who interact with the participant. In this inquiry, many of the participants repeated what others had said to them. Whilst the researcher discouraged "gossip", some perspectives from other parties were none the less enlightening, which is consistent with narrative analysis, where the emphasis is on exploring the culture impacting events, and the source of wisdom is less important.

Wilkinson and Kitzinger (2013) query whether any research is truly objective, and it would, therefore, be more honest to make any assumptions explicit. Reflecting upon her study, Smith (2012) felt it was unrealistic to remain detached from the accounts of these women whose stories were like her own and some of whom were colleagues and friends. This emphasises interviews should not be treated as normal social interactions, and for Smith (2012), this was an on-going and delicate balancing act. The balancing act was a little easier in this inquiry because, unlike Smith (2012), the researchers' friends and close colleagues were specifically excluded from participating. This allowed a little formality to enter the discussion, and for the researcher to remain slightly detached. Further, many of the

participants were working in fields of which the researcher had no experience, and she admitted ignorance, requesting explanations when appropriate.

3.4.3 Pilot interviews

Two RNs agreed to be interviewed as a pilot for this research. They understood their interviews would be excluded from the analysis but would nevertheless contribute to the research. The pilot interviews allowed the questions to be tested to verify they yielded the hoped-for data. They did indeed, but they also provided much additional material about the participants' current posts. The pilots also showed the interviews could take longer than was acceptable. The number of questions (subsequently remodelled as prompts) were consequently reduced in number, whilst other questions were refined to encourage discussion about the decisions leading to career moves. The pilots also showed the arrangements for recording the interviews were satisfactory and allowed the recording to be transferred to a computer for playback, but the arrangements for transcribing had to be revised. These two interviews also provided the opportunity for the researcher to start to hone her interview skills.

3.4.4 Management of the interviews

Once someone had agreed to an interview, a mutually agreeable time and place were arranged. One participant (Trudy X) was no longer based in London, but her data could have been valuable because she was the only participant who had been unhappy in her nursing career. However, the very fact which made this contribution valuable also made it most difficult to collect because she was reluctant to revisit an unhappy time in her life. She opted to provide written answers. These responses were brief but illuminating and used to compose a short career story.

Each interview commenced with the researcher thanking the participant for helping and both completed and signed two hard copies of the consent form, one was kept by each of them. The participants were also provided with a hard copy of the information leaflet. These, and all other

communications with the participants are available in appendix 3. Research interviews are not a part of everyday life and even these professionally competent workers could find them intimidating. Therefore, the interviews followed the advice of Cousin (2009) and started with non-threatening questions, to help the participant relax and start to build a rapport between participant and researcher. Thus, before the recording was commenced, the participant was asked to choose their pseudonym, which they seemed to enjoy. The recording was commenced, and the researcher asked the first formal question, about their original decision to enter the profession. This was another question most participants found it easy to answer, and some even found it amusing to look back on their younger selves. The participants were usually then asked about their present post, after which, each interview followed a different path,. Each interview took about one hour. At the conclusion, the recording was stopped, and the researcher checked any biographical information unclear from the interview. The participant was again thanked. One situation arose on three occasions: after the recorder had been switched off, the participant added something of great interest. This relaxing of tension as the recorder is switched off was noted by Beuthin (2014). In each case the researcher requested permission to add this to the data, using written notes (or in one case the recording was restarted), and this was always granted.

Following each interview, the researcher engaged in self-reflexivity to consider how her understanding and interpretation had added to answering the research question. The emergent narratives could affect the selection of participants. For instance, no account had been taken during the initial planning to allow for where nurses had been born, grown-up, or trained. However, discussions showed nurses from outside of the UK were significant in London and could not be ignored in a study about the careers of London nurses. Two of the early participants (Gem N and Josh N) were trained overseas and others were born overseas but were trained within the UK. It was felt this may not fully reflect all the complexities involved, especially as, by coincidence, they had both trained in the Philippines. Another nurse who could provide data about that aspect of nursing careers was sought (using participants already involved as informers), and Pitchie N accepted an invitation to participate.

3.4.5 Transcription

During the interview, the researcher kept brief written notes, but keeping a full written record was likely to prove a barrier to the researcher responding to what the participant was saying. Silverman (2000) recommended audio-recording interviews. He acknowledged not even a video camera could record everything, but an audio recording would retain more than the researcher could remember. It is difficult to recall everything important, and almost impossible to recall issues not appearing important at the time, but which could assume greater significance later. Therefore, the interviews were recorded using a digital voice recorder (Olympus WS-310). The participants were asked whether they agreed to this and all, except for Trudy X (see section 3.4.4), agreed.

The recordings were transferred to a computer, then deleted from the recorder. The voice-recorded interviews were to be converted into written transcripts, which Riessman (1993) refers to as "fixation" (page 11). Most researchers find it easier to work with written texts and they are easier to share with the research team and the participants themselves (see section 3.7.3, below). Further, transcription was essential if extracts were to be included in this thesis. The recordings were played whilst the word-processed document was prepared. It is possible to use the computer mouse to control the tape, but the pilots showed this was inaccurate and cumbersome. Therefore, transcription of the interviews was achieved using a foot pedal (*Infinity* USB foot pedal, operated by *Express Scribe Pro* software) to control the recording, leaving the fingers free to type.

Kvale (2007) points out transcribing an interview is not just a clerical task and is complicated by the differences between speech and writing. Transcribing was described by Emerson and Frosh (2004) as an act of meaning-making. Occasionally, researchers must go to elaborate lengths to capture the essence of what is being said (Riessman, 1993; and Emerson and Frosh, 2004) and find it necessary to add additional vocalisations or to break down speech into stanzas, to do justice to the richness of the vernacular. Emerson and Frosh (2004) explained this is more likely if the participant's culture is very different to the researchers'. In such situations, the analysis may not even commence until after

the transcription. However, in this inquiry, the researcher and participants shared a similar background, and the data analysis started during the interview and subsequent transcription was part of the analysis.

No transcript can fully capture all the data available. Some data (such as body language) is lost when the interview is recorded and more is lost (such as tone of voice) when the recording is transcribed, although both losses were reduced by adding in material from the written notes. The lengthy process of transcribing the interviews, and the multiple decisions made in representing them, meant the researcher became familiar with the data and confirmed many authors' experience (for example, Silverman, 2000) that the very act of generating the transcript is part of the analysis. Each section of the recordings was played at least three times. During the first playing, just the words were transcribed and in the second playing the non-verbal utterances and repetitions were added, along with occasional inclusions from the researcher's notes and non-verbal clues were used to insert grammar (full stops and so on). On the third play-back, detailed corrections took place. It was necessary to replay several sections repeatedly, to fully capture the participants' true meaning and render the transcript as reliable as possible. The final transcriptions were therefore verbatim, including all the repetitions and non-verbal utterances such as pauses, repetitions, laughter, and exclamations. These all add to the meaning of the discourse (Dynel, 2011), along with non-verbal communication, because how the story is told is important in narrative inquiry (Cousin, 2009). Non-verbal language such as gestures, posture, and body language were difficult to record and were mostly excluded from the transcriptions, although occasional gestures were added to the transcripts when they contributed to the meaning.

3.5 Participants

This section will explain and justify the selection of participants. The crucial issue of how they were protected is examined in a sub-section on ethics.

Nursing is a large and complex profession, with several different branches (or fields) and it is not possible to give full attention to them all. The research team needed to decide which aspects to give attention to and ensure the scope of the inquiry was tightly defined. Defining these parameters kept the inquiry manageable and assists the reader in applying the research to their own needs and situations.

Students embarking upon nurse education in the UK must choose whether to study adult nursing, mental health nursing, child health nursing or, more rarely, learning disability nursing. There are some combined courses available and there is some limited possibility of changing fields. Many adult nurses subsequently choose to train as midwives, but since the early 1990's it has been possible to take a direct-entry route to midwifery (Radford and Thompson, 1993). The inquiry involved only nurses registered in adult nursing. Nurses in other fields or midwifery were only included if they also held an adult registration. There were several reasons for this. First, adult nursing is the single biggest group of RNs, which means this inquiry will be more widely applicable. Second, adult nursing is the researchers' own field. Third, but possibly most significantly, adult registration is more like the nursing registration gained overseas. Indeed, nursing registrations other than adult are often not recognised by other countries (Royal College of Nursing, 2020). By restricting this inquiry to adult nurses, the results will be more readily transferred to other contexts. Further, the insights gained from the literature review (chapter 2) will be easier to apply to this inquiry. Participants included nurses who were employed as RNs and RNs who had opted to leave the profession. All were working at the time of the inquiry, although some were in part-time work. These are all referred to in this inquiry as "nurse participants".

NHS employers recognise five different fields of nursing (see figure 3.1). This research involved registered adult nurses working in only four of these, namely:

- Acute and critical care.
- First contact, access, and emergency care.

- Supporting long term care.
- Family and public health.

This omitted mental health and psychosocial care. Nurses working there would normally hold a registration in mental health nursing and this registration - along with the registrations in Children's Nursing, Learning Difficulty Nursing and Midwifery - were excluded from this inquiry. Unqualified nurses were also excluded. Those preparing to register as Adult Nurses could have aspired to work in any of the above four segments, and anecdotal evidence suggested graduates move freely between them.

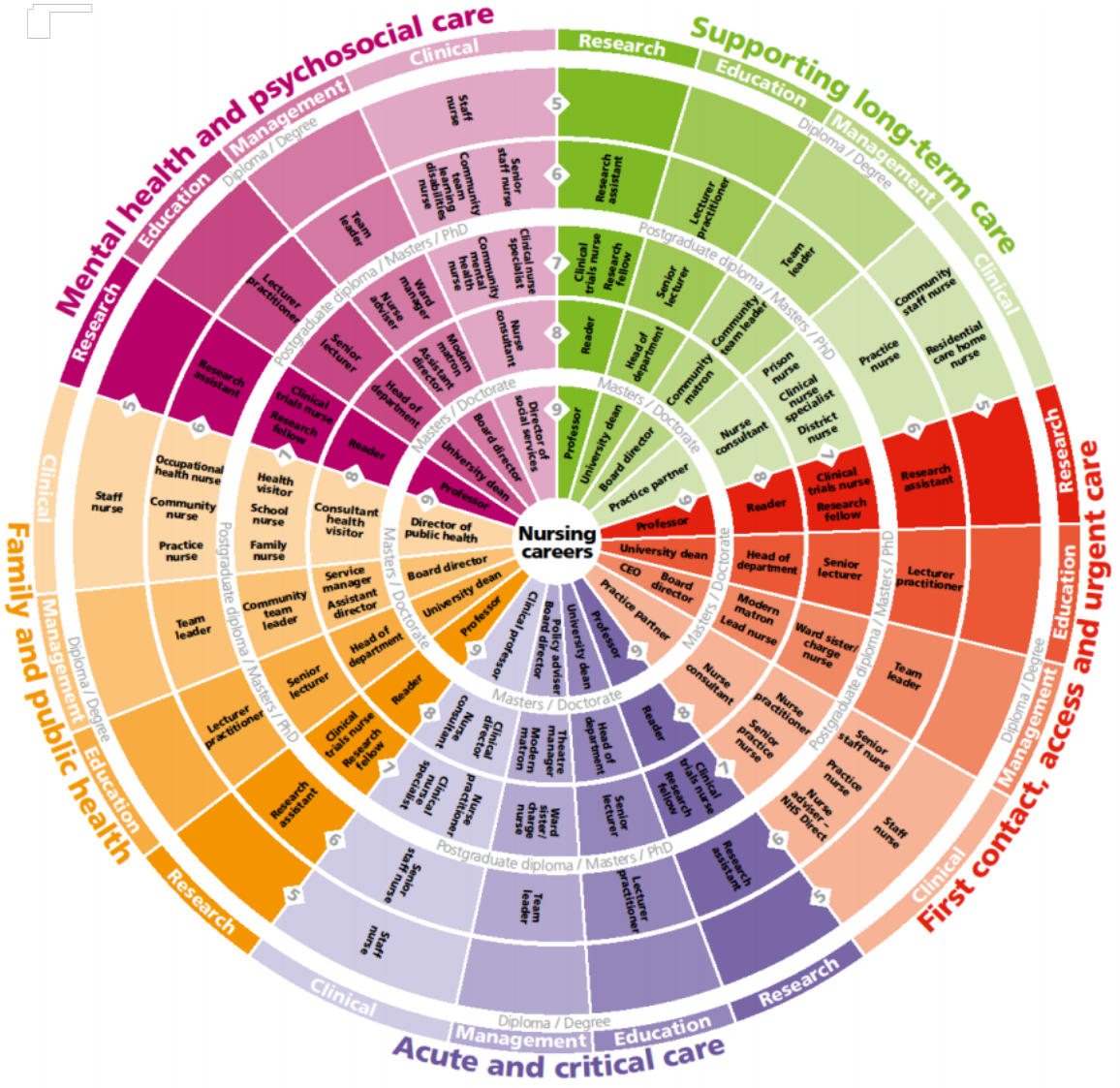

Fig 3.1: Nursing wheel, as envisaged by NHS Employers (2010)

Additionally, the study was restricted to London. There is evidence (Buchan, 2011) London acts as a national powerhouse for nurses in the UK, because of the wealth of professional opportunities available there. This means the situation in London had national significance and, therefore, the findings of the research could be relevant beyond London. London was defined as any of the London Boroughs, in other words, the area administered by the Greater London Authority. Nurses and ex-nurses were only invited to participate if they had worked for at least three years of their careers, following registration, in London. Three years was chosen because that would have provided them with the opportunity to move post or to undertake additional educational opportunities.

To capture recent trends in career decisions, initially the nurses invited to participate had qualified (or obtained their NMC registration) between five and fifteen years previously (1998-2008). However, it became apparent this omitted senior nurses who had made a series of career decisions, and nurses who had been demonstrably successful in their careers, both of whom could offer useful insights. Therefore, the registration time was revised to between five and twenty-five years ago (1988-2008). The participants are identified by a pseudonym, which they chose. This was another example of efforts taken to prevent the possibility of the researcher imposing her feelings on the stories. One participant chose the name of a much-valued (non-nurse) colleague, and another chose a name she had always liked. Some of the participants would have chosen a rather obvious name, such as their second given name, but the researcher advised against this because it may have made them identifiable to a reader who had even superficial knowledge of the participant. To the pseudonym was added a letter at the end: the letter "N" denoted they were currently working as a nurse, and the letter "X" denoted they were no longer working as a nurse. Table 3.3 shows the inclusion and exclusion criteria for nurse participants.

The data included the transcripts of the three educators and three managers. They were not to provide their career stories, instead they were asked about their perspective on career decisions in nursing. However, when the transcripts were analysed, there was little to distinguish between the two

sets of data. This was because the nurse participants also told stories from the careers of friends and colleagues. Conversely, the educator and manager participants told their own career stories. Nevertheless, the two sets of data were kept distinct and were analysed differently (see section 3.7).

3.5.1 Identification of participants

Selecting the participants is central to any research.

Potential participants were recruited using purposive sampling, which is choosing participants likely to contribute a useful perspective. Whilst no attempt was made to make the sample statistically representative, there was an attempt to ensure as many aspects as possible of the wide and complex profession featured in this research.

To fulfil the criteria of a nurse participant, they had to:
Be (or have been) registered with the NMC as an adult nurse.
Obtained their NMC registration between five and twenty-five years ago (i.e. between 1988 and 2008).
Have spent at least three years of their career after registration in London.
Be (or have been) working in acute and critical care; first contact; access and emergency care or supporting long term care; family and public health.
Exclusion criteria included:
People who had other nursing or midwifery qualifications (e.g. mental health, learning disabilities nursing or child health nursing) but not adult nursing. Nurses holding an adult registration as well as another registration were eligible to participate.
Midwives, or nurses now working as midwives.
Nurses who registered less than five years ago or more than twenty-five years ago
Nurses who had never worked or studied (post-registration) in London or spent less than three years there.
Friends and close colleagues of the researcher

Table 3.3: Eligibility for nurse participants

The selection of nurse participants started with one of two strategies:

1. The researcher was granted access to some details of alumni who had undertaken pre-registration nurse education at the researcher's HEI. These lists provided degree title (which revealed the branch

of nursing they were registered in), their date of graduation, their current post, and when the data was updated. These brief details were used to select alumni with a wide range of current posts and training dates, within the criteria. Some potential participants were excluded because they were, at the time of data gathering, again students of the HEI, or had applied to return. Others were excluded because they had not had recent contact with the university. Once the researcher had identified alumni she would like to interview, she sent the student numbers to the alumni office who used the details they held to contact the identified alumni, inviting them to participate. The email had been drafted by the researcher but was sent by the alumni office. If interested, the alumni were asked to respond by emailing the researcher directly. Thirty-four nurses were approached this way, six contacted the researcher and all of these were interviewed. The alumni office sent a reminder email to those who had not responded after three weeks, but there were no additional replies, and no further contact was made. The transcripts of all these communications can be viewed in appendix 3. This occurred before the General Data Protection (GDPR) legislation of 2018 but would still have been compliant: the researcher did not view the alumni names, contact details, or other identifying information; only their student number. Further details were only revealed by the potential participants when they contacted the researcher. These lists were compiled as each cohort of students completed. At that point, alumni were invited to keep the HEI informed of their career moves and changes of contact details, but the onus for so doing was upon the students. By providing such details, the alumni granted permission for their HEI to contact them. Excluding those alumni who had not maintained their details with the alumni office had the effect of excluding any who may not have wished to remain in touch with the HEI.

2. Nurses and ex-nurses who were professional acquaintances of the research team. This included ex-students and other professional colleagues, who met the criteria, but not anyone the researchers worked closely with or had a friendship with. These were approached directly by the researcher. The approach was made using email, which allowed them to decline or simply ignore, thus avoiding a face-to-face refusal. All six nurses who were approached in this manner were willing to be involved and were interviewed. Additionally, one nurse heard of the research and offered an interview.

   These two approaches led to the third strategy:

3. Snowball sampling occurs when one individual with an interest in the research recommends another who could contribute. On some occasions, the researcher contacted the named person, again via an email address supplied by the informant. Usually, however, the informant approached the potential participant on the behalf of the researcher. Eight potential nurse participants were approached in this

manner, one did not respond to the email, but the others all responded positively, so seven of the nurse participants were recruited in this manner.

All potential nurse participants were checked against the inclusion and exclusion criteria before they were invited to partake.

In this way, experienced adult nurses who had worked extensively in British health care - or who had that opportunity - were identified. Twenty participants was similar to the number involved in the research by Greenbank (2012) but rather more than Magnuson, Wilcoxon and Norem (2003) and Smith (2011). It was also more than the minimum of five that Cousin (2009) recommended, but it was felt this number was needed to provide sufficient insights into the variety of posts within nursing, whilst not being unduly onerous and still allowing in-depth examination of each transcript. Even with the application of the criteria, this sample was heterogeneous, in terms of their current and previous posts. Jones (2013) stated a small, varied sample can be complex to analyse, but also means any recurring narratives are likely to be genuinely important findings.

The participants' pseudonyms are listed in table 4.1, with their year of registration; the title of their current post (including any upcoming, known job changes); their gender; and their approximate age. It was interesting to observe one unintended consequence of snowballing was a high number of nurses working in one specialism, namely gastrointestinal or nutritional health. In contrast, nurses in the community were difficult to recruit, and this may have reflected one problem of working in the community, which was that it can be professionally isolating.

The educators and managers were identified using insider knowledge and snowballing. Two educators and two managers, known to the research team, but not close colleagues or friends, were approached directly by them. All four agreed to participate, and suggested one additional educator and one manager who could make a valuable contribution to the research. These two were approached and agreed to participate. These participants are referred to as “educators” or “managers”. Like the nurse participants, they chose a pseudonym to which has been added an M (for

manager) or an E (for educator). These transcripts yielded additional examples to embellish the narratives derived from the career stories. During the interviews and subsequent analysis, it was evident the educator and manager participants volunteered information and insights from their own careers.

By the end of the interviews, the researcher had 26 transcripts. They varied in length but were usually about six to eight thousand words, derived from an interview which was typically just under an hour in duration.

3.5.2 Ethical considerations

Ethics are paramount and all research involving participants should consider the effect of the research on them, in the immediate and longer-term (Kvale, 2007) and their welfare must be reviewed at all stages of the research. Ethics is even more important in narrative inquiry, because the participants have built up a relationship with the researcher and they have shared their private stories (Clandin, Pushor and Orr, 2007; and Bell, 2002) and, in so doing, have opened themselves up to the researcher (Beuthin, 2014). To tell a story successfully, there must be a meaningful relationship between the participant and the researcher which facilitates the development of a finely nuanced understanding (Berry, 2016) and this trust must not be abused (Beuthin, 2014). Narrative inquiry blurs the boundary between life and research, allowing one to intrude upon the other, which further increases the ethical duties of the researcher (Clandin, 2006),

Research integrity is an even wider issue and concerns the honesty of the researcher and the transparency of their work. Integrity is especially critical in research done through interviews because social interaction is the chief tool for obtaining data. According to Berry (2016) nurses are familiar with learning from stories because it is a well-established tradition to learn from the stories of clients. This means they are particularly skilled at building a rapport with individuals. In narrative inquiry, the researcher creates an apparently safe situation and has the privilege of hearing private thoughts and

feelings which are shared for later public use. This means participants could reveal more than they intended, leaving them feeling exposed and vulnerable (Berry, 2016). Therefore, the researcher was vigilant against probing any areas the participant appeared to be reluctant to talk about and avoided discussing details not relevant to the research question.

The power of storytelling is indicated by the observation that storytelling can be used as a therapeutic tool. This is because story telling helps people make sense of their situation and attribute meaning to what has happened to them (Hunter, 2010). This can be used to help distressed clients to review their situation, but it also reminds us the tool can unleash powerful emotions. Therefore, the researcher needed to be particularly vigilant in guarding the rights of the participants, by adhering to ethics guidelines and by being circumspect in contributing her own opinion to the discussion (Kvale, 2007). Many authors (for example, Finlay, 2002) have expressed concern about the power imbalance in the research interview, and insist it is the responsibility of the researcher to guard the rights of the participants, and not rely upon the participants expressing concerns about the research process.

This research involved NHS staff and potentially required ethics approval from the NHS Health Research Authority. However, a decision tree on the NHS Health Research Authority website (NHS Research Authority, 2015) showed this was not necessary (See appendix 3) at the time the inquiry was conducted, but it still required ethics approval from the HEI. Research organisations run ethics committees which apply guidelines such as those provided by the British Educational Research Association (BERA, 2015). These underpin the processes of the ethics committees and researchers use them to ensure all areas have been considered when planning research. This inquiry was overseen by the department responsible for supporting learning and teaching in the HEI. A proposal was submitted to the department's ethics committee, which comprised several individuals; some were experts in research ethics, whilst others represented interested parties, including the public. This committee scrutinised plans for the inquiry, particularly the information to be given to potential participants and other arrangements designed to protect them, such as ensuring anonymity and

storing the data. The ethics committee granted permission for the inquiry. Additionally, research and development approval was sought and granted from one of the major Trusts the HEI worked with, to allow the use of Trust facilities, such as a room for interviewing their staff. Staff from other Trusts were interviewed at the researcher's HEI or a public place, such as a coffee shop.

These procedures safeguarded the rights of the participants, who were autonomous and could give or withhold consent freely and without coercion. They knew in advance the purpose of the study and the commitment participation would involve, with an estimate of time commitments. The initial email explained the status of the researcher; why the participant had been invited; what participation involved and how long it would take (between sixty and ninety minutes); participation was voluntary; and they could withdraw at any point. People who expressed interest in the research received a further email attaching the list of the prompts in use at the time; a copy of the information leaflet; and consent form. They were encouraged to reflect on their career in advance, potentially leading to richer data. Although desirable to fully brief the participant about the interview beforehand, this is not always possible, because the interviewer could not know exactly the direction in which the discussion would proceed (Kvale, 2007).

There was a risk of exploiting the "dependant relationships"; where the participant feels themselves to be beholden to the researcher. Costley and Gibbs (2006) stated some degree of exploiting personal contacts is inevitable, and indeed is an acknowledged advantage of insider research (Wilkinson and Kitzinger, 2013), but the researcher was obliged to proceed with extreme care. She worked as a university lecturer involved in nursing programmes and one potential source of participants could have been post-registration students of that HEI. However, they, and applicants to the HEI, were excluded to prevent any perceived coercion or exploitation. Friends and close colleagues of the researcher were similarly omitted.

Kvale (2007) stated participants should enjoy the interview because most people like receiving the undivided attention of someone listening to them (Cousin, 2009). Smith (2012) stated the interview

was empowering for many of her participants, allowing them to gain new insights into their lives and the choices they had made. Indeed, in their review of the ethics of participant research, Costley and Gibbs (2006) state the caring ethic is more important than the research findings, and the opportunity to help the participants must be expected and welcomed. Most of the participants in this inquiry knew the researcher was a lecturer in nursing, and one even stated they were looking forward to the interview as they wanted some career advice. Ignoring this would have been ungracious, and so the researcher had to accept some participants would regard her as an expert and narrative therapy is a known approach to people in distress (Holstein and Gubrium, 2012). Nevertheless, these interviews were absolutely not opportunities for therapy, and the researcher had to be wary of the desire to help participants, perhaps with feelings of disappointment or by giving career advice. Not only would engaging in therapy be outside the scope of the inquiry, but it would also have been potentially harmful as the researcher did not have the training to offer counselling.

Privacy and confidentiality apply to people and locations and is one of the oldest of the tenants relating to ethics, because of the long-standing importance attached to the private domain. They can be difficult to achieve in qualitative research, where the findings are not "computed averages" (Kvale, 2008, page 28). Maintaining confidentiality was important in this inquiry because the data was the views and experiences of the participants, so colleagues and employing Trusts featured. The pseudonyms were intended to allow each participant, but no one else, to recognise their contribution to the report. The researcher kept a paper record of participants, their pseudonym, and their contact details along with their signed consent form, locked in the researcher’s office, not on a computer. Care was required in using direct quotes in the final report so no reader would be able to identify either the person or the situations involved. If the name of a person (other than the researcher) or place was used in this thesis, it was removed, and the omission indicated with [].

Another aspect of ethics considerations is macro-ethics (Kvale, 2007), whereby the research is of value to the wider community. The participants themselves may have wanted to know the benefit the

research could ultimately be, but the researcher needed to avoid making ambitious claims for her inquiry. Nevertheless, it would have been wrong to use the participants' time and good-will in an endeavour with no chance of being of value to others. Indeed, many of the participants stated they thought the inquiry was important and attention to nursing careers was long overdue. All the participants featured in the final inquiry and all of the participants were directly quoted at least twice, which demonstrates each contribution had been valued. The findings of this research could be used to help guide nurses in their career decisions and to increase staff retention, and these could both be positive outcomes, of benefit to both nurses and the patients they care for.

The final ethics consideration is to ensure the safety of the researcher and participants. The interviews were arranged at the participants' or researcher's place of work, in a public place, or by telephone. The researcher's calendar was open to several people within the HEI and contained details of the time and address of the meeting place, but not the name of the participant.

3.6 Data analysis

The analysis is a crucial aspect of any research project yet reports vary in how much detail they provide. Frieze and Silver (2013) stated the analysis of data is under-explored in the social sciences, but researchers have a responsibility to explain the process they have gone through. Sometimes interpretation is conducted without formal protocol and is described as intuitive, almost mystical. Stake (1995) and Frank (2012) stated analysing stories is a craft, not a procedure. Nevertheless, as narrative inquiry becomes more established, its methods are becoming more complex and rigorous (Holstein and Gubrium, 2012). This is one of the most important aspects of reflexivity (Finlay, 2002), where the research process is examined, and by making this transparent, the private experience of conducting the research becomes public knowledge. This section will describe and justify the process of analysis, so the procedures taken here can be challenged by the reader and possibly repeated.

Representation commences with an account of an experience, which is often unplanned and un-sought. We all have multiple experiences most days which could be potential studies, yet most are overlooked. Sometimes, however, interest is piqued. Riessman (1993) reminded us there are several stages in analysis and some have already taken place before the research even commenced. The participant had an experience, yet their attention would have been selective, with more attention devoted to aspects important to them at the time. This differential attention is increased if they then tell the story to others before the researcher. At each telling, the listeners contribute by requesting more details or clarification. By the time the researcher hears the story, parts may have become embellished as a response to the interest of others, whilst others may be overlooked.

Hunter (2010) discussed five "lenses" (page 4) used to analyse narratives (or stories). The first lens is the uniqueness of human actions; second is the verbal actions and choices made; the third is the impact of social circumstances; the fourth is the interaction between the participant and researcher and the fifth is the role of the researcher, which can be important in some participant observations. Like Hunter, (2010), the lens most relevant to this inquiry is the second and third lens, which emphasise the decisions taken and what has influenced these, and it was these the analysis focussed on. When a story is told, only some portions of the whole story are related and only some of these are included in the analysis. When the researcher has made the selection (rather than the participant declining to share details), this selection must be transparent, and so the analysis should be presented as a "series of choices" (Clandin, 2006, page 6). This means building a meaningful description is largely inductive.

Most empirical studies yield two types of data. First, data which confirms the researchers' and readers' existing understanding *(etic* issues), and then there are new findings extending or challenging that understanding (*emic* issues). Traditionally, researchers derive great satisfaction from developing *emic* issues. They are important for a doctoral thesis such as this where the researcher is seeking original knowledge to contribute to what is known. It was apparent new insights were indeed

emerging. The stories were both de-constructed to reveal powerful individual discourses and hierarchies (Hunter, 2010) whilst also analysed within the broad social, historical, and cultural contexts. This context was provided by the researcher's inside knowledge and by the participants themselves.

Most researchers provide at least some details of the analysis, but often suggest it started once the data collection was complete. Others (for example, Smith, 2011) state the interpretation begins earlier and is ongoing. As explained in section 3.4.1, above, the latter was the approach adopted here and the participants helped to create and develop the emerging ideas. The narrative changes again when it is transcribed and analysed and for a final time when the analysis is read and the readers apply their own understanding, thus contributing the final layer to the account.

The analysis is the most complex stage of a narrative inquiry because there is a danger the researcher becomes entrapped by a wide range of stories which lack a discernible pattern (Holstein and Gubrium, 2012). Frank (2012) stated analysis involves selecting material, by including only material with the most meaning. In this inquiry, material was only included if it helped answer the research question. It was tempting to include many interesting descriptions of the world of work, but the final report only includes details pertaining to career decisions. Holstein and Gubrium (2012) pointed out the participants have often already provided a structure because the stories they tell have been formed to make sense of their lives and their experiences. It is this meaning the researcher endeavours to capture. It has already been identified the researcher is less interested in the historical accuracy of the accounts, but rather with the impact these had on the participants and how it influenced their career decisions. Nevertheless, the historical events remained important because many of these narratives were told against the background of re-organisations and shortages within healthcare. The importance of historical contexts may be greater in career research than in other narrative analysis.

3.6.1 Development of the stories

Once the transcription was complete, the researcher used them to develop a story for each of the nurse participants. These were written accounts of the participants' careers so far. They were about 1,500 to 3,000 words in length and were composed mostly of the participant's own words, with some commentary (or interjections from the researcher) to form a coherent story. They are all available in appendix 4. They were a tool allowing the researcher to identify the career decisions in the light of the beliefs, intentions, and motivations of the participants, against a background. Like Jones (2013) this inquiry used the career stories to make a coherent account of career decisions from the decider's perspective. The career stories emphasised the career decision-making processes. Extraneous material was removed, but the context was included, rendering it easier to examine the decision in context but without additional information which could obscure the decision.

Many interesting but less relevant details were omitted, such as an account of their current work, but information about past and potential career moves; the influences impacting these; how they felt about them at the time of the career decisions; and how they felt about them at the time of the interview were retained. To the narratives was occasionally added details provided through subsequent correspondence with the participants, usually about subsequent career moves. The stories included the three "commonplaces" of narrative inquiry (Clandin, Pushor, and Orr, 2007 page 23; and Kim, 2016, page 90), which are temporality, sociality and place. Temporality acknowledges all is in transition; people, places, and events are all processes. They are never static and an event may be interpreted differently on one day compared to another. Thus, as well as explaining what they did and why, participants could discuss how they felt about it both then and during the interview. This emphasises the dynamic nature of stories. Sociality acknowledges feelings are impacted by the environment and people surrounding them. In this inquiry, all the analysis concerned the world of work, which could be impacted by colleagues, politics, finance, and government imperatives. The stories included what other people had said to the participants. The last commonplace is place, which

is the physical or built environment against which the story took place. Thus, the working environment could be important to this inquiry. The stories included both *what* and *how* (Holstein and Gubrium, 2012, page 7). In the analysis of *what*, the researcher sought to establish what happened, and this approach is the oldest and most popular approach. A newer approach is to ask *how*, which is increasingly popular amongst psychologists because it explores the development of the participants' inner identity. Both were included in the stories and were important in this inquiry.

3.6.2 Coding of data and the development of the narratives

Frieze and Silver (2013) characterised the analysis process as NCT, which is Notice; Collect; Think. This linear approach was criticised by Sinkovics and Alfoldi (2012) who stated data analysis is more "messy" than this because it must contend with what they term the *etic-emic* tension (page 822). This is the conflict arising when the *etic* issues the researcher was expecting impede appreciation of the new *emic* ones, derived from the participants. A more fluid approach was, indeed, required in this inquiry because the researcher started with some broad perspectives based on the literature and highlighted in the reflexive narratives (throughout chapter 2). These are the etic issues which were used to start developing the lens. This was developed by adding the researcher's own perspective, for she was researching her own profession (see section 3.2.4 on insider research, above) and she added her lens developed by her own experience. This is exceptionally appropriate in narrative inquiry because Hunter (2010) explained stories should be interpreted within a wider context. As the data was gathered some emerging issues challenged these perspectives. These were the emic issues which, in turn, influenced the questions asked in subsequent interviews, which altered subsequent data, and so on. Sinkovics and Alfoldi (2012) argued this approach lead to progressive focusing, whereby the findings of the research are continually refined.

Frieze and Silver (2013) claimed much qualitative analysis is neither transparent nor repeatable. Yet the data does not "speak for itself" (Yin, 2012, page 15) and to make it accessible to the reader of the inquiry, the researcher codes it. The influence of the existing literature (chapter 2) was apparent

because the literature suggested some ideas the researcher could expect. This is explored further below. Each of the twenty stories, provided by the nurse participants, was read and, using a word processor, anything relating to career decisions was copied and pasted under a descriptive code. Hunter (2010) insists the participants' own words should be used as far as possible, so the codes were often lifted from a story. This meant the terms used for the codes were provided by a participant. During the analysis, the researcher had the opportunity to re-name them, which often involved choosing between different terms offered by different participants. The researcher also re-organised the codes to make a coherent account which would be accessible to the reader. The codes were terms best fitting what the participant was saying. When a novel idea was identified, a new code was created but, as the analysis progressed, existing codes could be added to. Each code arises first in one story and then is sought in the others (Berry, 2016). These codes were initial observations and were not erudite, but were a useful starting point for identifying influences upon career decisions.

Some examples may help illustrate the refining of the interpretive lens. Pay is much discussed in the career literature and it was expected to arise spontaneously in the stories and so no questions relating to pay were initially included in the prompts. However, few of the early participants even mentioned it, or did so rather dismissively. The researcher now had a choice. On the one hand, if pay was not important to nurses, she could just continue to ignore it, or she could specifically ask about it. She took the latter approach since pay is prominent in most career research. Further, different researchers draw different conclusions relating to the significance of pay to nurses, see Flinkman and Salantera (2015) as opposed to Meadows, Levenson, and Baeza (2000). This inquiry was therefore an opportunity to investigate what nurses themselves think about the influence of pay on career decisions. On the other hand, the early interviews showed relationships have a huge impact upon career decisions. The literature review only considered nurses' relationships with their clients, and these are indeed important to nurses. However, the participants in this inquiry spoke at length about the impact of their relationships with colleagues, especially nurse colleagues, on their career decisions. It was imperative the analysis reflect the significance of relationships to nurses, to do

justice to their stories. Therefore, the impact of relationships with colleagues on career decisions was specifically sought and coded in the stories. Similarly, the literature mostly discussed the retirement of nurses as a problem in terms of the nursing workforce, yet an early participant expressed exasperation that nurses themselves never discussed retirement. This alerted the researcher that it may not arise spontaneously, it was therefore added to the prompts to be sure to gain the nurses' perspective on this important career decision. On the other hand, the literature review (section 2.4.4) suggested post-registration education was an important feature of a nursing career and this was indeed prominent in the stories and was coded early in the analysis. These examples show how ideas from the literature helped the researcher to focus upon aspects of the stories whilst constantly refining the emerging narratives.

Smith (2012) advised against coding the data too early, which can distort it or allow some material to be lost. In this case, coding was commenced after the last interview had taken place, and by that time the researcher had some ideas from previous research and the stories and was seeking to formalise these into a coherent account. This meant by the time coding was commenced, the researcher and participants had already developed some emerging ideas, and the coding was a means of verifying these. One important advantage of electronic handling of the data is the codes can be repeatedly re-organised. This allowed a progression of the coding. Initially, codes simply reflected different aspects of the participants' stories. These codes could then be examined in the light of the literature review (chapter 2), allowing a more theoretical approach. This progressive refining added finesse and made the data more accessible to the reader. For example, as the analysis progressed it became apparent some different codes had been used but they related to a similar influence. When this happened the codes were merged. The existence of a code did not necessarily mean it would feature in the final discussion, merely that anything pertaining to it would be noted.

The codes started as a simple list. These were then grouped together because it was apparent different codes shared similar characteristics and these codes were grouped to form narratives. The

codes could be re-organised into different narratives and different means of presenting the data could be assessed. This was done on multiple occasions to render a coherent account of the influences on career decisions, but one that was still faithful to the participants' stories. A code could be a narrative in its own right, as happened with relationships, but more commonly they were merged with other codes to form a narrative. This is what happened in the case of pay (which was considered as part of the narrative on work-life balance) and retirement (which was considered with leaving nursing). Thus, the lens used to analyse the data, first established from the existing literature, was not fixed but refined with each additional story and continued to be refined throughout the analysis, as new ideas were examined and rejected or developed.

During this stage, the researcher was looking for anything coinciding with existing theories, expecting to use it as a framework to organise the codes into narratives. It was noted (section 2.5) that no single theory was utilised by the literature reviewed in chapter 2, so a wider exploration of the literature beyond nursing was conducted for a suitable theory. The most promising was Planned Happenstance (Mitchell, Levin, and Krumboltz, 1999), but the match was poor, with some of the Planned Happenstance themes (for instance, risk-taking) barely featuring in the data from this inquiry, whilst other codes and narratives which were important to these participants (for instance relationships) were not featured in Planned Happenstance. Therefore, a new structure of five narratives was devised. This novel structure was an early attempt at a new theory. It was based upon the participants' experiences and their telling of it, refined by the researcher. This new approach is presented in the remainder of this thesis. Chapter four presents the extracts from the stories contributing to the narratives and they are explored in chapter five. The stories are presented in appendix 4. Each narrative in chapter 4 commences with a chart showing all the codes forming the narrative.

Once the narratives were emerging, the transcripts of the educator and manager participants were examined. Anything that added to, embellished, explained, or provided examples for the putative

narratives was added. Thus, these transcripts were not treated as stories and the data yielded did not directly contribute to the formation of the narratives, but they did provide additional insights and their use acted as a source triangulation, verifying the emerging narratives.

3.6.3 Member checking

Hammersley (2006) acknowledged there is a danger of over-interpretation and extrapolation of the data provided by the participants, leading to an account which the participants cannot recognise. For this reason, Webster and Mertova (2007) recommended the participants should have the opportunity to confirm the verisimilitude, or truthfulness, of the analysis. In this inquiry, member checking (Jones, 2013; and Kim, 2016) was used to seek assurance of the trustworthiness of the data and analysis. These were opportunities to verify the accuracy of the data and the researcher's interpretation. The first of these was the research interview. During this, the researcher would check her understanding of the participants' stories and provide them with the opportunity to revise or embellish this. There were three further opportunities for shared reflexivity. These were when the participants each received their transcript; when they received their career story and when they were invited to participate in the survey. These are explored now.

Each transcript was emailed to the relevant participant and their comments invited. Three participants responded: one nurse participant wanted to clarify the facts about her career before she entered nursing. Another was concerned the details in the transcript were sufficient to cause a potential breach of confidentiality. Although no names had been included, the nature of her pioneering work was and could have been recognised, so these details were removed from quotes used, inserting [] in place of the details of her work. This prompted the researcher to ensure other quotes did not include similar potential breaches of confidentiality; two further transcripts were identified, and quotes used were edited to ensure this could not happen. The third participant volunteered details of a career move occurring after the interview.

This was followed, several months later, by the career story, which was sent to each nurse participant as it was ready. The career stories were concise and easy to share. The participants appeared to find them interesting, because this generated more responses (six) than the original transcripts, even though several months had lapsed before they received their career story. These comments meant the participants had the opportunity to reflect on a version of their story emphasising the process they had gone through when they made career decisions and what had influenced these. These written responses were mainly courteous expressions of good wishes, but they also reassured the researcher of the veracity of the career stories. For instance, one had expressed some disappointment she was not working in a clinical setting; this was reflected in her career story and she said, in her feedback, she still felt that way and was glad this was present in the data.

There were two versions of the survey, one for the nurses and one for the educators or managers. They were similar, because they concentrated upon the same issues, but the former was phrased to ask about their own career decisions, whilst that of the manager and educators asked them about career decisions in nursing generally. Thus, the nurse participants were asked to respond to the survey using their own careers as a frame of reference, whilst the manager / educator participants were asked to respond more broadly, using nurses they had worked with. The surveys were emailed to all the participants, with one follow-up reminder four months later. The time lapse between the two requests to complete the survey allowed for one participant - who was known to be on extended leave - to complete it on her return, which she did. The survey invited the participants to state the extent to which they agreed with each statement, using a five-point Likert-type scale. By asking them to respond to some initial ideas, the surveys provided the participants with the opportunity to contribute to the developing theory, and so were a form of investigator triangulation. The surveys also invited additional “free written” comments. Appendix 4 shows the questions from the surveys and the raw data. Some of the data from the surveys are also included in the result chapter (chapter 4). All the raw data from the surveys can be seen in appendix 4.

The surveys were the last opportunity for participants to contribute to the data and analysis. It yielded quantitative data which was used to derive some descriptive statistics and some qualitative data in the form of written comments. The written comments were added to the data for analysis. It was not possible to identify which participant (or their pseudonym) had written each comment, so they were referred to by the # numeral the software allocated. However, it was known whether these contributions arose from the nurse participants or the managers or educators, because they had responded to different surveys.

3.6.4 Writing the report

Reading is the final stage of Riessman's (1993) narrative analysis, when others encounter the written report, and the researcher could benefit from feedback. At the end of the analysis, this inquiry had several career stories and a series of coded extracts which had been grouped into narratives. This was not ready for most readers beyond the research team and needed to be presented in a manner allowing the reader to appreciate the overall pattern of influences on nurses' career decisions. It is noticeable, however, that Riessman (1993) omitted discussion of how the analysis is transformed into a written report, merely stating it could not include all the minutia. This is in sharp contrast to the care and detail she provided relating to the transcription of the interviews.

Other writers do suggest how to proceed. This stage of analysis has been likened to weaving (Saggar, 2018). Each story contributes one or more thread, and several threads are woven together to form a narrative and several narratives are woven into a new cloth. It was important each story was respected and made its unique contribution to the overall fabric. This contrasts with quantitative approaches, where the reader learns about the aggregate; narrative analysis depicts what it is like to be at different points in the bell-curve (Saggar, 2018). However, Saggar (2018) goes further and recommends storytelling. This is where the researcher constructs new stories to convey the ideas the research has generated. Whilst this is emphatically not the approach adopted in this inquiry, Saggar (2018) cautions this is precisely the approach adopted by the popular press, to persuade the readers

of the veracity of their interpretation. In this inquiry, the aim was to provide an account the participants would recognise (Riessman, 1993).

This thesis adopts the conventional academic style, and the writing is in the past tense. However, chapter 4 is mostly presented in the present tense, because that is how the stories were told. Additionally, the analysis and application to practise are discussed in the present tense because this has relevance now and in the future. The participants quotes were presented using standard notation to assist the reader, which is explained at the start of chapter 4. The writer refers to herself as “the researcher”, but she is occasionally named in the quotes. This piece of work is referred to as “this inquiry” to distinguish it from the many other pieces of research used.

Charts, tables, and diagrams are included throughout the thesis. They are presented with white and cream backgrounds to reduce contrast and make them more accessible. Each has a subtitle underneath and are labelled with a two-part numeral and a name. The first numeral indicates the chapter number and the second the sequential number. Charts in the appendices are labelled in a similar fashion but start with “ap”, to indicate this is in an appendix. The name indicates the purpose of the inclusion or how it relates to the text.

There is currently confusion as to how to refer to the person the nurse cares for; should they be referred to as the “patient”, “client”, or – less commonly – “service user”? Bonsall (2016) investigated the origin and history of the first two terms and explained “patient” suggests a passive person who is suffering, whereas “client” suggests an autonomous person who has sought help. The term “client” is, therefore, preferred by many modern scholars and has been adopted in this thesis. However, as Bonsall (2016) acknowledged, the term “patient” is mostly used in speech by healthcare professionals and, indeed, was the preferred term in most of the interviews. In the extracts used in this study, the words used by the participants have not been changed because it was important the participants’ own stories are heard and the direct quotes, as described in chapter 4, are verbatim and have not been “corrected” or modernised.

Another dilemma for the modern scholar is the correct use of pronouns. English does not have a gender-neutral, singular pronoun. Traditionally, writers must use he or she, thus denoting the gender of the individual being referred to, and often used the pronoun “he” because that was understood to refer to a male or female. Many writers are now uncomfortable with this convention because it could be seen as sexist (Oxford Dictionaries.com, 2018), and therefore use the pronoun “they”. Strictly speaking, this should be reserved for the plural, but it has become acceptable to use “they” as a gender-neutral “he” or “she” (Oxford Dictionaries.com 2018), and is the term used in this thesis.

3.7 Conclusion to methodology

This chapter has argued qualitative research is most suited to exploring career decisions from the deciders’ perspective and narrative inquiry was the most appropriate methodology to answer the research question. This is because narrative inquiries offer unique and practical insights into people's understanding of their world and the relationships in it. The contribution of the literature, the benefits of insider research and co-construction of knowledge have been explored and challenges considered, along with how to minimise these. The collection of data has been examined along with ethical issues and concerns relating to the welfare of the participants and researcher. This chapter went on to outline the complex process of exploring and analysing stories, and the challenges in presenting the data and analysis in such a way as to allow the reader to assess the trustworthiness of the research.

The next chapter presents the narratives found within the stories, using the participants’ words. Chapter 5 explores these narratives alongside references to the existing literature. The final chapter examines what this inquiry has revealed about career decisions in nursing and presents a graphic and tools – woven from the narratives told to the researcher.

Chapter 4: Results; narratives in the career stories

This chapter outlines the participants' details and then presents the data re-organised into narratives, with minimal commentary (as explained in chapter 3). The 20 complete career stories are available in appendix 4 and consist mainly of the participants' words verbatim. Appendix 4 also has the complete raw data from the online survey. The narratives arose in the career stories, supplemented by insights provided by the manager and educator participants, and the results of two online surveys. Each narrative opens with a brief introduction and a chart to show the codes contributing to the narrative. The charts are headed with the narrative in a green box. Most of the codes are in blue boxes. These are aspects nurses like and are likely to discourage career moves, or they are neutral about. Some codes are in red boxes and relate to codes nurses dislike and can trigger career moves. Some codes are in two colours to represent nurses reporting this code could be both positive and negative aspect of their career stories. Each narrative closes with a brief overview. The narratives are: relationships, job satisfaction, finding the right role, stress, and work-life balance. The narratives are of different length, for example the narrative of finding the right role is extensive, which reflects the question this inquiry seeks to answer. The following chapter (chapter 5) explores these narratives and places them in the wider context.

The narratives are presented mostly in the participants' own words. Using verbatim quotes can render an articulate, coherent discourse difficult to comprehend when in the written format (Kvale, 2006) so extracts used here were edited before insertion: most (but not all) of the non-verbal utterances, repetitions, and phrases such as *you know* or *kinda* (kind of) were removed to assist the reader, but grammatical errors, idioms, and jargon were retained with explanations - if required – in square brackets []. This is because a story is being told and using the vernacular is the most appropriate use of language (Kvale, 2006). Other symbols in the quotes are provided in table 4.1, below.

symbol	[]	()	…	-
meaning	material omitted to guard confidentiality Insertions to improve clarity	unintelligible	omitted for brevity	interruption

Table 4.1: Symbols used in quotes from the participants

Finally, most of the interjections of the researcher (Alison) were also omitted.

4.1 Participants

The participants are presented in alphabetical order to facilitate the reader in identifying participants mentioned in the text.

Nurses

Pseudonym	**Year of registration**	**Current post at the time of the interview** (known, certain job moves are indicated with an arrow, ⇒)	**Gender**	**Approximate current age**
Alice X	2008	Aircraft cabin crew	Female	40s
Amber X	1989	Senior lecturer (science)	Female	40s
Daisy N	1993	Clinical nurse specialist (band 8a)	Female	40s
Danni N	1991	Practice nurse	Female	40s
Dee N	2005	Research nurse band 6 ⇒ Nurse practitioner	Female	30s
Faye N	1991	Clinical nurse specialist (band 8)	Female	40s
Felicity N	1982	Clinical nurse specialist (band 8a)	Female	50s
Florence N	1988	Preceptorship coordinator	Female	50s
Gem N	2000	Senior sister, intervention radiology	Female	40s

Jack N	1994	Senior charge nurse (band 7)	Male	40s
Josh N	2010	Clinical nurse specialist (band 7)	Male	30s
Margaret N	1991	Researcher, community nursing	Female	40s
Mark X	2008	Ambulance service - planner	Male	30s
Mary N	2005	Ward manager	Female	50s
Melody N	2007	Clinical nurse specialist band 7	Female	40s
Paula N	1989	Senior executive nurse	Female	40s
Pitchie N	2001	Charge nurse	Male	40s
Rosie N	2008	Research nurse, commercial sector	Female	40s
Tanya N	2005	Quality assurance and compliance nurse	Female	40s
Trudy X	1989	Social worker	Female	40s

Educators

Jess E	1982	Senior lecturer, adult nursing	Female	50s
Sadie E	1976	Professor of nursing	Female	60s
William E	1988	Associate dean for education	Male	40s

Managers

John M	2000	Matron, acute medicine ⇒ Assoc. director of nursing	Male	30s
Sarah M	2000	Lead nurse, workforce development & quality	Female	30s
Laurie M	1982	Nurse consultant, pharmaceutical suppliers	Female	50s

Table 4.2: Participant details

Sixteen (80%) of the twenty nurse participants were women and four (20%) were men. This is a higher proportion of men compared to the NMC figures, which states 11.4% of nurses identify themselves as men (Nursing and Midwifery Council, 2018b). Of the twenty nurse participants, sixteen (80%) were still working as RNs, and so were all the managers and educators. As explained in the method (chapter 3), nurse participants had obtained their registration between five and twenty-five years ago. This is reflected in the ages of the nurse participants, who ranged from their 30s to nearly retirement age.

4.2 The narrative of relationships

All participants discussed relationships at work and eighteen of the twenty nurse participants (90%) talked about influences of relationships on their career decisions. The exceptions were Josh N and Mark X, who mostly talked about how the technical aspects of their work influenced their career decisions.

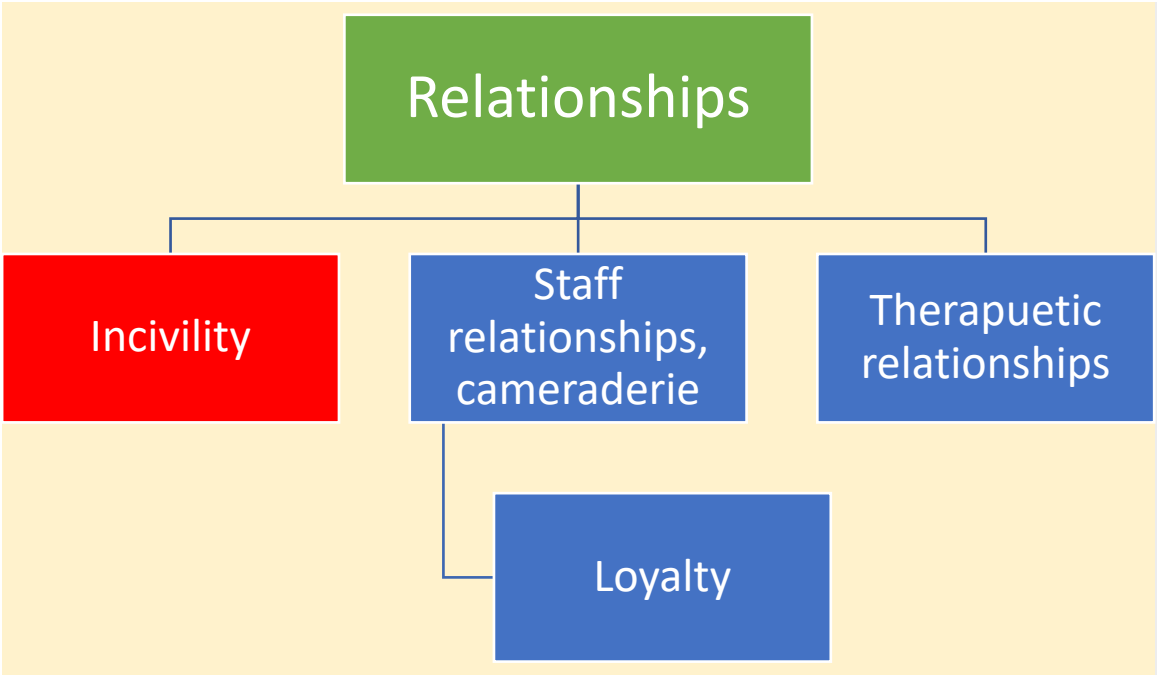

Table 4.3: The narrative of relationships

The most frequently discussed relationships were with colleagues, especially nurse colleagues. Good relationships within the team will compensate when other aspects of the work are difficult:

> ***Faye N**: The fact that you're with a good team, with a good leader and with the two consultants that I very much respect…. So even if you've had a rubbish day with patients or whatever being difficult, if you've got a nice team, then that's okay.*
>
> ***Alice X:** that was a nice environment, I worked with really nice people, it was challenging, but yes, I really enjoyed [it]*

Relationships with staff and loyalty to the team are some of the most rewarding aspects of nursing and frequently discourage career moves.

> ***Gem N****; I'm staying in this department because of the relationship that we have with the multidisciplinary team. So, we get along well with our doctors and with the radiographers, and my nurses are excellent, I should say. They're very supportive and we work as a team. So, even though it's a very stressful environment, I think that's one of the reasons why I stayed in this department… But then I don't want to leave my - that's another thing, the reason why I couldn't leave, I didn't want to leave my nurses in the lurch.*
>
> ***Jack N****: I think I'd feel I was leaving, letting down my team; who would take them on? … Because a lot only stay here because of the support and the camaraderie of the team. Because they could all go to get the same money, on a much easier ward than what we've got here… And then once a year, what we sometimes do as a team, we all used to go away, so the band 6's, myself, the families, and then we'd all hire 3 or 4 caravans…. they bring their husbands, their children. Last year we had 3 caravan fulls. Have a barbeque. And they used to do it around about my birthday.*
>
> ***Nurse respondent #5****: My team is what keeps me in the role. If I go on secondment, feel guilty for leaving them. But the fact been on same ward / role for past 17 years; without the team job satisfaction, be very different.*

Mary N left a supportive environment, but soon regretted it and applied to return to her original ward:

> ***Mary N****: because the patients become ill, that fast, it was so fast paced! You know, everybody was - they're there for you really…: the ward's always been like that… I knew, the first week that I got there* [her new job], *I thought 'Mm, this isn't for me.' I mean, because the staff on [], they were, they were like friends and I'd know them when I was a student, even my mentors that were here. They were like friends!*

Daisy N's first post was with the same health trust she trained with, and she has been there ever since. She was almost lost for words as she described how she felt about her team:

> ***Daisy N****: I've found it very welcoming and - I didn't ever want to work anywhere else, I just found the community here to be such a nice community. That was the team - it was - it was most – oh, it was lovely!*

Nurses describe seeking work where they believe there are good relationships to be enjoyed. For example, Amber X describes making a difficult decision between two posts. One was more

prestigious and had the added advantage of being close to her home, yet she opted for the second post, in London, because she met and liked one of her prospective colleagues:

> ***Amber X****: it actually made me ill, trying to make the decision, because they were both amazing opportunities, one post was more prestigious and also nearer home but then I met her and just, I don't know, (sighs) I went with my heart! I went with my heart, we just clicked and, yeah, it just felt right, but my head was telling me that I should have taken the position in []; it would have been much better for my career, academically, because at the end of the three years I would have ended up with papers - it was very research-based. It would have been 20 minutes from my house. I wouldn't have had to travel up and down to London.*

If good relationships are absent, they are sorely missed.

> ***Alice X****; but bank nursing wasn't helping me feel part of the unit, and that's when I enjoyed nursing, when I was part of the unit. Actually, you know, it's staff that make it. Well, I suppose you pull together, and you have a team here, kind of friends - I didn't know where I was going in nursing.*
>
> ***Rosie N****: In the NHS nobody is friendly; not because they're not friendly in nature, but they're so under pressure not to help you... I just was determined to just look for* [other] *work*

Alice X's inability to form good relationships with colleagues was a major contributor to her decision to leave nursing, which she is now regretting (see section 4.4).

In view of the importance of relationships to the participants, this was investigated in the survey, which shows the near unanimous agreement of the value nurses place on relationships with colleagues at work.

	"Nurses value relationships with colleagues"	
	Nurses	Managers / educators
strongly agree	7 (58%)	2 (40%)
agree	4 (25%)	3 (60%)
neither agree nor disagree	1 (8%)	0
disagree	0	0
strongly disagree	0	0

Table 4.4 Survey: the influence of relationships with colleagues

Nearly as important are relationships with clients and their families. These often attracted them into nursing in the first place and remain a source of satisfaction:

> ***Paula N****: I was always interested in people's lives and where they came from and where they're going back to. I always spent far too long with patients; always got told off for spending far too long with patients!*
>
> ***Amber X****: it felt a privilege, actually, to be a nurse, and I have always felt that. And to be present at moments in people's lives in terms of distress, but happiness, joy, the whole remit, it's always just been a pleasure, and I have loved every single bit of it.*
>
> ***Felicity N****: I don't want to be a not very good doctor (Alison laughs) that might be unfair, but I want to be a really good nurse. And I think we've got really good doctors in our service, so I don't need to start trying to compete with them, because I think I'm offering something else… and I don't know if that's a nursing skill but I think that's my skill, talking to patients in a way that they understand and giving them the freedom to actually ask questions and feel comfortable asking questions.*
>
> ***Pitchie N****: it's a career which is so rewarding and so satisfactory and you're actually helping other people to gain back their life. It's so amazing actually!*
>
> ***Margaret N:*** *I met some nice people, nice patients, nice staff,*

> ***Dee N****: They send me pictures of their grandsons, and yes, we have got a very good relationship, because I see them so often. I mean the nice thing about research is that we can spend two or three hours with your patients and not feel guilty, you can actually spend time with your patients, yes, they come away saying you know, "you are really lovely", you know, it's just that we have luxury of being able to spend time and actually give them the care.*

Florence N has established a role as a self-employed foot health practitioner and has worked hard at this role for over a year, not knowing whether it was going to be a commercial success. The aspect of the work helping her to persevere is her relationships with her clients:

> ***Florence N****: I love it - I've got my regulars, who I sort of see and catch up about, their holidays, what they're doing with their families and all this kind of stuff, and then you meet new people, and you find out all about. I mean, I love meeting new people.*

Melody N knew her clients relied upon her and had struggled into work when not well, but a job change eventually meant closing these relationships:

> ***Melody N****: it was just heart-breaking, I had one clinic for patients, they come in every week, and you get to know them, you really bond with them and some of them cried, it was, even now, I am just - it was the thank-you cards; the presents; it was just – overwhelming!*

So far, the discussion about relationships has been positive (even when it comes to closing them). However, there is a darker side of relationships for nurses, when there is incivility present, which Paula N and Florence N both identify as bullying. This can lead to a devastating loss of confidence:

> ***Florence N****: So, then I went to another London trust, and unfortunately, although it was a really good job, I was managed by the general manager - a complete bully. And she made my life absolute hell. I hated it… I thought, I've gotta get out of this place, you know. Because it really eroded my confidence in a dreadful, dreadful way. It was absolutely awful; I can't tell you. And so this was an opportunity that came up that got me out of the situation. It's like fighting your way out of a paper bag!*

> ***Paula N**: Well until I got bullied and then you don't know you're being bullied - that's the problem and then it's much more difficult to move because then your confidence is completely knocked… And it's only later on when you reflect years later that you just think "Oh how on earth did you ever, how did you ever find yourself in that position?" but, you know, everybody does… You don't know you're being bullied…I left because, yeah, I left for personal preservation reasons, and it was the best decision because then I came to the []. So again, I probably would never have left health visiting because I loved the job had it not been for that manager, so I've got her to thank in one bizarre respect… 'cos I've had my fingers burnt with that bullying, I just used to move.*

Tanya N experienced a different sort of unhappy relationship when a peer made a serious allegation against her. The effect was catastrophic:

> ***Tanya N**: Some people have got a passion to love but with her, in summary, she's got a passion to hurt which is very sad, very sad. Because what then happened was they just plotted something with her patient. They told the patient what to say about me, so a lie was created and that lie, instead of it being managed properly, it was mismanaged. Every corner, the wrong thing got to be believed, and it got to be believed to the extent that what I thought was a joke tended to be a nightmare. It costed me a lot, meaning my mental status, my well-being, my ch*[ldren] - *everything, because it got to the point where I didn't even know what it was all about… But what I didn't know was this was a well-framed plotted thing. It only came out to surface three years down the line. [Alison: gosh] Investigation upon investigations, I went through a disciplinary process, I went through a nightmare, until it was so bad that you start to have dark thoughts in your mind, because you're thinking, why is this happening? Well, it didn't make sense. Why? What was happening? Then I had a breakdown, so I collapsed, I lost my hair. I never used to wear this. [Alison: Is that a wig?] It's a wig, I never used to wear a wig. I lost all my - It's like my hair just fell!*

4.2.1 Overview of the narrative of relationships

This section has shown relationships at work are of huge importance to nurses. Friendships with colleagues, especially other nurses, are a source of pleasure. They enjoy the camaraderie of teamwork which leads to feelings of loyalty. Friendships within the team discourage career moves because nurses are reluctant to break these ties.

Nurses derive much satisfaction and enjoyment from therapeutic relationships with clients, which can sometimes extend to friendship. They worry that a job change will involve them leaving their clients, some of whom have come to rely on them.

On the other hand, uncivil relationships, or bullying, can be devastating for the victim. The three accounts here only resolved with the recipient making a career move.

4.3 The narrative of job satisfaction

This section examines aspects of nursing contributing to satisfaction at work and some detracting from that. This is an important part of the answer to the research question and is a longer section.

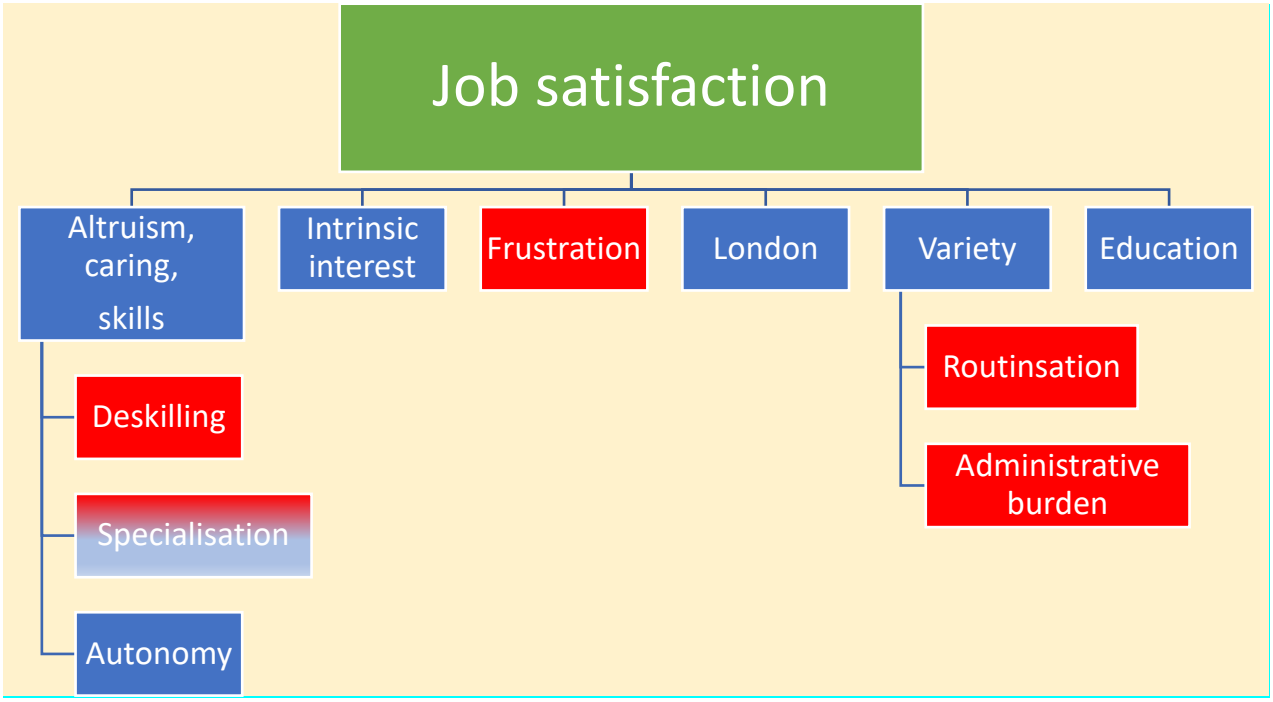

Table 4.5: The narrative of job satisfaction

Nurses often enter the profession with altruistic ambitions and seeking to do something worthwhile. For many this is satisfied:

> ***Jack N**: Wanted to care, wanted to do something that was worthwhile, rewarding... to make a difference to somebody.*

> ***Rosie N**: I had worked previously as a support worker for nurses and health visitors. I began to know a lot more about their role and I felt it was quite a responsible role that was recognised and had quite a good contribution to society and also quite respectable; I worked with health visitors, so what they did was very worthy and worthwhile protecting children, and I felt I had the skills to do it.*

***William E**: If you want to make a difference to people and you want to make a real difference, but not be in the spotlight for doing so, I think nursing is wonderful... some will see it as an anonymous way of making a contribution to people, without having to take centre-stage.*

***Dee N**: It sounds really corny but knowing that I am going to be able to help and make a positive impact, and it sounds really cheesy, but if I am just coming to work ticking boxes and that doesn't give me any job satisfaction at all - because I have done something to help that process - that's what makes me happy in my job.*

***Pitchie N**: He'll tell you, 'Thank you, nurse, I never knew I was going to walk but I'm walking'! So, I'm helping people, you are seeing the results and the people are really happy. Their lifestyles change, they're back again to their independence. So!*

***Faye N:** I like to work hard, and I like to feel I'm giving something back and doing a good job and I know that it sounds really bleurgh, but that's what I need to do.*

However, altruism did not drive any of the career decisions discussed. Instead, nurses have other aspects of their work they like. The first to be reviewed is work that is intrinsically interesting:

***Mark X**: It looked really interesting, and I kinda wanted to do the role of [] was focussed on the kind of preparedness, resilience kind of thing,*

***Jack N**: We were doing some chemotherapies to patients there, and then thought "I want to look more into this". So then ended up - eventually getting a job on the bone-marrow transplant unit here.*

***Josh N**: What motivates me? Well Alison, it's the challenge - for every case, a different case - you have to face every day, because some of them it will be just be easy to talk, but some of them will be a little bit tricky, you know, they will not answer you directly (laughs), so you have to work around it. And sometimes they would not right away believe your explanation, so you have to be really evidence based, know what you are talking about.*

***Danni N**: I've met an awful lot of people with COPD* [chronic obstructive pulmonary disease, once referred to as chronic bronchitis]… *but at least I have some understanding of what COPD is; the difficulty. I am seeing the other end of the spectrum, aren't I, of COPD management now, the last ditch, we'll ventilate, we*

don't really want to but we will because it will save this person's life, all the way back to first diagnosis and the initial management

***Faye N**: Then I got a job there, on my last ward which was colorectal surgical unit that I **really** loved.... I loved my gastro-nursing, colorectal surgical nursing and… I did some research with patients who had pouches.*

Learning how to care for people and using clinical skills is what attracted some into nursing in the first instance and remains important. Jack N moved jobs to where clinical care was required:

***Jack N**: But because - to go for your bone marrow transplant then you* [the clients] *had to be quite fit and well, there wasn't much hands-on care. And it was getting right back to – 'cos the population was generally older - getting back to what I love doing, which was the hands on, physical care.*

Faye N had always aspired to be a children's nurse and moved to London to take a "conversion course" for adult nurse to child nurse:

***Faye N**: within two months I realised I absolutely hated it - stuck it out for nine months; passed every assessment but thought "this isn't for me" and decided to leave, because parents look after children in hospital, which is quite right, so you weren't actually able to do much as a nurse really (Alison: So what were you doing if you weren't nursing?) well you would - giving medication; taking observations. But you weren't doing, you weren't involved in the way you are in adult nursing.*

The high value nurses attach to clinical skills means if the clients are not sick enough to require much hands-on care, nurses can become disillusioned.

***Rosie N**: so, you're dealing with healthy volunteers. I even hated it more because they were just all healthy (laughs)! We were just doing procedures.*

As they progress in their careers nurses often gain increasingly specific skills.

***Faye N:** And I thought "I'm at the point now where I do want to specialize in something" but I didn't want to be a stoma nurse, and I didn't want to be a ward manager because I am not into meetings and things... And I thought "Yeah, I like this, I can do this, I kinda like this, it's gut stuff which I love"!*

However, some nurses believe gaining specialist skills can limit career options:

> ***Daisy N:*** *I think when you do get to a certain level in [] - that's where you are. The only other things you can do is to go into more of the protocol side and that - I'm already in that slightly - I don't see it as an avenue of being someone that wants to work up to being a senior nurse - deputy head of nursing for a trust, that sort of thing.*

Gem N works in the small field of interventional radiology, which is using imaging such as x-rays to guide treatments. She contrasts this with cardiology, which is bigger and so may offer enhanced career opportunities:

> ***Gem N****: I always thought you have more option of transferring somewhere else if you're cardiac trained. Because there's nothing in interventional radiology unless you become a matron. There's just no CNS* [clinical nurse specialists]*, there's nothing else. So, unless you transfer to another hospital as another senior sister, then the only way up, is a matrons' post… I think, if I'd stayed in cardiac, it's easier for me to find another job. But since I haven't been doing cardiac for a long time now, then it's hard for me to transfer to a cardiac setting again… There's not many people who know what radiology is, or what we do here for example. But it seems as if everybody knows what cardiology does!*

Some of the nurse participants chose work based on their skills. In the extract below, Josh N describes looking to move on from his ward, which cared for patients with neurological conditions. This had piqued his interest in nursing clients with gastro-intestinal disorders, yet he appeared to need reassurance the putative post was still appropriate.

> ***Josh N****: it caught my attention because these patients often experienced gastro-intestinal disturbance - I was able to decide "Oh I think the job is little bit - it's interesting"... I was also* [reassured] *by one of my colleagues that, "don't worry if you don't know everything about gastroenterology because I know you are coming from neurology; there will be studies to be done, there will be trainings to be done, so - the only thing that we want to see if you have the character, and if you have the responsibility that you can take on the job"*

Other nurses are surprised but pleased to find the skills they have developed in one area are applicable to another clinical specialism:

> ***Jack N**: They* [nurses newly allocated to his ward] *all think "Oh it's Oncology, oh my God it's gonna be –" (Alison: They'll be frightened). And by the end of it's like, it's general… yes we are a speciality, but management of pain, management of nausea it's all transferable to any other area. You go in the community, it's transferable!*
>
> ***Felicity N**:* [The job on an oncology ward] *wasn't actually a job I particularly wanted to be doing - but I loved it! It just drew on everything I'd ever done; it drew on my school nursing, you know I felt comfortable talking to kids, about their sexuality because I'd done sex education in schools… I'd done sixth form focus groups with young boys and girls about what they wanted from sex education, and I felt quite comfortable; and I had teenage children. I bring to this job my adult nursing experience, my time in the community because I absolutely recognise the value of engaging with GPs, practise nurses… so I think I bring that experience to the work that I'm doing now.*
>
> ***Florence N**: I said to her "you need to phone these people up, and say… 'I'm interested in doing this, I don't have community skills, but can I come and talk to you?'" You know, and I said "and you really need to focus on just transferable skills that you've got, not what you haven't got" (both laugh). So anyway, so I'm pleased about that, I think she's going in September -.*
>
> ***Danni N**: I do really like the way practice nursing is helping me to pull together all of the experience that I have got previously; plus, I am being offered the chance to develop my role in whichever way I choose to go.*

Nurses particularly like being able to carry out specific clinical procedures and may even overestimate their importance:

> ***John M**: but they're obsessed with doing things like taking blood gases and that. You know that's the first question: "Could we start doing blood gases?". I was like "When you start giving proper care to patients, and I know that patients are being looked after properly, I'll consider it. But until that point, no, no". They want such an extended role, they want to do all the fancy stuff and - that's fair enough, we shouldn't discourage it, but actually I don't want them going around doing 10 blood gases, and then ignoring a patient needs the toilet. And that's the difference!*

Some nurses regret moving away from clinical care:

> ***Mark X***: *I think, in hindsight, if I did it again, I would be tempted to spend some more time clinically…*
>
> ***Florence N***: *I really wish I'd have kind of – although I've enjoyed what I have done, and I have really enjoyed the management side of things... I feel very de-skilled, and I wish I'd have kept more of a clinical focus.*

Other nurses remain in clinical care yet fear becoming de-skilled, which is losing the much-valued set of skills, through lack of use. Mary N moved from her training hospital to work with older men within the charitable sector, but was disappointed with an apparent lack of skills required to do the job.

> ***Mary N***: *You know there's a lot of lovely men there. And they had lots of good stories to tell… But, when I got there it wasn't what I thought it was going to be! It was more like a nursing home type of environment. Because I thought it was gonna be medical admissions; so if they were ill, they would come to this ward… but what I didn't know, they couldn't do the I.V.* [intravenous] *antibiotics there, they would have to go to []. So even, sort of to give in IV's and, things like that…. And I thought "this is no good cos I'm gonna lose all those skills" that I learnt when I was here, So, I applied for my job back on here.*

Trudy X left nursing partly for this reason:

> ***Trudy X***: *When I worked in* [London], *I was pivotal in introducing a new treatment for leg ulcer management and trained over 20 nurses in using a Doppler to improve assessments. I also arranged training sessions for local GPs. When I moved to [] I worked part time on a lower grade and even though I had the experience, I was not permitted to assess patients, support with leg ulcer management. This increased my frustration towards nursing… I think I would have given up nursing anyway. I, like many of my generation, look back at the "good old days" of nursing when nurses nursed and cared for patients.*

Nurses like the autonomy to employ their skills and work largely independently to meet clients' needs in the way they consider best:

> ***Daisy N***: *I'm an independent practitioner, I provide a good level of care to the women that attend and see me... you know, I'm a key worker for a lot of women…*

I do like runnin' my own service and knowing that that is - before I took it on - it was always a doctor's role.

***Felicity N**: I think that the clinical nurse specialist roles allow people like me to work at an expert level - but using that expertise at a more clinical level perhaps - I mean I work with a medical team, but feel like an equal within that team, I'm treated as an equal within the medical team, I feel quite well respected by the medical team, I think I've got something to offer the service and I think nurses can.*

***Melody N**: I really enjoy what I am doing, yes, I think working autonomously - So, you really have to think and that is a big responsibility, but I find that very good, actually, it makes me feel you know you always want to, really want learn more and you want to develop yourself, you don't just sit, it challenges you, yes that is it, It really challenges you.*

They will seek work with enhanced autonomy. This is what Dee N was looking forward to and Mark X hesitated over:

***Dee N:** I'm over the moon. it's completely clinical and it is autonomous - lots of challenges and huge learning that I am going to be undertaking which also motivates me.*

***Mark X**: I work quite closely with all of our directors and our chief exec, and I'm not sure that I want - if you had asked me a year ago I would have said there (Alison: that's where you were going, you were going up the hierarchy?) yeah, but I look at what they do, and they don't have any more influence to change things, they just have an influence on different things.*

However, the nurses fulfilling specialist roles can be rather isolated and may form their own support network, as Felicity N describes:

***Felicity N**: This morning I was meeting with a group of reasonably newly appointed* [] *nurses, we have a sort of supervision - it's an informal group but they can bring to that group any clinical issues that they'd like advice about. I guess it's a bit like clinical supervision.*

The clinical nurse specialist (CNS) posts (termed community matron in the community) are perceived as a job offering the opportunity to deliver highly skilled clinical care and offering a lot of autonomy. Felicity N had carved out such role for herself:

> ***Felicity N:*** *'cos although our children come out of their treatment with chronic long term health problems so they don't fit nicely with any particular service, but they do have chronic health problems… I pursued the idea that we should have some sort of transitional service. So, I took a business case to our senior nursing group and said I want to set up a nurse led-transition clinic where the focus is on patient education, health education, healthy lifestyle, and preparing these young people for life in adult health care.*

Frustration is widely reported in this inquiry and caused some job changes. Dee N described why others left their jobs and she herself was leaving research for a post as a nurse practitioner.

> ***Dee N:*** *Lots of the time I am a glorified secretary…. It's not very satisfying because you don't get ownership of anything. I think that's why there is quite high turnover with research nurses here, because we are not used to our full capabilities. Which is a shame! I will be working on various studies and then I'll go into work the next day and I'll have a week's notice to say that I am being moved off from my cardiovascular studies and into diabetes. Diabetes I know very little about, I really had to do my reading about chronic kidney disease and different stages, and yes I find that very difficult because again the sense of ownership of your studies and being able to talk people through the protocols and the patient information sheet is completely gone out of the window really, and it doesn't feel great when you are talking to patient and they ask you a question and you can't answer it, yes I have never worked in diabetes and I have to say to them that "I will answer that question for you, but I just need to go and ask my colleague" and it just doesn't make you feel particularly good at your job when you are having to say "no, sorry, I don't know".*

Others have been frustrated at the apparent impossibility of nurses changing things:

> *Alison: so why didn't you stay in nursing?* ***Mark X****: um (long pause) I think, getting towards the end of my nursing degree I was really enjoying the clinical placement fine, but finding it really frustrating, I think, I don't know, I guess I have always had an eye on the wider politics, and the finance. So, seeing some of the things that*

were going on round the care that you were giving on the ward and elsewhere was just really frustrating sometimes.

Nurses are proud of their skills, knowledge, and insights. They may use them (or plan to do so) after they leave nursing or even after retirement:

***Alice X**: I will tell you another thing; people get sick, quite a lot, in the air. You know what, I mean fainting - I am really good at fainting, what you know from nursing, but you know your first aid - your first aid is really good.*

***Mark X**: what was really nice in that it* [his job outside of nursing] *still gave me some clinical insight and I think I have found that all the way through… It is that clinical insight and being able to kinda understand, then influence from a clinical perspective as well from a management perspective (Alison: mmm) has been really useful.*

***Rosie N:** When I don't have the responsibility of children and families, I would like to do more charity work in developing countries. 'Cos I'm originally from developing country. So, I would like to do that. I'd like to go back to a situation where I'm really looking after people who sort of - like my services will be quite essential. And would make a real difference… I thought, that is my sort of my ideal work. (Alison: Yes, do you think you will?) I think so, I'd still like to do that. Yeah, that would be absolutely amazing!*

***Tanya N:** When I retire, I'm not going to be a sitting at home person, not me! Because I do have some time, I believe I will do it as long as I focus and I put my thoughts into it, I'll do it. There's some projects I do want to get involved in, back home, I want something that will stay, I would love to be involved in the health of women, part of having women in gynae because in the African culture there are still a lot of beliefs where people use potentially dangerous products for their well-being.*

***Paula N**: me and* [my husband] *dream every now and again about - oh, wouldn't it be brilliant if we could retire but then I immediately think about all the NGO* [non-governmental organisation, or charity] *stuff I could do! (Alison: So, it's not going to be retirement?) No, because I would go and do NGO work, because the amount of stuff that can be done in [] is huge, so it would just be changing places. I might retire from a job, but then I'd have freedom. Aw, I can't wait, it would be amazing. So, I've already got potential, potential things I can do.*

This was investigated in the online survey, with rather mixed results:

	"Nurses who have left nursing often continue to use their nursing skills"	
	Nurses	Managers / educators
strongly agree	2 (17%)	0
Agree	5 (42%)	3 (60%)
neither agree nor disagree	3 (25%)	1 (20%)
Disagree	2 (17%)	0
strongly disagree	0	1 (20%)

Table 4.6: Survey: use of nursing skills after leaving the profession.

Nurses like caring for people and this leads to feelings of respect and loyalty to the NHS, where this care is usually delivered. This means they sometimes have a sense of obligation to the NHS:

> ***Alice X****: I quite used to feel guilty when I first left as I thought: I was trained so I should be giving these skills. Sometimes you hear about the nurses in NHS hospitals, and bringing them in from other countries.*
>
> ***Margaret N****: I've since seen... who as soon as they've got that master's degree they are out of the NHS, teaching, and I do always say to myself "well I am glad that wasn't me"… I am glad that I've, you know, done my God knows how many years in the NHS!*

They are wary of working in the commercial sector:

> ***Laurie M****: I think there is a stigma, still this perception of private companies, commercial companies, are all working in competition to destabilise NHS services and there's this perception that if you work for a commercial company as a nurse, you must have to cut corners; you must have to put profit before patients etcetera, etcetera, all of which are incorrect.*

This inquiry is based in London. The participants report they liked working in London teaching hospitals because the variety of clinical specialisms, social mix, and up-to-date practices make it especially challenging:

> ***Danni N:*** *because all the really exciting stuff getting shipped to London.*
>
> ***Paula N:*** *I* [left London and] *went back once, I said I was never going to go back. Don't ever go back, but actually what it did for me was to cement why I was in London in the first place because* [] *are about 20 years behind, and I was told categorically by my manager that over her cold wet dead body were they ever going to have nurse consultants in* [] *and I said, 'Goodbye' so I came back. And they just weren't listening and I think I was ten years ahead of them. It wasn't they were ten years behind everybody else, but I was ten years ahead of them thinking-wise. And I didn't fit, because nobody understood what I was talking about. I was talking about population in health and public health and they didn't get it. They still don't get it!*
>
> ***Jess E****: I think mainly London's a great place to study and to train as a nurse because, if you train here, you can nurse anywhere really. (Alison: is that still true?) I think so. I think it's very different. We still get quite a few staff nurses in my clinical link area, that have come from perhaps more rural areas. And they do say that it's a bit of a culture shock coming to work* [here] *but also, especially for younger people, I mean London's a great place to be isn't it? And I mean, I do think there, there's a lot to be said for reputation.*
>
> ***Jack N****: But then I think you work in London, you should, you've got most of the opportunities here*

Participants report London offers chances of rapid promotion, although some were uneasy about this.

> ***John M****: I think London is unusual in the fact that promotion's quicker. The chance to do other jobs is much quicker. Where I grew up in [], the ward managers had been ward managers for years… one of my friend's parents who had been in that job since - I can remember! And now I see some of my friends* [I trained with], *or people that I've know from that hospital, are still band 5's* [but] *I'm about to become associate director of nursing!*
>
> ***Nurse respondent #5:*** *London is now full of many nurses climbing up the career ladder with limited experience but in senior positions. CNS nurse now is not like*

we're a very experienced nurse who has done their time on the ward and doing shifts; these days is seems anyone can apply!

***Jack N**: And I think a lot of CNSs get their roles now far too early. And now they're quite junior who get in them. And I just think "What, you've got a band 7 as a CNS, you've never even looked after that group of patients?". Somebody who's got a post recently has got no experience, has got a band 7 CNS… I think there's too many people getting them they're giving them out, and then that sort of then devalues those CNS's, like our uro-oncology CNS, who's been doing it for donkey's years who, what she doesn't know you write on a post-it note!... But these people think they can do that role. And they haven't got a patch on them, this girl, she's a friend but, you know she's been a band 5 on the ward, went to the community, didn't like that, come back, got a band 6 research nurse post. Has done that for about 18 months, she got a band 7. I just think it's ridiculous that they're putting people into these things. But then you think "Oh she was the only applicant, so –".*

Even the nurse themselves may not benefit from this rapid promotion:

***John M**: another one of our team leaders has gone to do a specialist role, which is traditionally a band 7, but other foundation trusts will give you a higher grade. Because all you're getting is a higher grade for doing a band 7 job, so you're not getting any of the experience when you want to go up… apparently, he is stuck in this job now, and he can't really get out. But I advised him against it. But I suppose the lure of money's too great, and you know. If you're 8 years out of University, and you're being offered an 8A post – .*

Another aspect of their work nurses like is variety:

***Mark X**: Really varied, really rewarding and I think because I have got a fairly project-based role, and because I have done lots of different things over the last five years, I am quite lucky in that they are all - you know they are quite happy to set me up with a new challenge, and say "we want you to look at this for the next year, and then we are going to pull you out and get you to look at something else".*

***Mary N**: But it's a good, there's a lot of new thing, like there's variety, when you're doing the management stuff and then you're looking after your patient, and I enjoy it, when I get a day when I do have to look after the patients and I don't think about that management stuff. So, I can have the best of both worlds really.*

> ***Paula N****: because I'm like, is it a magpie? I just go, "Oh that looks really good, oh can I do that now, oh that looks good!"*

Some participants describe moving jobs even when there was nothing wrong, but just to have a change:

> ***Paula N****: If you looked at my CV, I have never done a job for longer than two years at a time in the whole 20 odd years, no never, because I just can't be doing with it, And I don't think about what I'm leaving be'ind, I could leave stuff behind, I don't care, I'll just go and do it. So, that eight years was the most tied ever!*
>
> ***Margaret N****: I just said to my agency "ah, have you got anything different?" and they said "we've got a line of work in the community" and I said "fine, I'll take it!"*

Other nurses worry that, in the future, they may find their present job becoming boring and routine:

> ***Florence N****: I think I'm getting to stage where I've kind of been there, done that, seen it. And I'm probably looking for, if I'm completely honest looking for more of a challenge, now - I can do it fairly easily.*
>
> ***Pitchie N****: I do think about the future, not being stuck in one place. Probably at some point I might get fed up with this and say I've managed so much; the same thing has become a routine. Decisions that I make now I don't really () to make because it's same things I've been doing for years.*

One way of resolving this would be to offer rotations into different areas:

> ***Nurse respondent #12:*** *early career decisions would be easier for those with a clear vision of what they want, however I still believe that a rotational programme for newly qualified nurses can help in deciding early career decisions as they spend time in different specialities i.e. 3-6 months*
>
> ***John M****: We've done a lot to try and engage with nurses. We try a rotation - that's not easy - and actually, realistically, people don't want to finish it when they do it. That's what's very strange. Because they change their mind on where they wanna go for their second placements. So, they'd love the idea of working on a ward, and then going to A and E* [accident and emergency department, now often referred to as emergency department, ED], *But when they get up to there, they're like "Well actually I don't know if I really want to go to A and E". Or they suddenly think of, "perhaps I would rather do ICU {intensive care unit]". So, I think, traditionally it's*

not out as well as we'd hoped, it's quite hard to enforce. You can't make someone leave, if they're happy where they are, why would you wanna move them? And obviously the ward manager don't wanna lose them if they're happy, they fit into the team. So, it is a very difficult thing to do. So, we are trying to do, actually, like personal rotations, so they come to us, if they wanna move, and we'll find them somewhere to go. Which seems to be better. And that's working easier, so not having to go through the entire process, but you know, "I wanna work in A and E", "Ok, give me 10 minutes, yeah, give me a couple of weeks and I'll find an A and E that will take you".

The lack of variety is even more serious if their work is dominated by a high degree of regulation and an administrative burden. This can be accompanied by a dissatisfaction with management.

***Jack N**: And more audits, and you've got to justify things, and what the government, there's lots of tick box exercises. You know, you can be judged, not on the care you provide but, have you produced the right piece of paper? And I think really? And it's quite frustrating sometimes, and if, you know, that's not picked up on, but there might be a compliment on excellent care that's been provided, that doesn't matter, 'cos that's not a tick!*

***Faye N**: I think it's so much more complicated now, and I wish it wasn't quite so complicated to do a good job and get caught up in auditing and all the stuff I hate, because I'm not very good at it and it scares me.*

***Paula N:** Now, if I was a deputy director of nursing, but not in [], I would not be in that job… Their jobs don't appeal to me. They're too structured, you're in a massive organisation that is constricting you because you are just another - you're on a treadmill, and you have very little autonomy actually, because there are rules and regulations and targets and financial penalties, and the system pushes you. And so there's this huge thing about the revolving door of nurse directors and it's absolutely true. There is a revolving door! They don't last very long!*

***Danni N**:* [working in relief efforts] *was more bureaucratic and administrative than I was hoping; as a nurse I wasn't expecting that at all, the things that I really enjoyed was the clinic visits and the training of the healthcare workers, that's what I was signed up to do, I didn't expect to spend nearly a week every month doing reports! Yeah, it drove me mad, it's probably a large reason why I didn't stay.*

***Florence N**; what is frustrating me about the job at the moment is that, there's sort of changes happening in the macro environment, but it's not filtering down, in a*

very timely way, or communicated very well in the micro way. So that sort of concerns me about how it's gonna go. And I think that's just par for the course, in the NHS anyway.

***Daisy N**: there's an awful lot of paperwork, lots of computer work, but you do, when you're doing a clinical session, when you've got ten, twelve women booked for an afternoon or a morning, you do actually need to have a break from the constant one on one and doing examinations and doing a lot of talking about []. You do actually need to have this.*

Finally, nurses like learning. Most nurses acknowledge teaching and learning are an important and enjoyable aspect of their career:

***Tanya N:** I would always say "today I want to learn something from patients I look after, every single one of them, the difficult ones, the quiet ones, the boring ones, the talkative ones, I have to learn something".*

Some nurses may choose posts offering good support for professional development and opportunities to learn.

***Josh N**: To be honest, professional development, I believe that UK has big things to offer when it comes to education… UK is offering the competitive heads when it comes to nursing.* [Once in the UK] *so I am just saying "how I am going to do my further studies if the workload is too much, if it's physically exhausting at the same time mentally exhausting?". So when I saw this job on the NHS jobs, so it's like "Oh, it's giving me something to – you know - it's like something I hope that professionally and personally will develop me as a nurse."*

John M explains this is evident even at interview:

***John M:** Most students come "How can you support me as a newly qualified?". And I know that they're going probably for 3 or 4 jobs. And I'm like "yep, we got a clinical educator here, she'll work with you at least for 25% of your time". It's something that probably makes you think "Oh actually I probably will get a bit better supported". So hopefully they'll choose our area over somewhere else. And that's quite important.*

One aspect of support in a post is the induction offered to new appointees. Most employers recognise the importance of induction and helping new starters to settle in:

> ***Sarah M****: I would say in district nursing that there's a quite a good induction package… and they get supported, there's a professional development team who spend time and actually organize the induction for the new starters… so the professional development team arrange their induction, they make sure that they get all their mandatory stuff done, so they're not stressed when they are actually going out with all this mandatory stuffs, it's done in that supernumerary period.*

Yet, induction can be the first thing to go if the department is busy.

> ***Jack N****: I suppose I didn't really give it long enough. I stayed there 3 months, but well, you know when you feared for your registration? And you just did not know, no orientation, no nothing. And they said, "Oh this was your orientation, but they've just slashed our staffing, so it got ripped up". I was like "Oh!". And they said, "You're in charge", this was on my second day, and I went "could somebody tell me how you bleep* [call] *a doctor?".*

Rosie N has had varied experiences. In one post, induction was a rushed affair. It should have included someone verifying ("signing off") she was safe to administer medicines, but this was not what happened, leaving her relying on the British National Formulary (BNF, a catalogue of drugs available), which caused her anxiety.

> ***Rosie N:*** *it shouldn't be like that, but I was signed off my drugs in one night. How did it make me feel in terms of security? Every day on the train I'm reading my BNF. Because I didn't feel I should have been signed off.*

Paula N also required feedback to feel comfortable at work:

> *Alison: So, when did you realise you did have the skills?* ***Paula N****: About four weeks ago! Yeah! When I was in it for a year I suddenly felt "ah, it's okay, I'm not going to get found out"… So, I've been in this job now a year and people, the big people in this organisation are beginning to know, "Oh Paula, right Paula, I know Paula, oh you're Paula." Then I started to get feedback from people who actually deliberately have given my boss feedback to give to me.*

In spite of enjoying learning, several of the nurse participants do not consider themselves to be academically able.

> ***Faye N**: I knew I didn't want to go to university - I'm not particularly academic.*
>
> ***Margaret N:** I'd have been doing my A levels at school and wasn't predicted to do very well, and my mum said "why don't you become a nurse?"*

Nurses often prefer practical courses:

> ***Jack N**: I'm much stronger on the practical type ones - in comparison to the theories - So like, I struggle, when I did* [the academic modules] *more about your professional and accountability. And then the preparation for research! That's what I struggled with! I've just done acute cancer care, and then you're in like the simulation lab and things like that, which was the first ever time I've done something like that. That's been quite good. And the ones that are all practical related, but, some of the more theoretical ones –*
>
> ***Felicity N:** I think there's a place for people like me who have a clinical expertise. I don't think I am academic, but I think I've got something to contribute.*

This lack of confidence in their academic ability can have an ongoing effect on their career decisions:

> ***Sadie E**: they have to decide if they're going to go on the PG Dip* [postgraduate diploma] *or BSc before they hand in their first assignment. So, I've got one person who decided that she was going to go for the BSc route, she's outstanding! I've had a number of discussions with her, encouraging her and she probably is aware that I'm disappointed that she's not doing the PG dip. Because a lot of them, the main reason they're here is to get the professional award. So, people who've low self-esteem don't expect that they can actually achieve at PG Dip level, they choose to do the BSc because it's safe. So, we have quite a few who do that... It would be very good for them, and it would be very good for practice obviously, if we had more MSc people out there.*

Most of the nurse participants registered with a diploma in nursing. Several of these had felt pressure to obtain a bachelor's degree (BSc) or risk missing opportunities:

> ***John M****: we've still got people who haven't done degrees. And they're gonna be overtaken by people who have done degrees. You know, and that, that's not necessarily fair. But that's the way it is, I suppose.*
>
> ***Jack N****: But they said, I think I got one of, they said one of the highest ones in the, in the thing* [scores in a job appraisal exercise] *(Alison: oooh!) But the only thing that pulled mine down was the fact I hadn't got my degree. And you sometimes get the comment of, "Oh, what do they know? If they've not got a degree, how can they teach us?". You do sometimes get comments like that.*

This apparent moving of goalposts means some nurses feel pressure to undertake further studies, which triggers anxiety and resentment and even caused Trudy X to leave the profession:

> ***Felicity N****: I don't have an MSc and I know that there's a real push now for nurses working in my type of job - I think I'm probably quite unusual but I think my expertise was recognised, but I don't think going forward that people without MScs will be able to do jobs like mine.*
>
> ***Trudy X:*** *At the age of 38 it was make-or-break; nursing was changing. In order to progress further I would need to complete a nursing degree. I made the decision to train as a social worker and qualified at the age of 40. I have never looked back.*
>
> ***Faye N****:* [a family member, also a nurse] *is due to retire in a few years and they could drop her band if she hasn't got a degree, so she's working all the hours God sends, paying I don't know how much to do it. Also, part of me - it's just I'm a bit of a rebel: "bog off, I'm not doing it, because I didn't do a degree for my nurse training does that mean it was any less good and why penalise us for it now?". Isn't that bloody awful? 100% I will not do one! So partly on principle and partly because I don't want to do it.*

The possibility that nurses experience pressure to embark upon higher education was explored in the survey and had broad agreement. The results are presented below:

	"Nurses feel under pressure to undertake further study"	
	Nurses	Managers / educators
strongly agree	1 (8%)	5 (100%)
agree	7 (25%)	0
neither agree nor disagree	2 (17%)	0
disagree	1 (8%)	0
strongly disagree	0	0
don't know	1 (8%)	0

Table 4.7: Survey: the influence of pressure to undertake study?

The pressure to study is perceived even by graduate nurses and some are now contemplating a higher degree, usually a Master of Science (MSc), even though they seem unsure of how and even why they should do so:

> ***Josh N**: it would improve my, er, er, nursing skills; my nursing knowledge and at the same time my, yeah, mostly with my skills and knowledge in order to - you know - to further improve my nursing.*

> ***Rosie N**: maybe do my masters – 'cos I don't want to do my master for masters sake. I want to do my masters in something I'm interested and passionate about, and really want to research. So, I haven't found it yet.*

This is important, because some nurse participants describe undertaking an inappropriate degree:

> ***Felicity N:** This degree wasn't taking me to the career that I actually eventually want to have, and actually when you're getting to my age you can't hang around messing about doing the wrong thing, because you haven't got time to switch and do the right thing. So I withdrew from the degree course.*

Felicity N returned to a more appropriate degree, and her dissertation examined transition care, which is the care of chronically ill young people as they are transferred to the adult care sector. This led to

her appointment as a nurse consultant and she now advises on transition care at national level. Paula N also experienced career gain through her studies, although in her case it was indirect:

> ***Paula N:*** *'I said, "What's that mean? Who are you? Where do you work?". I'd never heard of it in my life, and I went to shadow them for the day as part of the course, and fell in love with it. Shortly after graduation, one of these students emailed me about a vacancy, which I applied for successfully: and so I've got her to thank!*

In view of the pressures to learn, John M was concerned his Trust is unable to fund much education:

> ***John M****: but obviously we've lost the ability to get as much training now. I think that does factor. It's been very hard for me to get my masters funded. And it's only 'cos I've been speaking to different people that I have access that I know that maybe I can get that funding. But if I was a band 5 – yeah, you would be really stuffed! And actually, it's £2000 a module. So, you know that's not possible when I've got a mortgage.*

On the other hand, Josh N accepted responsibility for paying tuition fees:

> ***Josh N****: if you work hard, if you get to do some bank shifts - you will be able to pay for your university fees.*

4.3.1 Overview of the narrative of job satisfaction

This section has shown the multiple aspects of their work nurses enjoy. They find their work interesting and believe it to be worthwhile – something which attracted them to nursing in the first place. The participants expected, before they entered the profession, they would learn how to look after people and, once there, they like clinical care and bedside nursing. Not having clients unwell enough to require care can cause nurses to change jobs. Some of the participants describe seeking work which exploits their clinical skills. Developing and perfecting these skills is important and one way they measure their career progression. This often occurs as they move into more specialist areas. Several of the nurse participants are CNSs. These roles often provide more autonomy. Several participants spoke of using their skills after they have left the profession, or even after retirement. The survey, however, did not fully endorse this. The managers and educators, in particular, did not

support the notion that nursing skills are used after leaving nursing. Most of the participants like working in London and believe London offers good career opportunities.

Learning is important to nurses. They expect to continually engage in informal learning and to receive support in this. There is some ambivalence about higher education; they acknowledge it can be important but are sometimes unsure of the exact benefits and some were resolute they were not prepared to undertake a degree.

On the other hand, the participants dislike a heavy administrative burden and fear routinisation. Indeed, boredom or a lack of variety can, on its own, trigger a career move. Even more serious is experiencing frustration, which almost inevitably leads to a career change. Increased specialisation can be perceived as a disadvantage because some participants fear their skills may not be recognised outside their area and this could impede their career progression.

4.4 The narrative of finding the right role

Nursing is a large profession with a variety of different roles. This section explores how nurses attempt to identify the correct role for them.

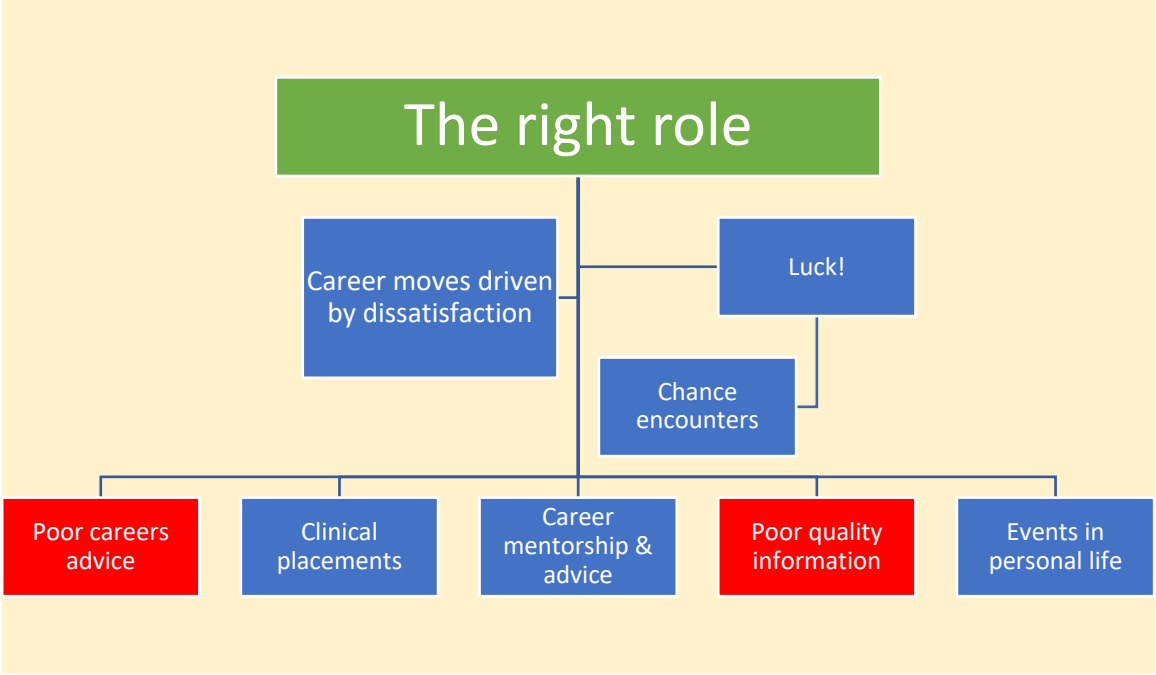

Table 4.8: The narrative of finding the right role

Commencing their careers, very few participants had ideas about what a career in nursing has to offer beyond their pre-registration education and they appear to have received minimal careers information about the profession:

> ***Florence N****: Our "careers advice", if you like, was secretary or maybe go and work in a factory - or something like that, or a mill or whatever and I thought "this is not for me". Yeah, it was very limited. My sister was a nursery nurse, and that wasn't something I was particularly interested in, but my mother had quite a lot of health problems, so I guess kind of nursing seemed the most appropriate progression. And that's really I suppose what made my decision was I suppose - dismissing all the other - well the other two options (laughs).*

> ***Danni N****: but there wasn't any such thing* [courses in alternative medicine] *in 1987 and I fell into nursing by default basically! My plan was to do nursing, get the basic physiology, then go to do alternative medicine.*

Several nurses stated poor careers advice at school caused them to enter the profession late, which is one of their few career regrets. For instance, Rosie N first trained as a computer programmer:

> ***Rosie N****: thinking I could learn programming* [of computers] *quite quickly. But I think also it was a bad decision without any guidance, just following the boom (laughs). Yes, so I dropped out quite quickly within a month I dropped out. So, yeah, it was a poor, very poor decision.*

Mary N's career decision when she left school was based upon wishing to stay with her friend:

> ***Mary N****: I went to college with my friend and did hairdressing and beauty culture; And I wasn't really that keen on it!*

Once embarked upon their student nurse programme, their clinical placements are a key means of identifying a role. The last one or two placements seem to be decidedly influential:

> ***Margaret N****: I don't know why - I wanted a job in urology, I kind of - I don't know – it would have been 1991 or something, and you know, you do your management* [final] *placement, and they kind of promise you job, don't they, back in the 1990's, and the sister kind of promised me a job when a vacancy came up.*
>
> ***Mary N****: And then the manager then, because I was really interested, she said "Well if you'd like to come back for your last placement, we'd be pleased to have you". So, I came back in my last placement and they offered to consider me for a job on* [the same ward]. *So, I got the job and started as a newly qualified nurse.*
>
> ***Nurse respondent #5:*** *I was certainly influenced by final placements. Gave me the knowledge that I wished to focus on the medical area rather than surgery and to further specialise in a sub area of medicine in future.*
>
> ***Nurse respondent #6:*** *placement experience is crucial about career choices within the speciality.*
>
> ***Nurse respondent #8****: Final placements are often chosen by the student and so are commonly linked to their likely career path.*
>
> ***Pitchie N****: I realised that: orthopaedics was a straightforward thing! It's a specialty where a bone is a bone, there's no guess work in there. You have a fracture, it's a fracture and you can see where the fracture is, there is no guess work. If you have*

to nail it, you nail it… If they have to chop off your leg, they'll tell you they have to chop of your leg because they see the damage. But when I look at medical, someone comes in and complains of stomach pain, I don't know how many things are inside your stomach (Alison: laughs)… I had job satisfaction with the orthopaedics. I stopped here and said, "I'm not going anywhere; I'll work here and that's it!"

This tendency to take the offered job may not be the best arrangement for the nurse. For example, Rosie N took a post offered, even though she disliked it:

***Rosie N**: I got offered a job with… the one I had the worst experience. (Alison: Right. And you took it, you went?) I took it, because I was advised to, because the clinical nurse educators said "just get a job, 6 months experience, you can move on" was their advice they gave me; I stayed a year! (laughs) I stayed a year!*

Career inspiration came from watching other nurses or even lectures:

***Melody N**: Because we will get the specialty nurses come on the ward and watching them and a friend of mine… we used to stand back and just admire them. So we always say "gosh we will go into specialty!"*

***Mark X**: towards the end of the nursing course, we did a study day on major incident with [] and got talking to him and to people I knew who worked in the field and decided that at some point after I qualified I would do a masters in that, which I did!*

The habit of watching others and identifying role models continues after registering. Dee N was becoming disillusioned, yet saw a nurse practitioner's job could be attractive and started to work towards an appointment of a nurse practitioner:

***Dee N**: I just became very disillusioned with public and society in general because we see such a squeewed perspective of what people are like, because in [] A&E you get all sorts coming in and four years of, like, people shouting at you; threatening to stab you; vomiting; spitting; kicking; hitting. But seeing what the emergency nurse practitioner were doing was just - wow, it completely ignited my fire! To carry on with nursing. I did it the scenic route but finally! So yes, definitely, and I finally got my dream nursing job and so I am ever so excited about starting!*

> ***Melody N:*** *I would like to be nurse consultant, that's what I am looking up to. Oh yes, this afternoon I had a chat with - I was late coming down - with a nurse consultant [] and I just admire her so much, I sat in her clinic a few times, Tuesdays, and I just - Oh Gosh! You can tell that she knows what she is talking about, the information, how she speaks and how she answers questions from patients and the way she explains things, and even with her, how she examines patients its different, its completely different.*

Some participants wonder about clinical areas they did not experience. Daisy N has a sense of wondering what might have been:

> ***Daisy N****: you know you do sometimes wonder "well I never got to see what cardiac nursing was like - I never got to see what - you know we only had a short exposure to midwifery" and it does make you wonder; I might have been interested in one of those.*

In view of the prominence given to pre-registration clinical placements in the career stories, this was investigated further, and the results presented below:

	"The final one or two placements as a student influence the remainder of a nurse career"	
	Nurses	Managers / educators
strongly agree	1 (8%)	0
agree	10 (83%)	2 (40%)
neutral	0	1 (20%)
disagree	1 (8%)	2 (40%)
strongly disagree	0	0

Table 4.9: Survey: the influence of clinical placements

Felicity N was looking for a different job based on her clinical placements, even about 10 years after registering.

> ***Felicity N****: when I had trained at [], I had enjoyed working on the paediatric oncology unit - that had been probably one of my highlights. Before I had the children that would always have been my plan to go back to that. So I started just looking out for other jobs. And I saw a paediatric day care oncology job advertised.*

John M is keen to appoint newly registered nurses, and to confirm this appointment early in their final year. This is what happened to him but is not yet usual practice where he currently is:

> ***John M****: They came for interview in February. We took them and we said we'd give them a job, because we just knew that we'd have a cycle of vacancies… I was at [] and went to* [the same hospital], *yeah. That was the norm, you know, by the middle of 3rd year you knew where you were going to work. I'm surprised that doesn't happen. I really am surprised!*

Managers continue to have an important role in career progression for their staff. This can start with offering them experience of learning what a more senior post would be like. John M offers the opportunity to "act up" when a senior colleague is on leave. This means staff nurses can experience a sister's role:

> ***John M****:* [the ward sisters' job is] *a difficult job… So they* [senior staff nurses] *get a full week of really experiencing what the band 7 does. And it's always the same, they always come back to us saying "Well, all anyone ever cares about, it's their annual leave and the rota". And it's like "yeah, that's probably about right!"… I am a very strong believer in growing your own.*

This means managers can look to their own staff when they have a senior post to fill. It is also encouraging for junior staff to see their colleagues getting promotion.

> ***Sarah M****: So generally, most of them are all home-grown and you find that talent and you kind of just let her grow, really, to keep them (sighs).*

Managers can point out suitable posts and encourage nurses to apply:

> ***Gem N****: I used to have a matron who spoke to me to say, "You should apply for the band 7". I wasn't planning to, but I thought, It's another stage"… So, I applied for a band 7, and got the job!*

***John M**: quite often I will say "there's a band 6 out and I think you should consider it". "There's a band 7 out, I think you should consider it".*

***Jack N**: I ended up* [applying for the ward managers post]*, well actually I was told I needed to apply for the post. Because there's been a number of sister's who'd had it, who were either short term, covering, maternity leave, people on long term sick.*

The advisor can next help the candidate prepare for their application:

***Rosie N**: She gave me just a hint just to think of examples, because their interview is very example based. And that's very, very difficult. "Give us an example where you find it, where you found challenges and contradictions and things and what you did"… But I found it very difficult, and it was quite traumatising interview in the sense.*

***John M**: I've coached people into the kind of questions that they should be asked as well… I don't think there's anything wrong with that.*

This could be important because it appears some nurses do not prepare for interviews:

Sadie E: [The applicants invited to interview] *were required to read a couple of papers, or at least the abstract, or the summaries of these papers but they were just - lots of them were clueless… unfortunately were lacking in knowledge. It's been, I think heart-breaking is the word.*

Sometimes the encouragement can come from some other nurse already active in a specialist field:

***Melody N**: Actually, this afternoon, during my lunch break I was having a chat with someone who works on medical ward and she said she is fed up with the ward and it's just too much; she wants to move out, so I was advising her.*

At other times encouragement can come from medical or other professional colleagues:

Felicity: *So, that was quite exciting for me because I was starting to do stuff that I would never have even contemplated doing…the* [medical] *consultant I worked with... encouraged me to apply, to be a clinical advisor on that project, so that was a national project and I don't know that I would have had the confidence to do that, but by now I was beginning to sort of feel quite comfortable with myself, I was beginning to be recognised as a nursing expert within this field, and with his encouragement I applied to that position and I was appointed.*

> ***Daisy N****: so, they* [medical practitioners] *basically said: "I'm going to be doing this lady's surgery for this and this, would you like to come and watch me do this operation?".*

One reason these informal arrangements are so important is the career pathway is not always transparent:

> ***Mark X****: some people take a really structured route there, but working a lot with kinda police and fire brigade, where, to become a sergeant you go on a course and sit exams and is really structured, the NHS is really haphazard, in comparison, in the way that it recruits and develops managers.*

There are electronic resources to help nurses find a new job, such as *NHS Jobs* https://www.jobs.nhs.uk or *LinkedIn* https://www.linkedin.com),

> ***Florence N****: I think a lot of it's about knowing where to go for the information. Because the other thing that I spent a lot of time with her - going through the NHS jobs website, and putting the appropriate filters in for her.*

Some nurses do take a passing interest in these, but they may not be genuinely looking for a new job:

> ***Margaret N****: Oh yes! I get daily alerts from jobs.ac.uk, I'm always flicking through it! (Alison: laughing, why?) (laughing) I don't know why! Just in case, you never know, so yeah, everyday get daily alert -*
>
> ***Paula N****: so I've got a LinkedIn profile; I've got bits and bobs to hand but, it's not brilliant, it's okay. It's a way in. The only reason for LinkedIn is for scouts. So job scouts get hold of me and say "Would you like to come work in Dubai?" I say "no thanks. What a lovely thought; very happy where I am; off you go." Some other people have made contact, but not that many.*
>
> ***Pitchie N****: that link I was even trying to do, thinking I might have a go because I've got requests... but do I have time actually to sit down to prepare all these things and really put all those information in?*
>
> ***Gem N****: I think this is more about for everybody working in the NHS at the moment, they're all looking for jobs, and they look and then they decide "Oh that looks nice", but then you end up staying in the same place because it's not always great somewhere else!*

Even if change appears inevitable, nurses may not be energetic in seeking new work. Instead, they tend to wait to see what will happen.

> ***Florence N:*** *I've not made any plans for my NHS career or my nursing career if you like, beyond January* [this recorded in July] *which is a bit scary, but is also a bit, kind of, well just wait and see what happens, you know, I have survived this far (laughs).*

Mary N is "acting up" to a more senior role and is aware this will finish when the colleague returns from maternity leave and Mary N does not wish to return to her previous role:

> ***Mary N****: I don't really want to go back to long days and night shifts! Sometimes I say "I need to start looking", but unless somebody says, "Oh I've seen such and such a job", and says "you know, there is some heart failure specialist nurse posts out there". I looked the other week, but - there was some posts out a couple of weeks ago, but I thought "Oh no, I'll leave it for a bit and just wait and see what happens". I would like to stay in this role, but if it doesn't work out that way, then yes I will look for something else.*

One difficulty in job hunting may be due to a belief job adverts do not provide useful information about the post:

> ***Dee N****: When I applied, I was supposed to be a dermatology research nurse. Before I started my job, role was changed there many times and since then it's changed immeasurably.*

After this, Dee N moved to another research nurse post. This job had the same title and grade as her previous post, yet she found it very different:

> ***Dee N****: My first research job was great; I had lots of my own studies and – yes it was really good, I didn't realize how lucky I was being so clinical in my previous research job. The way they run research jobs in [] was very different from []… Whereas at* [her previous post] *it was very much clinical even though both posts had the same title and grade.*

Some participants worry careers advice given to students is inaccurate:

> ***Sarah M****: they're still very much taught in university, I believe, that they should spend time in hospitals and not in the community, which is an absolute nonsense, it's not true… we've got I.V.s and things like that, but we can train people to do that, so I think it's a real nonsense. And actually, people are better coming straight out, and we get predominantly new starters.*

Even the managers themselves may not always be sure of the basis of their advice:

> ***John M****: we've kind of said, "actually you probably need to be thinking about this in 2 years' time." Err, I always say 3 years for a manager, I've no idea why I always say 3 years, I didn't!*

Faye N was advised to continue with her children's nursing course (as discussed in section 4.3, above):

> ***Faye N****: [I] was very much told off by the tutors there saying "you will never get a senior nurse post, you've wasted this" and I said "I'm so sorry I've made a mistake, this is my one mistake in my career and I have made it"… and then got a job as a team leader on a gastro ward!*

Similarly, Jack N is rather cynical about advice, preferring to do what feels right to him. For instance, he applied to return to his own ward after, what he still considers, a disastrous career move. The manager at his old ward advised him not to return to the same ward, but offered another:

> ***Jack N*** *I phoned my old senior nurse at [], said "Can I have my old job back?" and she said "no. It won't look good on your C.V. But you can have a job, on the haematology oncology", which had the worst reputation - And again, I think some of that was the fact, that the other ward was desperate for staff!*

Later in his career, Jack N was advised against applying for a hospital which was expected to soon close. He opted to go anyway:

> ***Jack N****: But everybody thought it was the time when [] had the threat of closure! And everyone's like "what are you going there for, it's closing down?" I said "I want to go and see what they do in a specialist centre"…. and then I only ever thought I'd come for 6 months. (Alison: So that was the risk you were prepared to take?)*

And just think, for 6 months, then go back to []. So that I could then put into practise back their stuff, but, I've come and I've stayed!

The quote below is the final example of his ignoring advice, and concerns his career going forward:

> ***Jack N**: Somebody did say to me, "do not get stuck in that role for a long-" and I've done exactly what they said not to do. And I think now, because you're comfortable in it, I'm quite nervous about, (laughing) going somewhere else.*

One hindrance in job hunting could be their work is already exhausting, making it hard to apply for a new job:

> ***Rosie N:** I did it for a year partly because it's very difficult to find work when you're in a job that just takes everything out of you! Completely… My ideal job was a community work, but unfortunately when I went for interview, I was so exhausted and I thought that the commute to there would be too far - when I got it I turned it down for a research job that was quite near home, it was probably just 15 minutes from home by car. I didn't really want to go into research…(Alison: So why did you go into research job?) Because I was exhausted and just needed an escape! I needed something easy. Something to look after me.*

Two participants describe using their heart to make a career decision. This is an interesting phrase, perhaps suggesting emotions are more important than reason in making career decisions. One of the participants using this phrase was Amber X (see section 4.2, above) and the other was Jack:

> ***Jack N:** So I looked at the positives and the negatives of each role... I mean my head was telling, cos one of the jobs was a 6 month temporary job, which was on a ward I was working on, and the other post was a permanent post at [], in the end I went with heart, rather than what my brain was telling me, my heart was saying I want to stay with the team that I've worked. And then, weighed it up, but in the end I think my heart was - I was a medical nurse rather than a surgical nurse - I did do the right thing.*

The concept of using the heart to make career decisions was therefore investigated in the survey. The results are shown below:

	"when nurse make career decisions, they tend to 'go with their hearts'"	
	Nurses	Managers / educators
strongly agree	3 (25%)	0
agree	4 (33%)	2 (50%)
neutral	3 (25%)	1 (25%)
disagree	2 (17%)	1 (25%)
strongly disagree	0	0

Table 4.10: Survey: the influence of the 'heart' in career decisions

Consistent with their approach to career planning and reluctance to move, it is likely nurses will be in the same post when they retire yet there is some disquiet it may not be possible to continue working as they are doing at the moment:

> ***Faye N****: It was mega busy. I'd have 19 patients in my team with me and maybe a healthcare assistant - really busy and heavy, you'd get everything, and I loved it and it was a great team, but you couldn't do that for ever more.*

Pitchie N and Jack N both refer to "Zimmer frames", which are walking aids for frail people, when they consider the future:

> ***Jack N****: I will probably still be here, when we retire! But then other times we think "How can we still be running around like this? We'll be on our Zimmer frames!"*
>
> ***Pitchie N:*** *You see, at some point one has to start preparing to retire, what are the things I have to do? You know, I keep thinking. Sometimes we talk here, "You don't expect me to be running here at some point? Would I be using a Zimmer frame to run to catch up with a patient who is using the call bell?!"*

Although the butt of jokes, the possibility of becoming physically unfit for nursing is a genuine dread:

> ***Sarah M****: I remember we had someone had tremors and at first it was fine, but it got to a point that actually it could impact on them drawing up things generally and actually going into homes and the confidence of the patients and families, and the*

more she was getting aware of their feelings, she had more anxiety and in the end… she could retire anyway, so there was that option there, so to support people… eye sight been another one we had. We've had eyesight before and we've had to go to meetings to get someone to leave because they didn't want to, and we were like "but actually you've made an error and we're very sorry but you could potentially kill someone, harm them, quite seriously". It's not a nice – it's one of the worst things you have to do, it's, it's awful

Mary N: *You know, we have got a nurse on here, he's been in the trust 25 years, then he's a few years older than me, and he's thinking about retirement. And I think his body's just about had enough. And I'm thinking, 'Oh gosh', just have to keep fit, and keep going… I don't want to think about that, cos it's thinking about getting older!*

The nurses' own lives occasionally impact how they perceive their work and can trigger career moves.

Sadie E*: A lady who had a premature baby and had fantastic health visiting, she was quite a senior person in her area of nursing but decided to come into health visiting, so I don't think she'd ever thought about it before. So that happens, not infrequently.*

Florence N*: my husband's diabetic, and he was having somebody to come and do his feet, and, and then he was having difficulty finding somebody, so I thought "oh well, yeah, maybe it's something that I could do".*

Tanya moved into ED shortly after registering. This was inspired by the death of her daughter in a road traffic accident, several years previously:

Tanya N*: because I just wanted that direct care to people who are having tragedy just like me, so that's the point when I accepted to say '" can now relate to people who are going through what I went through". So that's how I got the healing for my daughter, that's the time I stopped talking about it, because I never used to stop talking about it. I could explain to you the death as if it happened yesterday (Alison: I'm sure) yes, but working in Accident and Emergency, it was just like "here I am, this is the place". When I come across people coming in after road accidents, trauma, anything, I can relate to them. So it helped, it worked.*

Tanya N subsequently experienced a complaint against her (see section 4.2, above). One effect was she chose to move to a branch of governance dealing with complaints:

> ***Tanya N****: He's the one who'd been given the dirty job to investigate me and he felt so bad, every time he sees me. He said to me, "What do you want to do?" I said "I don't know, but I wouldn't mind managing complaints for you". He just said, "Are you mad?" I said "no, I'm not, I just want to manage the complaints!"*

On the other hand, nurses can avoid work which reminds them of their own pain:

> ***Alice X:*** *In the interim, I lost my brother and that probably stopped me nursing as well, he died very suddenly from cancer. I probably might have gone back in a bit earlier, but I backed off for a few years and I think, maybe I would have tried to nurse, but he died unfortunately after I left nursing that probably was - And that gives you, maybe made me look at nursing differently.*

Danni N had a job in cutting edge work in pre-implantation genetic diagnosis (PIGD), when her son was diagnosed with a genetic condition. Words almost failed her as she described her feelings about this:

> ***Danni N:*** *But then, once these problems started to come to light it was, yeah, 'this isn't this isn't gonna work'. He has long term health problem, he has a genetic condition actually, which the irony, the irony of that just never, it never, yeah.*

The participants themselves cannot provide a coherent account of their career decisions but many feel there is one overriding factor, namely chance or luck:

> ***Paula N****: I've never, ever set up an alert with anything ever in my life. I fall in and out of jobs. Oh God, I think I've just been extremely lucky! I fell in - you fall in and out don't you? And I think this is the point, in nursing you fall in and out of stuff, and it's not good enough.*
>
> ***Margaret N****: I don't think I have ever, ever made a career decision; everything has just been chance, knocked onto chance, knocked on to chance, knocked onto chance. I have never made any major career decision… and a few people kind of knew [me], so that's why I was approached about that position, but it made sense for me to apply to that… it's just been kind of chance really, people telling me about jobs, asking me to apply for jobs -*
>
> ***Daisy N****: I think you take steps along the way and I think you have to make it as something comes up.*

> ***William E****: For some, it's complete serendipity. So you start off, opportunity X comes your way, "That's interesting, I'll take opportunity X," then with opportunity X is a requirement to do a CPPD* [continuing professional, personal development] *course and away you go. "Oh, that's quite interesting, I enjoyed doing that course, I think I might try and expand this a bit further and a bit further."*

Some participants describe being influenced by chance encounters:

> ***Danni N****: I* ***stumbled*** *into that job completely; I was talking to somebody in a bar and they said, "you would be a great person to come and work for us" and they gave me just an address… I was at a conference in London when I was working in [] and got asked to come down "oh, come and have a chat with our clinical director, she'd love to meet you and blah" when I got there it was basically a case of "right, we're interviewing you and this is the job!" Came down to London with a five-year plan. Yeah, that was a long time ago (laughs)!*

> ***Margaret N****: I went to do some agency …, and I got sharps injury…. so, I had to go and see the site manager and the site manager essentially offered me a job and I thought "this is silly, I have been waiting for my urology job so long that I might as well take this job" and it was the wrong decision.*

Finally, this section will briefly examine the decision to leave nursing. Leaving nursing should be done with caution, because it is a decision difficult to reverse.. She has twice tried to renew her registration. On the first occasion, she found the academic demands too great:

> ***Alice X****: I was working full time here and the course was there and - you know there was couple of days in the university and then you were just left to try and get this placement done and this essay which you got given a sentence say, I am not the most academic person and it was - how do you find information, when there is no one to help you? And they came back and said you didn't ask us enough but, they didn't really help you, you given a sentence and got to try and make an essay out of it, I found that incredibly hard, and so I gave up.*

The second attempt was recent, but she was unable to obtain a place on the return to practice course:

> ***Alice X:*** *they mentioned 14 funded places; but then I think she got a lot of people and basically I was on a holiday for the first round of interviews and so I missed*

that, she did interview me and then said we don't know with your commitment with []…, but she didn't let me on the course. So, I should get back in touch and try again.

Alice X left because she wanted a change and enjoyed this for a while, but now would advise simply taking a short career break.

> ***Alice X**: I just wanted to break and - yeah that's [*working as a cabin crew member*] what happened to be. It's not stressful job, unless something's going to go wrong on the plane, but it is not really a stressful job, there's no pressure. So I would say take a year off nursing, fly for a year, and see the world and then go back to nursing and that wouldn't be what I would do that year, but that would what would recommend someone to do, just if you are a bit jaded or anything, come and do this!*

Most of the nurses are aware of their retirement, but have the same relaxed approach to planning it that they have to other aspects of their careers:

> ***Felicity N**: I don't feel anything like old enough to retire yet. You don't do you? You sort of - it comes up on you - I'm 54 now - I don't want to retire! I'm not ready to retire at 55. But I'd quite like to know I could if I wanted to (laughs)*
>
> ***Paula N:** I'm 45, right; potentially I could retire at 55 'cos I'm on that pre-1995 and I'm going to keep that bugger as long as I can! But to have the option. So part of me just thinks, "Oh, I can't go in ten years, are you joking? That's really weird." I feel like a ten-year-old. I feel 20 still but my other part of my brain goes, 'Well, we have family who live in [], and I want to be in [] thanks very much - but in really weird way, in a kind of ethereal way really because I can't imagine ever not working - I can't imagine being any older than I am!*

4.4.1 Overview of the narrative of finding the right role

This section has shown career moves in nursing can be rather haphazard. Nurses rarely have career plans and tend to only move if they are actively unhappy at work. They comment upon the poor quality of information available to them when they entered the profession, and this appears to continue throughout their careers. They find job titles or descriptions can be unreliable. More helpful information could be provided by informal, or pre-employment visits. There were only two such visits

discussed, suggesting they are not a common feature of nursing job applications. All this means career pathways are rather obscure in nursing, which contrasts with other occupations.

Some describe receiving encouragement from managers, but none benefit from formal career mentoring and some are wary advice they receive could be biased and report inaccurate information. Few consistently used the online resources available. Even if they need to move jobs, they will often opt to wait to see if something nearby arises. In the face of all this, it is little wonder participants often attribute their career success to luck, especially chance encounters. Another overriding message from this section is the importance of clinical placements as students, which can be observed several years later. They can often identify a role model. Finally, experiences in their own lives, both positive and negative, can have an impact upon career decisions.

Nurses may need help and encouragement for another reason, because seeking new work is stressful and tiring. Many used their emotions in career decisions and the online survey show some limited support for the notion nurses follow their hearts in career decisions.

The stories show career decisions can have life-long implications, so support may be important at these times.

4.5 The narrative of Stress

Stress is a constantly recurring narrative in the stories. Although not always perceived as a bad thing, participants are aware of the danger of too much stress, and many had experienced that.

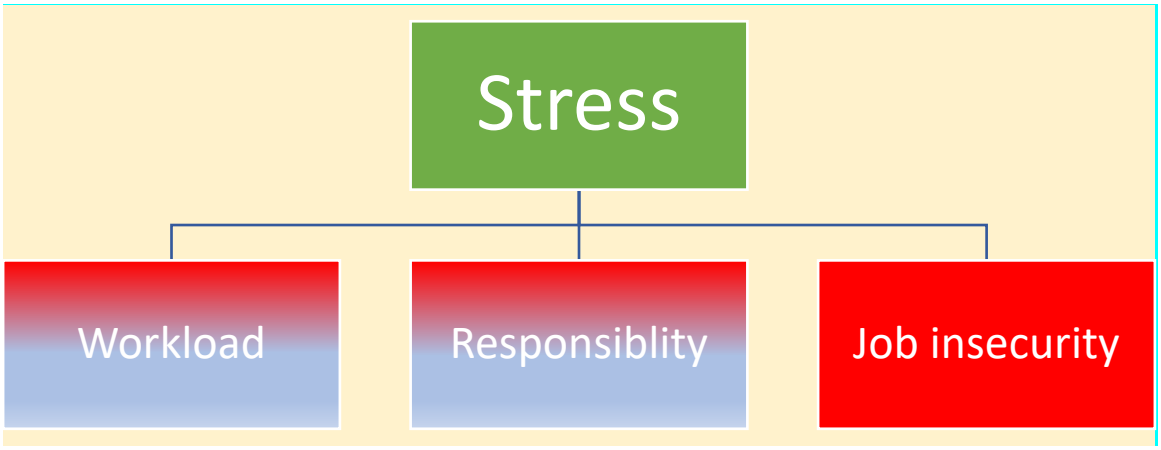

Table 4.11: The Narrative of stress

Some of the participants accept stress as part of life, and even seek challenges:

> ***Dee N****: I think maybe I am a bit of a stress junkie; I like busy, busy clinical areas like A&E and yes, I do like physically being busy and running around. A&E was a brilliant experience and at the time it was lots and lots of hard work and being very tired for years, but I learnt so much being in A&E!*

If their work can be done easily, they are at risk of becoming bored:

> ***Florence N:*** *So I've been doing it as band 7 since, I suppose, January. Am I still enjoying it? I'm enjoying it (short pause) to a point, I think I'm getting to stage where I've kind of been there, done that, seen it. If I'm completely honest looking for more of a challenge, now. I can do it fairly easily, the programme runs, the programme's set…. It's not, it's probably the least stressful job I've ever had, so that part's good, so I know I can go to sleep at night!*

Participants describe tolerating stress, or not even realising it was occurring, but eventually it becomes too much:

Alice X: *I didn't realise, I think that the environment was highly stressed, I think people in that unit were highly stressed… It really rubbed off and you got to the point when you are worried about going to work because when you got something wrong…they really came down on you!*

Margaret N: *I had been working clinically more or less from the age of eighteen to forty-four and I couldn't deal with the aggravation anymore. I felt it was taking years off my life that is – well, just having palpitations every day thinking it was normal to be super anxious - it wasn't fun anymore!*

Some participants have left work that was too stressful. One source of stress is a high workload, which is particularly keenly felt if clients are very ill, and their care potentially affected:

Rosie N: *In terms of the nursing skills and practice and experience that it gives you, it's amazing* [but it was] *probably one of my worst experiences. It's just the workload, the work shifts; they do this 12-hour shifts – very heavy ward! I couldn't even walk from the station home; I would beg my husband "please pick me up" … In the NHS no-body is friendly; not because they're not friendly in nature, but they're so under pressure not to help you, nobody helps you or trains you, looks after you, there's absolutely nothing. You're just thrown in - survive. I just was determined to just look for work and when I looked for it, I found 3 jobs at once.*

Amber X: *having a 24 bedded unit and being told that you had to get 3 lots of patients into the same bed during the day, so actually you were nursing sometimes 36, 38, 40; and then running a ward and just finding everything being so stretched - I had already started to feel really frustrated - just finding everything being so stretched, and the one thing that I remember really vividly, was working in a hospital and on a Sunday of a bank holiday weekend I was asked for a blind lady to be discharged back to her home, and she was frail, she was single, and it just made me question everything.*

Dee N describes moving from clinical work to a research post to find a less stressful role. This may have been influenced by seeing the effects of stress on her colleagues:

Dee N: *One of the nurses I worked with in A&E, one day she just didn't come to work, a few days later we were told that she was in a mental health institution, her hair's gone grey, she spent a month there, literally after two months she was learning how to wash her hair again, and you just wouldn't have known, because she would come to work, and be all jokey and lovely, but actually she was having*

a massive break down… it was that that made me think, actually you know it's making my marriage suffer.

Stress was most discussed in relation to the ward (or team) managers' posts:

***Sarah M**: You sometimes find that teams managers will be team managers for a while and then go into matron because they burnt out by being a team manager; they enjoy the patient care side of it, but actually the team management side of it just isn't for them, but very rarely the other way.*

***John M**: The band 7 job is the most underrated job. The ward manager is - we almost need a grade in itself for a ward manager, I think. It's above a 7, but possibly below a matron role. I mean I really do think that, it used to frustrate me when you'd have a clinical nurse specialist who'd be a ward manager, same grade as a ward manager, and do nothing in comparison to the expectations of a ward manager.*

Another participant describes not applying for promotion because she could see the amount of stress involved:

***Florence N**: I was potentially thinking that I could do the general management job, when I was doing the deputy general managers job; but actually now I am glad I never did, I mean I don't even look at those jobs anymore because it just doesn't – the stress levels are just huge, and, you know, life's too short (laughs), and to me it's all about, now it's, it's all about quality as opposed to quantity*

Another source of stress occurs when nurses are asked to carry too much responsibility.

***Alice N:** I thought I could stay there* [in Australia], *but they nurse differently there - within three months you are like - you run the whole ward - I wasn't enjoying it.*

***Mary N:** everything on the ward, especially cardiology, because the patients can become ill, that fast, it was so fast paced! And it was pretty scary… I did leave once - And at that moment I was a bit sort of, "Why did I come into nursing?". And we were short of staff and it was so busy, and I was a bit sort of disillusioned with the whole thing - So I applied for a job.*

***Gem N**: We have a chest pain assessment unit, and as a senior E grade, you're there. And you look after people who have chest pains… but you sort of work as a clinical nurse specialist, because you look at ECG's* [Electrocardiogram, a

representation of the functioning of the heart]. *And then you, "this patient's having a heart attack or ischaemia"… then you discuss it with a consultant. And I thought "This is too stressful". And not, how do you say it, it's not in your pay grade! Because if you're on a day, the lead person in a chest pain unit is a band 7! … and then they would expect you to do it at night. Well, you do it every day anyway, but, I just thought "I do not like this kind of environment, it's too, you're putting a lot of pressure for somebody who's more or less junior".*

Carrying too much responsibility or being too busy can cause anxiety about a complaint and some nurses may even fear this could threaten their status as an RN:

> ***Jack N:*** *I suppose I didn't really give it long enough. I stayed there 3 months, but when - Well, you know when you fear for your registration? 18 beds were elderly, stroke, gastro. So there was quite a lot of alcoholics, all trying to jump out the bed, things like that, having GI bleeds, and the other end of the ward was a 6 bedded oncology bay, and 5 side rooms, they were doing stem cells, and you'd often go and be the only qualified nurse on… But I just thought "No. I won't end up nursing, the way this was".*
>
> ***Nurse respondent #6****: The reason why nurses may worry about complaints and disciplinary action is because they know that not everything required of them is physically possible to be done, because of the pressure of their workload, therefore they will have to prioritise on covering their back with the paperwork side and neglecting direct patient care, which is part of the frustration.*
>
> ***Nurse respondent #12:*** *Nurses worry always, especially complaints from patients and family and worry of disciplinary, especially where there is lack of good management support.*
>
> ***Manager/educator respondent #4****: I worry about getting something "wrong" and not doing the best for my patients, so there is a moral worry about not always doing the best I can.*

The table below indicates further support for the notion nurses worry about complaints.

	"Nurses worry about the possibility of a patient complaining about them"	
	Nurses	Managers / educators
strongly agree	2 (17%)	0
agree	4 (33%)	4 (80%)
neutral	2 (17%)	0
disagree	3 (25%)	1 (20%)
strongly disagree	1 (8%)	0
don't know	0	0

Table 4.12: Survey: the influence of worrying about complaints

Several of the participants identify that job security is important to them and they worry about the possibility of losing their work. Indeed, job security is what attracted some into nursing in the first instance and they now avoid job insecurity:

> ***Faye N****: I was going to go to drama school and then my mum was diagnosed with terminal cancer… I thought "no, I will do nursing 'cos I need to be in a job where I am getting paid". I just thought "I need to know that I am going to be okay and she will know that I will be okay". Yeah, so I did nursing!*
>
> ***Tanya N:*** *So, I did stay in NHS, mostly for security, that's the main thing why I stayed on because of security.*
>
> ***Margaret N:*** *obviously security so, take into account whether it is permanent post or not. So when I came into this post at [], initially it was a one year fixed term contract, so I arranged for it to be a secondment from my permanent employer, but still obviously didn't want a fixed term contract, it's no use to man nor beast, is it (both laugh) so, I arranged to go on secondment, so certainly to a certain extent security.*
>
> ***Jack N****: I've always wanted to be, like, a lecture-practitioner. But, because of working here, they usually, when we've had them, they're the first posts to be – gone!*

Jack N had a particular need to worry because he had been part of the consultation, when two trusts merged, with some down-sizing (reducing the establishment, with the risks of redundancy) or down-banding (reducing pay to a lower scale whilst still working in a similar manner).

> ***Jack N**: But that was an awful time for all the band 7's. And those who didn't meet it were then either, slotted into different positions, and it was when we was all work - I suppose it was at the time when they were looking at [], there would be different number of wards, a way of justifying who'd got what Job…*

The survey reflects some concerns about redundancy but does not uphold the notion that it is a major source of stress.

	"Nurses worry about the possibility of redundancy or down-banding"	
	Nurses	Managers / educators
strongly agree	0	0
agree	4 (33%)	2 (40%)
neither agree nor disagree	2 (17%)	1 (20%)
disagree	5 (42%)	2 (40%)
strongly disagree	0	0
don't know	1 (8%)	0

Table 4.10: the influence of redundancy and down-banding

The discussion above could suggest several of the nurse participants are risk averse. Paula N was the only participant happy to discuss taking risks, and she revelled in this:

> ***Paula N:** I've taken some risks in my career, believe me: I went from a G grade to an I in a completely different organisation. God only knows how I did that but anyway I did, probably not the right thing to do but I did… So, it's just, it was moon and stars, it was just that kind of - nothing could have been planned it just plonked in my lap and I went, "Oh I will give it a go, I've got nothing to lose. I'm bored out*

of my tree now"... I've been a maverick all my career - I don't like people saying I can't do things, I push boundaries, I say "why?". I don't like rules, I hate rules.

4.5.1 Overview of the narrative of stress

There was a feeling amongst the participants the high levels of workload may be enjoyable for a while, perhaps even years, but it is not possible to continue working at a very high pace without suffering burnout. The realisation they were approaching burnout can be a slow process. Eventually, however, the personal costs of continual fatigue and anxiety caused several to leave very busy posts. The ward sister (or manager) posts are difficult to fill because of the high level of continual stress. One participant did not pursue a career in senior management due to the amount of responsibility involved. Another reported an additional source of stress and frustration, which was the busyness of the unit meant she was obliged to engage in what she believed to be unethical practice.

However, two participants who had left their job looking for a quieter one, at the interview, both expressed some dissatisfaction because their current roles were not demanding enough.

Another source of stress occurs when the nurse is asked to carry too much responsibility, or the responsibility does not coincide with their skills. This is made more complex if they believe the amount of responsibility they are asked to carry varies, depending upon whether more senior colleagues were present. They may also feel some resentment if their pay is not commensurate with the skills they are asked to employ.

4.6 The narrative of Work-life balance

This section examines how nurses balance the many aspects of their busy lives. It includes discussion of pay because, for many nurses, the value of their pay is their ability to provide for their dependants.

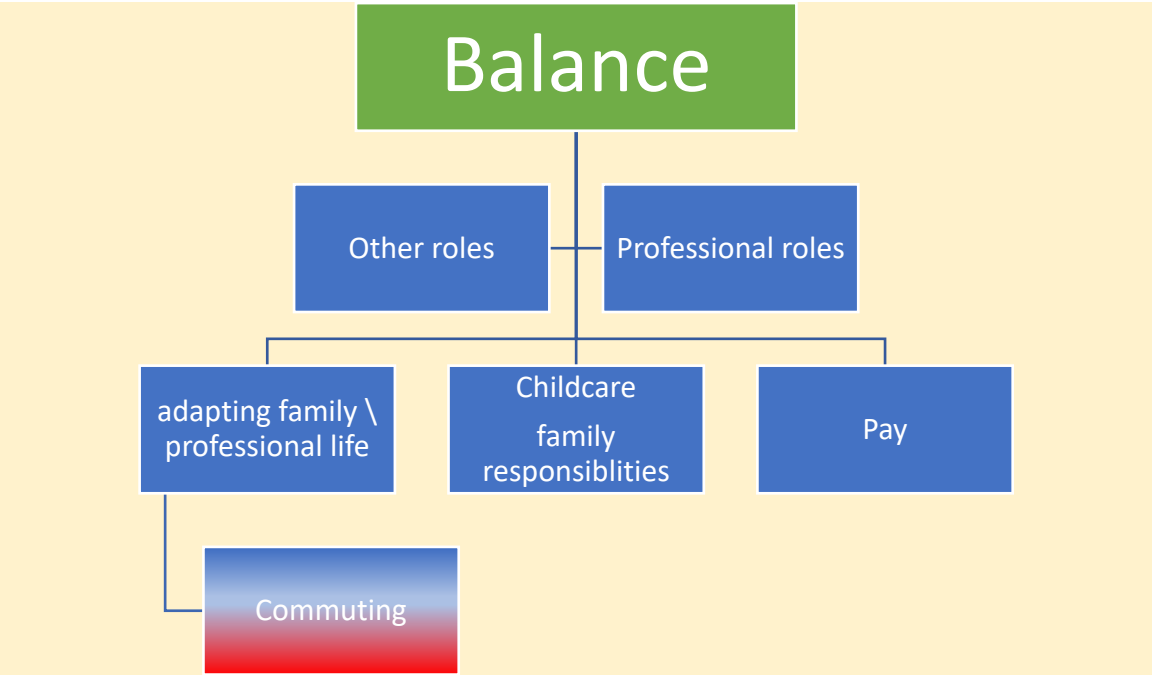

Table 4.14: The narrative of work-life balance

It is possible for nurses to feel completely fulfilled by their work:

> ***Paula N***: *'cos my job has never been a job, and my being a nurse and my career is my life, and I happen to shoe-horn my family and my child into that life. It consumes me!*

More commonly, participants' personal lives are important to them, and they are careful not to give their lives totally over to their work:

> ***Felicity N***: *but then your work is everything you do in life, and actually I'm more than just being a cancer nurse. You know, I've got adult children now who I enjoy being with and I enjoy a social life, and if you're not careful your work can become the all-consuming thing and I don't know if that's entirely healthy, actually.*

There is potential conflict between the wish to have professional challenges and the wish to have a reasonable quality of life, particularly if there are children at home. London offers excellent professional opportunities (discussed in section 4.3) but can be difficult and expensive to live in. One way of balancing these is to work in central London and to live in the suburbs, as Paula N describes:

> ***Paula N**: I said to my husband, "We've got to move out of London, I can't do this anymore. It's driving me – I can't, I'm so stressed out getting to and from work every day. I can't do it." So we bought this little house out in [] and just the very fact that I was going on a train, out in the open. Back and home. I thought, "How nice is this, I can see the sky, beautiful."*

Transport in London allows nurses from a wide geographical area to engage with the professional opportunities in London:

> ***John M**: The younger staff it certainly is that they're coming in… We're on the overground, we're gonna be on Crossrail. Which sounds funny but actually it takes you directly to somewhere like Brentwood, in 40 minutes.*

However, this travelling can itself cause problems with family life:

> ***Danni N**: I worked 12-hour shifts, so I was only 3 or 4 days a week, but even that is three or four days a week; but twelve and half hour shift so I was leaving the house at 6, getting the half pass 6 train up to London… getting home at 10 to 10 and I couldn't carry on doing that.*
>
> ***John M**: I mean there is a massive turnover, the A and E's, the ICU's, people get the experience, and they go home. They move out. I mean it's not unusual for them to think about going somewhere more local. So, we've got an effect where people are coming in to get particular experience, and are prepared to put up with a journey from hell or whatever, 3 days a week, get the experience, but then, within, what, how many years? They've been here 5 years, they've got - Yeah, they've had a baby and now they're thinking, "actually, I've realised that I can have a 5-minute drive to, to work". Not necessarily even do the same job as they did before, but just do a job.*

Occasionally, it is impossible to accommodate both the professional and family demands:

> ***John M****: we have had a few of our local community who have left because they've not been allowed to work nights and weekends, and because their family don't allow it… You know one of our nurses got married and started to become really tired, then requested to go part time, then requested only to do day* [shifts]… *Her family expected her to care for her in-laws. So, she was sometimes up all night with relatively young in-laws who just became dependant on her. I think it might be a Bengali tradition. We do see our Bengali nurses get married, then get pregnant, then not come back. Or, come back and then have appalling sickness.*

More often, nurses find a balance. Having young children, in particular, is regarded as especially demanding:

> ***Amber X:*** *I do miss being a nurse, I mean I will always be a nurse and it's still the first thing I tell people about myself (Alison: so I suppose the obvious question is why did you leave?) I had my family... at a time before child-care really came in, so there wasn't much child-care, and my husband was also doing shifts, so between the two of us it was almost impossible!*
>
> ***Paula N****: I don't know anybody else, by the way, who is in my position with a four-and-a-half-year-old at this level. No! Everybody will say to me, "You've got what, a four-and-a-half-year-old? Jesus"! Most nurse directors are older, or they've had kids younger, because I'm late aren't I?*
>
> ***Felicity N****.* [family life] *wasn't going to interfere with my career and I was gonna go back and I was gonna carry on in my career path; I always assumed that I'd be a ward sister - and then I had a child and I loved being a Mum… I did all the school bits, I helped out at school, and I enjoyed being a Mum - what I did I liked to do well so if I was gonna be a Mum I was gonna be a good Mum. So, having said that it wasn't going to interfere with my career it completely did, but I enjoyed those years, and I could still do a bit of nursing - those years were good years.*

For many participants, caring for their children involves a delicate balancing act, which almost inevitably involves compromise:

> ***Rosie N****: I like the conditions in terms of the work life balance that I need in terms of family life, and time for your children and family. I'm happy with that here, but in terms of the work, I feel like here I'm reaching the ceiling, in terms of the work and the challenge and you know, the learning, the learning curve……. Ok I'm going on*

in age, do I accept that? (short pause) Shouldn't really. (laughs) I don't have that extra feeling that I'm still learning, I'm still challenged.

*Alison: Have you changed the way you make career decisions? **Danni N**: yes, because it used to be purely on a professional level, but having had a family and having got bit older there's other considerations now.*

***Paula N**: I have worked my arse off (laughing) for 25 years. I really have worked my arse off. I absolutely love it though… Before I had a child, all my life until I had [], I used to be at work until seven o'clock/eight o'clock at night, all the time. It was fine. That was my life, I never bothered, never minded, it was my life, I loved it - can't do it anymore! … The minute I got pregnant that was it - finished, gone home, rest, relax, and I have done it very well since. I had a whole year off with him which was the best year of my life, of my life!* [On maternity leave] *ooh, I loved every minute of it! I absolutely loved not being at work. I never missed it for one sec (laughs).*

Participants rearranged their work to fit around family commitments:

***Faye N:** when the kids were little, I did community night nursing for 2 years, three nights a week, nearly killed me because I'd work from 10:30 to 6:30 and then come home, get them off to nursery, have, like, 2 to 3 hours sleep, get up and get back to work again. I don't know how I did it now – I think I was brain dead half of the time, but you do it, don't you?*

***Felicity N**: you don't see your child before you go to work in the morning and you don't see them when you get home at night and I didn't want to do 12-hour shifts and there was no flexibility about that so that sort of pushed me, I guess, into the next move. I saw a paediatric day care oncology job advertised. So that gave me Monday to Friday. It wasn't a formal interview I went and have a chat and I was very cheeky, so I said, "I have children" they were at secondary school by now but they were still needing my input; "they still want their Mum". So, I said: "I would really like to work on your ward but …I can manage, um I'd like a term time only; Monday to Friday; three days a week job!" and they'd never considered that before, but they said they would think about it. My husband thought I was really pushing my luck to ask for a term time contract but actually - you don't ask you don't get. So, they'd apparently never offered a term time contract to anybody before, but they considered it.*

Trying to be flexible, however, did not work for Danni N:

Danni N: *I worked Tuesday, Wednesday, and Thursday instead of full time, my consultant wanted me there full-time. He would ring me on a Monday and the Friday, when I was home with my son - he was an astounding person to work for but, he did have a slightly, um, archaic view of how nurses should be, so yeah, family got in the way of my career really... I realized that actually, it was the sort of job that took over your life and you know - my son's first Christmas - he was born in July, he was about six months old, I was called into work on Boxing Day; I was supposed to be off, but something had gone wrong and I was the person that was rung when stuff went wrong, and I realized then "I can't continue doing this" if I want to have a family… yes, but isn't it appalling that… Do I mind? Yeah, I do a bit really… it was the right decision, but, I would have preferred not to have to have made it.*

Managers and educators understand this:

Sarah M*: I think, because of family*, [community nursing] *it's a better option for them, because of the hours: we have a twilight service which is five till midnight, so that suits people with children; there's an overnight service, and the day shift is half eight to five so actually – its personal... You don't rotate, whereas on the wards you have to, and you have to do your long days and you have to do nights.*

Jess E*: A lot of the nurses in cardiac rehab are in cardiac rehab because they like cardiac nursing, but also 'cos they have got children and the hours, there is no weekend working… because if you have children, and both partners are doing shifts, it makes it really difficult to organise childcare.*

It was evident most required at least some informal help caring for children whilst they worked:

Mary N*: obviously it affected my daughters when they were younger, you know they had to go to after school club and breakfast club, even though they didn't want to. But where we live, we've got some good friends, and you know we used to take it in turns to take the kids to school, so it - I've always had good support. And my husband, he's really good, he'll put himself out, for things that I want to do, vice versa. But, you know, sometimes you just have to go and do it, and sort it out as you go along.*

Paula N*: We had a family meeting with the job description, and everybody went, "Oh fuck!" I went, "Oh yeah, this is a really big deal. This is a really, really bloody big deal, I have to know you're with me or else I'm not going to go for the job."*

They said, "Right we'll move 'ouse." So, they moved down, to do childcare, which they do, and it's worked out alright.

However, most of the nurses who have made adjustments regard them as positive changes.

Faye N: *So in some ways that's quite good because you don't have the choices that some people do () you don't have to do things and in some ways it limits your choices because you're not so driven then to have to do that.*

Felicity N: *My Mum sort of gave me an excuse because I don't drop out of things and I think I probably wouldn't have dropped out… We had - there were good times and she lived with me when she was having treatment, so!*

Having a young family and a demanding job is regarded as challenging and one pattern some of the participants have observed was to have a family early and then pursue their careers more aggressively once the children are older.

Danni N*: she had her children much younger than I did, and she worked - she's a midwife she worked on nights the whole way through when her children were young, and then over the past five years, her children are now - she's got 18-year-old twins and a 16 year old, the past five years she's gone boom, worked her way right up and she's now head of midwifery.*

Childcare responsibilities do usually diminish eventually, making it less of a balancing act and opening the possibility of concentrating, once again, on career:

Mary N*: I don't think I've got any constraints. I mean the children are sort of more grown up now, and I know my husband would support me in anything that I wanted to do.*

Felicity N*: I don't have young children now; it makes a huge difference, so I can do that and I enjoy my work… I think I've proved that you can dip out for quite a long time and still reach a reasonably decent level, in pay wise and satisfaction wise.*

Importantly, however, it is not just women with young children whose choices are limited:

Jack N: *I suppose with your parents getting older, it might sway you as to where… and my brother died about 3 years ago and was younger than me (Alison: Oh*

dear, I am sorry) because they're around, if I wanted to, say - then that could be moving, it could be work, like go further afield, that might prevent me from doing that.

***Josh N**: I loved the job - it was very interesting and challenging, and then - even though I loved the job - it just happened my wife, now, was working at London… so (I) took up the short straw (Alison: laughs) because, you know, I have to be with my girlfriend at that time, so I decided to look for something that would also would interest me.*

Dee N did not have children herself, but still valued her personal life:

***Dee N:** for the simple reason that the hours are nice; nine to five, your weekends are off and you know I mean it is really nice, you have lot more times spent at home… basically it's like a little respite (both laugh) … it offers a breathing space to think, rather than, "Oh God, o' clock start and back again tomorrow to do my shift". It would have been nice to solely focus on my career, but life gets in the way, doesn't it? And I think you need to do what's best for you to keep sane!*

The last influence in this section is pay. This is discussed here because it can contribute to family life.

***Faye N**: you have to keep going and now because I've got kids and everything, am married and I can't afford to not work… Some of the career decisions were around the fact that we would never had been able to pay our mortgage on my salary because we live in London.*

Nevertheless, there was a general feeling nursing is under-paid, but this is tolerable if they are still able to enjoy their personal lives. Some even feel that they do not really need the money.

***Jack N**: You don't do nursing for the money!*

***Dee N:** I think nurses are lucky and you do have an opportunity to do something you love and I think lots of jobs don't offer that, quite often its money or just pay the bills and yes it's not some - this is a vocation… When I said I was leaving my manager said, "well if we offered you a band 7 what would you say?". I just didn't have the heart to tell her that an extra £100 or £200 a month for doing the job isn't doing it for me.*

***Felicity N**: My husband's always earned probably at least twice much as me if not more so, he was always the main earner and - I feel a bit embarrassed to say it -*

but I was always saw my salary as a bit of an add on really. And his salary was what we all lived off… I don't think it's about financial reward I think it's about job satisfaction and I don't think I've ever come to work and not really felt like I was doing something purposeful and of value.

Tanya N: *I know people complain, "Oh, you know what, I'm not getting enough". I think sometimes it's about what you do with it, isn't it? And I feel contented with what I'm paid, the reason being, I am in a position where I see myself blessed. I'm living on it comfortably. I'm contented. I didn't stretch myself to be what I'm not. I plan my life with what I have.*

Pitchie N: *You know, pay is something people are never satisfied with, however much money they give you.*

The exception to this general satisfaction with pay was, once again, Danni N:

Danni N*: I was at one point Band 8A and I now find myself down at the bottom of the scale; I am employed on the same level as one of the colleagues who is been qualified six months! Considering I have been nursing as long I have, and I have the level of experience that I have, I think it's appalling really, but that's the way it is - they don't really give you an awful lot of credit for your previous experience.*

Other nurses to report some dissatisfactions are those believing others are receiving more:

Gem N: *The basic pay is actually - It's probably Ok with me. But I'm not happy with no increase every year. And you're stagnant. Unless you do increment… So, if you hear the news about MP's going to get 5% pay increase, or even the doctors. The doctors get a pay increase, I think? … and the government is saying no to a 1% pay increase for the nurses. And that's frustrating. Because what would happen, you're in the front line, if there's no nurses? Our radiographers for example, they earn a lot. But where's the fairness… And we cannot even go on a strike! You just still have to stay here, and look after patients. Although I must say some of my band 5's, earn more than me. Because* [they] *do on call. I don't do as much.*

The survey asks whether nurses prioritise pay, and the results suggest pay is a relatively low priority:

	Nurses prioritise increasing their pay	
	Nurses	Managers / educators
strongly agree	0	0
agree	1 (8%)	1 (20%)
neither agree nor disagree	3 (25%)	3 (60%)
disagree	6 (50%)	1 (20%)
strongly disagree	2 (17%)	0

Table 4.12: Influence of pay

To seek higher pay appears unusual, but some have done so:

> ***Melody N****: what I was doing I know it wasn't a band 6 post, it was a band 7 post. But I was told you know, because of the cuts and everything, we didn't have enough funding so I was told I won't get a band 7, I will be working for a band 6... 'till thy kingdom comes, so I said Well if something comes up, I will go.*

This lack of interest in finances includes financial planning for retirement.

> ***John M****: I've had a pension since day dot... most of my friends don't have pensions, who aren't nurses. I don't know what my pension's gonna look like to be honest… Yeah, I just certainly don't have a final salary pension anymore, that's changed, to a, well I don't really know what – (Alison: Career average?) Career average. But I don't really have a very clear idea of how much I'll get!*

> ***Margaret N;*** *this is me now, until retirement… Do I prepare? Um, no. I kind of think about my pension; so when I came to [], well obviously I was on secondment so I didn't have to worry about my pension, but then I became permanent at [] I had to start thinking about whether or not to transfer my NHS pension over into, erm, whatever it is called, and those kind of things. (Alison: are you paying any extra AVCs or anything?) No, I mean I have times thought about when I was working in the NHS because I had these kind of four years out, whether to buy back the years, and I remember enquiring about it, and I can't remember, but I never did*

buy them back; I kind of wish I had but - I don't even know how old I am going to be when I retire, so I don't know, I don't know.

The issue of missing years is pertinent for other participants. For example, Felicity's decisions about retirement are complicated because she believes the gap in her service could have a deleterious effect on her pension:

> ***Felicity N:*** *then I thought I'd have a little bit of a break… Now, I had no thoughts about pension or future 'cos you don't at that age. So, I suppose if you're looking at how people might be advised that's something that I regret, that I took a break in career at that time. I remember somebody saying to me when I was in my 30s: "I hope you're not one of these women who thinks they can rely on their husband's pension", because at that time there was an option to top-up and pay-back if you were working part time and I didn't think about the future - I just figured "well that's a long way off and I'd rather have the money in my hand now" and I was in a stable relationship; my husband was working; he had a good salary.*

Some participants plan to leave London when they retire, partly because that would make funds go further.

> ***Gem N:*** *But I don't think* [my pension] *is going to be enough if I stay here. That's one of the reasons I think. (Alison: How interesting, so do you think that your pension wouldn't be enough to live in London, but might be enough to live in the Philippines?) Yes it will be more than enough!*
>
> ***John M****: I mean, I live in Central London. I couldn't' be more central really. (Alison: what you'll do is sell the property you've got for a fortune) Well hopefully, and then move to country, move somewhere. I mean probably somewhere cheaper, but there isn't that many places that I'd wanna live that would be cheaper.*

4.6.1 Overview of the narrative of work-life balance

Most nurses have a personal life which is important to them and, if they have children, their welfare will always take priority over their career. The emphasis nurses place on their personal life's changes during the life course and is often most critical when they are also caring for young children. At such times, caring for their children is a major preoccupation for many nurses. This can involve adjusting their professional lives and using informal and paid-for childcare. Participants discussed the wide

variety of posts and work patterns available in nursing which can facilitate nurses finding a role suiting their personal lives.

Some nurses completely review their working pattern in the light of the demands of family life and they may move jobs to one nearer where they live, often in the suburbs rather than central London. This is the time when they notice, perhaps for the first time, local hospitals offering attractive careers. Sometimes these nurses are not even very particular about what sort of job they take.

Most of the participants liked London. Several had been attracted to the capital in the first place because they believed they would receive good training and continued to believe London provides a good professional experience. With all London has to offer, many nurses want to experience working there, even if only for a short time. However, some find London stressful and expensive. One way of balancing the conflict of wanting a good professional life against a good family or personal life is living outside London and commuting into central London. Some enjoy commuting and the change of scene. Danni N moved her home to the suburbs and travelled into London for work. Her commute was up to two hours each day. This was tolerable because she worked 12-hour shifts, so she only usually had to work 3 or occasionally 4 days a week. However, her working days were arduous and eventually became too much so she gave up for an easier journey, but on a lower grade. Her job outside London, however, failed to satisfy her and she subsequently moved back to work in London.

However, it is not just the worker or the workplace that may have to adjust. Mary N was uncomfortably aware her work had caused her daughters to make small sacrifices when they attended school breakfast club, and Paula N's parents had to move to be near enough to help with childcare. Paula N stated she would not have gone ahead without the support of her parents, which assured her that her child would be well-cared for. If this assurance had not been in place, many would not have continued nursing and left, just as Amber X did.

Their pay is important to them, but the exact amount appears to be less significant than its reliability. Pay required adding to the interview prompts because nurses appear genuinely disinterested in money and several participants joked, they had not entered the profession because of the pay. Instead, nursing offers other rewards. Some acknowledge they have enough money, and are grateful, whilst others cynically state that some people would never be satisfied with their pay. All this means pay rarely impacts career decisions. Most career decisions in nursing appear based upon the needs of their families or the intrinsic interest in the work, rather than making career moves to achieve a higher salary.

4.7 Conclusion to chapter 4

This chapter has presented the career stories in a series of narratives, supported, or refuted by results from the online survey.

There are many aspects of their work nurses enjoy. Relationships at work are greatly valued by nurses. Enjoyment of the work itself often focuses on bedside care and clinical procedures. These are a source of pride and enjoyment, and nurses worry about moving away from them. They enjoy learning new skills but are less certain about the benefits of academic qualifications. These satisfactions ensure many nurses rarely seek new work. Instead, career moves can be triggered and assisted by recommendations from senior colleagues or friends. Moves such as these are often promotion to a more senior post.

There are some aspects of their work nurses do not enjoy. These are important to the research question because being unhappy is one of the few triggers for career moves. However, there is less unanimity about these. For example, many nurses dislike administration, yet Daisy N acknowledged this can provide a welcome break from continual face-to-face meetings with needy clients. Another example is stress, which can be enjoyable for a short while, but eventually it can become too much. However, the point this happens varies for different nurses and for different times in their careers. Stress can eventually trigger career moves, especially out of ward or team management posts.

A recurring theme is a lack of reliable information relating to opportunities within nursing and guidance about navigating their way through the profession. Many of the nurse participants would like career counselling and this is an aspect of their role their managers and educators believe to be important and enjoyable. Yet, most nurses feel they rarely receive careers advice and take decisions on their own, or supported by their family and friends.

All the nurse, manager, and educator participants made at least three different contributions. The least quoted participants are Trudy X (who chose to make a short written response to the prompts) and Sadie E. They have each contributed to two different narratives.

Having organised, analysed, and presented these narratives, the next chapter will critically examine how these narratives can influence career decisions.

Chapter 5: Discussion of the narratives

This chapter explores the narratives presented in chapter 4, in the same sequence. These are the narratives of relationships, job satisfaction, finding the right role, stress, and work-life balance. The influence each of these narratives has on the career decisions of the participants is explored. This is supplemented with insights offered by other researchers, and theorists. If these are available, they can help verify the findings of this inquiry and to explore whether they can be more widely applied. Other findings extend our existing knowledge or are novel. This will allow an examination of the contribution this inquiry makes to our understanding of influences upon nurses' career decisions.

5.1 The influence of relationships on career decisions

It is impossible to overstate the importance of relationships to nurses. For many nurses, the most enjoyable relationships are friendships with nurse colleagues, leading to camaraderie, teamwork, and a loyalty towards their team. There are also important relationships with other professional colleagues and with the nurses' clients and their families. Good relationships are a source of enjoyment and satisfaction, and often compensate when other aspects of their working lives are unsatisfactory. Indeed, relationships may become even more important when there are problems at work; if everyone works together, then nurses enjoy additional camaraderie. During unsettling times, loyalty to their team becomes increasingly influential because nurses do not want to leave their team with problems. These high-quality relationships can prevent job moves which would otherwise occur during upheavals at work.

This means a job change threatens a whole network of important relationships which may have grown over several years. The effect of relationships to discourage career moves, or make them more difficult, was evident in the stories. For example: when she was a newly qualified RN, Daisy N was so happy with the welcoming atmosphere, she never wanted to work anywhere else. Nurses know a career move will lead to relationships changing or ending altogether. They worry about friendships

with their colleagues and ending therapeutic relationships with clients. Whilst this is mostly a positive aspect of work, there is a potential for this to be a hindrance because nurse respondent #5 spoke of feelings of guilt about leaving. Some aspects of this effect have been indirectly commented upon by others. Hitler (2011) noted relationships at work need to be broken if the worker is to move on, but does not seem to consider this a deterrent to career moves. In contrast, this inquiry shows some nurses are not prepared to break their relationships to achieve a career move. Instead, nurses may wait where they are in the hope that a suitable post or promotion arises locally, which it sometimes does. Alexander, Diefenbeck, and Brown (2015) provided one of the few pieces of evidence concerning the importance of relationships to nurses, although their research concerned only mental health nurses. They identified career plans are affected by three influences. The first of these was positive team relationships, which can bring about “longevity” (page 451) in nursing, due to the importance of workplace friendships. The two other explanations for longevity are treated as separate effects, yet it seems likely the staff relationships would foster both. These are overcoming negative perceptions of mental health nursing amongst their family and friends, and even amongst other nurses. Although Alexander, Diefenbeck, and Brown (2015) do not explore this, it seems likely good relationships helped the nurses to value their work and believe it to be important. The third factor was their approach to their clients and remaining hopeful; once again, a good team can foster an optimistic approach to their needy clients. These help counter the danger mental health nursing can sometimes be perceived as hopeless and therefore depressing (discussed in section 2.5.2.1), which can cause nurses to choose to leave. A contribution of this inquiry is to demonstrate relationships are equally important to adult nurses and become even more so in times of difficulty. Alexander, Diefenbeck, and Brown (2015) explain the importance of relationships by saying nurses enjoy these friendships, but this inquiry has shown, rather than just being one factor, nurses may consider their relationships as paramount and the potential effect on relationships is the most important influence they consider when they ponder career moves. Further, this discussion has argued even the other two influences

Alexander, Diefenbeck, and Brown (2015) identify could also be aspects of relationships. This inquiry has shown nurses themselves are aware of the importance of relationships at work because some try to assess the quality of the staff relationships available. This can be difficult to judge, but Amber X explained she made an unexpected career move because she "just clicked" with a potential colleague at interview.

Alice X and Rosie N demonstrated what happens when these relationships do not form. Alice X acknowledged these relationships were absent principally because she was working through an agency. Staff who work through an agency usually do so to gain increased flexibility at work (DeRuyter, 2007), but Alice X provides a cautionary tale that even these workers still want good personal relationships at work. Alice X left the profession, a decision she was beginning to regret by the time of the inquiry, a mere five years later. Rosie N came to hate her job due to the stress rendering good staff relationships impossible. She attributed this to a feature of the NHS and left for the commercial sector, yet this move failed to satisfy her.

The importance of relationships at work is well-known amongst nurses themselves, which is demonstrated by the strong support for the notion nurses value relationships with their colleagues, with none disagreeing. However, it is rarely discussed in research literature or in career theories. For example, relationships were not identified by Schein (1993) nor by Dobson et al (2014) as a career motivation. Bimrose et al (2014) suggested career theory has long been dominated by men's careers, and relational issues may be more readily acknowledged by women, and so have been overlooked. Indeed, it was noted in section 4.2.1 that the two participants not to mention relationships at work were both men. The significance of this inquiry could extend beyond the nursing profession because women are becoming more prominent in the workplace. Because nursing is a profession dominated by women, this inquiry could show features of work becoming more widespread as women become more prominent at work. Traditionally, many women regarded their paid work as secondary to their

role as homemakers (Anderson et al, 2000; and Sherry et al, 2017) and so may not have sought much satisfaction from their paid work, since life satisfaction came from their other roles, perhaps at home or with their families. There is some current evidence relationships are important to many workers. This thesis was completed during the lockdowns following the outbreak of COVID19, which has prompted some discussion in social media about the contribution of office banter and adult conversations to the quality of the work environment (for example *freshbuisinessthinking.com)* and suggests good working relationships may be valued more highly than has been previously recognised.

The nurse participants reported relationships with their clients were nearly as important as those with colleagues. It was the personal involvement in other people's lives which initially attracted Paula N and Amber X into the profession, and it remained a source of satisfaction to them. For Danni N and Felicity N, relationships with clients were the defining characteristic of nursing. Unlike relationships with colleagues, which is largely overlooked in the literature, that with clients is widely discussed. For example, Bridges et al (2013) found good relationships with clients are a means of getting work done and maximising the standard of care and the client experience. This is because effective therapeutic relationships with clients mean nurses can obtain their cooperation and trust, rendering work quicker and more enjoyable. Goncalves, Strong, and Nelson (2016) showed interventions to enhance nurse-client relationships could minimise the depersonalising effects of long-term elder care. Consistent with this, the nurse participants in this inquiry took pride in their effective communication skills and believed their relationships were an important part of their work. Nurses may put themselves out for their clients and encouraged clients to trust them.

However, this inquiry may have highlighted a different aspect of nurse-client relationships because many studies emphasise these in terms of the patient putting their trust in the nurse, who cares for them. This emphasises the effect of nurse-client relationships in benefitting the client. However,

Hagerty and Patusky (2003) claimed these relationships are mutual, involving connectedness and enmeshment in a two-way interaction. The nurses' enjoyment of relationships with clients is confirmed in this inquiry by, for example Dee N and Florence N. This further complicates the decision to leave a nursing job, because they are almost inevitably letting down their clients. Whilst a few participants, such as Paula N, were content with this, others, such as Melody N, worried about this loss. Indeed, this worry can be more severe than concerns about relationships with colleagues because these relationships almost always must end, for maintaining such a relationship would be impractical and can even be viewed as unprofessional (Ashton, 2016). Nurses receive much teaching about relationships, but this may not always include advice on how to end therapeutic relationships (Jennings, 2019).

The opposite of happy working relationships and camaraderie is described as incivility by Fida, Laschinger, and Leiter (2018, page 23) and was identified by two participants as bullying. Incivility is characterised by behaviour violating the norms of courtesy in the workplace and may even be a deliberate attempt to cause harm (Fida, Laschinger, and Leiter, 2018). It significantly contributes to staff turnover and burnout, (Hogh, Hoel, and Carneiro, 2011). Unfortunately, bullying is a feature of some nurses' career experience. Over 9% of new registrants reported being subject to bullying (Hogh, Hoel, and Carneiro, 2011). Ramsey (2014) even suggested bullying of junior nurses was traditionally regarded as an acceptable means of socialising them. However, bullying is destructive to the victim and perpetrator (Persaud, 2001), as can be seen by the severe effects on Tanya N's general health.

Fortunately, there was no evidence of incivility at the time of the inquiry, but three (15%) nurse participants (Tanya N, Paula N, and Florence N) believed they had previously experienced it. This inquiry confirmed such behaviour severely erodes the recipients' self-confidence and can cause endless distress. Tanya N believed the bullying she experienced directly lead to her having to face formal disciplinary procedures. She was exonerated, but not until after she had experienced even

more devastating loss of confidence than that described by Paula N and Florence N. Fida, Laschinger and Leiter (2018) state incivility can lead to emotional problems for the recipient and even chronic mental ill-health. Confirming this, Tanya N described having “dark thoughts” and Florence N going through “absolute hell”.

The loss of confidence reported by these three participants is consistent with the literature. For example, Fida, Laschinger, and Leiter (2018) claimed incivility at work diminishes the recipient’s self-efficacy and increases the risk of burn-out. Tanya N had not returned to clinical work at the time of the interview. The effects on Florence N’s career decisions may have been equally serious because she had been pondering entering general management, but the resultant loss of confidence caused her to decide that very senior management was not for her. The long-term effect on Paula N was different. She moved, “for personal preservation”, leaving health visiting, which she loved. However, this triggered a move into public health, which is where she was at the time of the interview. It is interesting to note that having her “fingers burnt’” meant she was no longer worried about career moves, and instead does what she wants to, so it is possible surviving bullying increased her resilience and has had a positive effect on her self-esteem and her career.

In view of the seriously deleterious effect uncivil relationships can have on workers, it is disturbing to note two of the three nurses affected had not reported this to managers and so there was minimal intervention offered. This is partly because the problem is often not recognised at the time. Neither Paula N nor Florence N had any help or support from their employer in dealing with the perpetrator, although Florence N arranged private coaching, and in neither case was the perpetrator addressed. The individuals had to deal with the situation themselves. This is especially concerning because Cilliers (2012) explained workplace bullying rarely takes place in isolation and is usually a symptom of unhealthy workplace culture. Fida, Laschinger, and Leiter (2018) stated it is difficult to control but doing so must be a management imperative. Two (Florence N and Paula N) of the three participants

reporting incivility only resolved the situation by making a career decision to move away and the third participant, (Tanya N) was moved to another role within the Trust. This confirms Hogh, Hoel, and Carneiro's (2011) finding that incivility is usually resolved by the recipient leaving and Fida, Laschinger, and Leiter (2018) suggested that, from the recipients' point of view, leaving may be the only safe option.

5.2 The influence of job satisfaction on career decisions

This is important to this inquiry since most of nurses' career moves are triggered by unhappiness at work.

Chapter 1 outlined evidence suggesting nurses enter the profession with high hopes but are disappointed with the career opportunities. In view of the wide variety of interesting careers available, it should not be necessary for many nurses to leave. This section will start by defining job satisfaction and examine how this applies to nursing. It then goes onto examine sources of satisfaction in nursing and some sources of dissatisfaction.

Job satisfaction in nursing is widely discussed by researchers, often in the terms described by Maslow's hierarchy of needs (Maslow, 1943). In the original article, Maslow described five levels to the hierarchy, with self-actualisation at the top. Liu, Aungsuroch, and Yunibhand (2016) examine how a nursing career can fulfil the nurses' needs in relation to such matters as the nurses' perception of their safety or their self-actualisation. This approach led to Liu, Aungsuroch. and Yunibhand (2016) to conclude nurses are satisfied if their work meets their financial needs, offers career opportunities, provides a gratifying emotional response, and they are valued. The participants in this inquiry did indeed want a satisfactory work-life balance and enough pay. It also found nurses valued the respect of others. However, this inquiry is based on nurses' career stories and uses nurses' own words to explore what they like. The nurses themselves tend to use a different vocabulary to Liu, Aungsuroch, and Yunibhand (2016). These nurses stated the most important matter is enjoying work for its

inherent, or technical, interest. This featured in the stories of 8 (40%) of the 20 nurse participants. Thus they discussed the interesting work (Faye N) the logical nature of client problems (Pitchie N, in section 4.4), the complexity of their work (Josh N), the busy atmosphere on the ward (Dee N, in section 4.5), and the needy clients (Jack N; Faye N). These would correspond to self-actualisation, because they find their work absorbing.

An important example is clinical skills or procedural knowledge. Indeed, nurses may even overestimate the importance of clinical skills (John M). Why are they so important to nurses? One reason is they are seen as prestigious (Munkejord and Tingvold, 2019), possibly because they are associated with medical practice. It is noteworthy that two participants (Dee N and Danni N) spontaneously mentioned venepuncture. This is an interesting example because overseas trained nurses usually do this as part of their pre-registration training (O'Brien, 2007) but UK educated nurses currently require additional training before they are ready to undertake this procedure. However, venepuncture is now part of pre-registration education in the UK (Nursing and Midwifery Council 2018a). This confirms these procedures are important but can be readily learnt (Carlson et al, 2014) and transferred to other clinical areas.

Conversely, nurses may underestimate the importance of so-called "soft skills". These are communication, teamwork, prioritising, teaching, and delegating. These are core to nursing and are how much nursing care is achieved (Smith, 2014). Felicity N acknowledged this (in section 4.2) when she said, "I think that's my skill, talking to patients in a way that they understand". In contrast, Josh N was rather dismissive of some of his work which he described as "just be easy to talk".

Another reason nurses value clinical skills is they represent their career progression (Dee N, Rosie N, Faye N). These skills need to be applicable elsewhere if the nurse is to move on and some participants described seeking work which would exploit them. They are then surprised when these skills are less important than their other attributes. This again suggests nurses put undue emphasis

on procedural skills, and insufficient on soft skills. The former may be specific to clinical specialisms, whilst the latter are useful in most aspects of healthcare. Florence N was aware of this and her role in staff development included encouraging nurses to apply for posts where they did not have the exact clinical skills required. The inability to transfer nursing skills to new areas is not much discussed in the literature, but it is something this inquiry has identified worries nurses themselves. Another concern some nurses express is the possibility of losing their skills (de-skilling). Nurses who believe they are becoming de-skilled may become disempowered and resentful of the potential loss of status (Munkejord and Tingvold, 2019). Mary N left a job caring for older adults, which she enjoyed, because she feared she would forget her newly acquired clinical skills. This concurs with Stevens (2011) and suggests nurses are denying themselves the opportunity of working in areas such as continuing care, even if they enjoy it. Yet, these areas offer excellent career prospects with interesting, satisfying work (Carlson et al, 2014; and Spilsbury, 2015) with opportunities for autonomy, creativity, and innovation. De-skilling is little recognised in research and is often only mentioned in highly specific situations, for example, the study by O'Brien (2007) of immigrant nurses. However, nurses themselves do seem to believe in the concept of de-skilling, and its threat to them (see, for example, correspondence between Gay, 2001 and Duffin, 2001, both in *Nursing standard*).

The satisfaction nurses derive from undertaking clinical skills represents self-actualisation. Koltko-Rivera, (2006), however, argues Maslow himself suspected there was a higher form of fulfilment, and presented a rectified version (see table 5.1). This highest level is termed by Koltko-Rivera (2006) as self-transcendence, which is described as a peak experience. If self-actualisation is when the person becomes fully themselves and fulfils their potential, then self-transcendence is when they go beyond that and the self, ironically, diminishes.

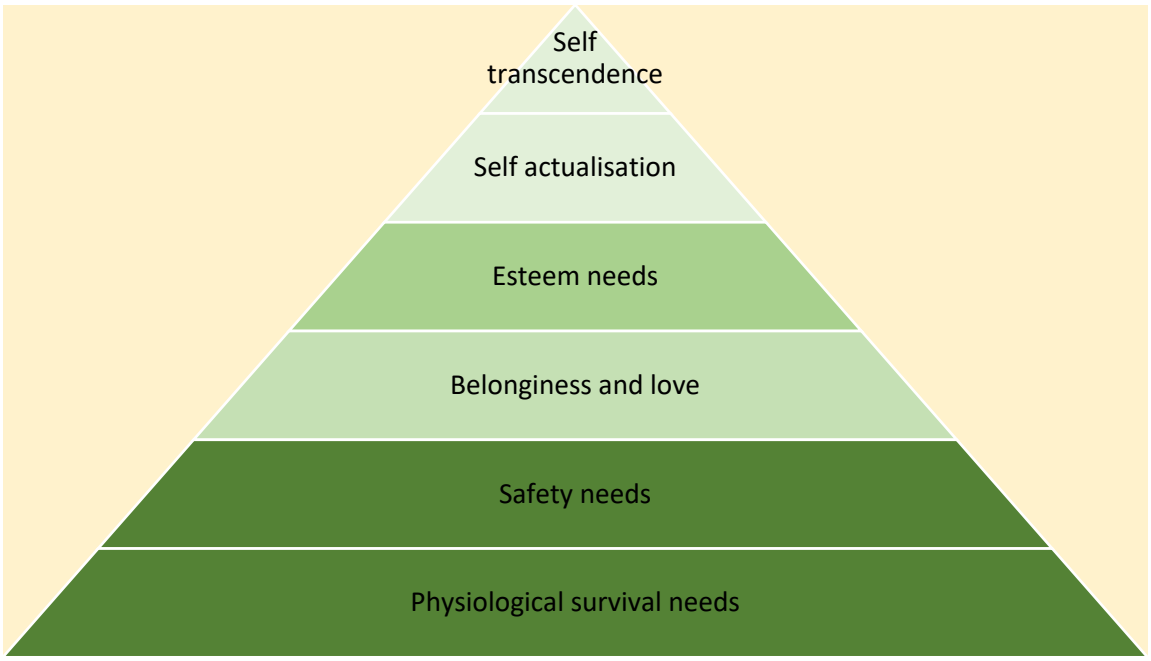

Table 5.1 A "rectified version" of Maslow's hierarchy of needs, suggested by Koltko-Revera (2006)

There are several examples of participants seeking self-transcendence. Being able to contribute to "something big" was important to Mark X and other participants had entered the profession partly through altruistic reasons, confirming the findings of other writers (for example, Eley et al, 2012). This suggests aiming for self-transcendence is present in the minds of young adults rather than, as Koltko-Rivera (2006) suggests, something that can only be achieved when all the others have been explored and satisfied.

Young nurses often wish to see clients get better (Mackintosh, 2007). However, Pitchie N was the only participant in this inquiry to report that as a source of satisfaction. Instead, these experienced nurses wanted to feel they had contributed in small but important ways. This may confirm Poulton et al's (2009) finding that nurses' career motivations develop, and nurses increasingly value areas such as health promotion. This inquiry adds the possibility that nurses also develop interests in promoting the long-term health of clients with chronic, often intractable, problems, sometimes referred to as

secondary health promotion (Rimmer, 1999). Thus, Danny N valued her role in the community, which potentially helped clients with COPD avoid requiring care in an ITU.

This inquiry corroborates research by Monkhouse et al (2018), showing nurses value autonomy. This provides the freedom to meet their clients' needs, without being controlled by rules or organisational procedures (Daisy N, Felicity N, and Melody N). Another effect of having autonomy is that it confers respect, particularly from medical colleagues (Felicity N). Wilson et al (2008) said nurses move jobs seeking enhanced autonomy and Dee N was poised to do just that. Wilson et al (2008) added that autonomy becomes more important to nurses as they progress. The nurses in this inquiry were all quite senior and did indeed value autonomy, but this inquiry cannot confirm this only developed as they matured.

Several of the nurse participants were CNSs and these are usually advanced nurse practitioners (ANPs or are working towards ANP status). Sarah M explained the roles of a team manager (who manage a group of nurses in the community) are rather like a ward sister and the community matrons (who have responsibility for a single group of clients with high care needs) are equivalent to the CNS post in the hospitals and clinics. These roles have developed slowly (McLoughlin, O'Brien, and Jackson 2009 and Savrin, 2009) and had not been formally defined in England (Begley et al, 2013) at the time of the interviews. This led to a plethora of job titles as posts evolved in response to local situations. CNSs are highly skilled within a tightly defined area. Some of them are very specialised. Examples include nurses trained in compression bandaging (Heyer, Protz, and Augustin, 2017) or in foot and ankle injuries (Derksen, 2007). This specialised nature can mean it is difficult to learn these skills. Daisy N learnt most of her skills from medical practitioners. This was a successful strategy but may not be viable in the longer term. Daisy N and Felicity N were involved in preparation of other nurses to take similar roles to themselves. This is a model for developing the high level of skilled specialist practitioner envisaged by Department of Health, Social Services and Public Safety (2006),

but it will not contribute to the nurse obtaining a higher degree, which may become essential for career progression. The contribution of their degrees is especially important in view of the costs (in terms of finance and time) of undertaking these additional studies, because Felicity N showed nurses will leave a programme of study if they feel it is not relevant.

Current research into the CNS or ANP roles tends to examine the care provided by these nurses (for example, Butler et al, 2019 and Begley et al, 2013), their contribution to professionalism generally (Savrin, 2009) or the preparation they need for the role (for example Futrell and Melillo, 2005). Most studies, however, overlook the nurses' perspective. Many of these roles developed in an ad hoc manner in response to local needs (Savrin, 2009) and often at the instigation of a local leader, which leaves the ANP / CNS vulnerable if the manager, who had the original vision for the role, moved on (Livesley, Waters, and Tarbuck, 2009). An example from this inquiry is Felicity N, who developed her advanced role as a direct response to the perceived needs of her patients, with encouragement from her medical consultant. Missing from much of the literature is a discussion of who takes these posts, why, and how they feel about them. The lack of national strategy means there is no single answer to this (Pearce and Marshman, 2008). A contribution of this inquiry is to identify nurses may aspire to these posts because they can provide a degree of autonomy and clinical freedom. They are client-facing roles with modest management or administrative responsibilities. They are widely respected within the nursing profession and beyond.

However, Luck, Wilkes, and O'Baugh (2015) found advanced practitioners attributed their success in obtaining the post to luck. This may be due to the lack of a coherent means of obtaining the posts. The career stories included in this inquiry confirm there has been no one route to ANP or CNS job. Felicity N and Laurie M had stepped into roles that had been a medical one. This is reminiscent of Casteldine (1997), who expressed alarm the title of Advanced Nurse Practitioner could apply to nurses taking on jobs previously undertaken by medical colleagues, rather than those developing

advanced nursing skills. The danger of becoming “mini doctors”, or even of being perceived as disloyal to the nursing profession, was a concern some nurses express (for example, Livesley, Waters and Tarbuck, 2009) when considering the ANP role. Davies and Mainwaring (2007), however, found these fears rarely materialised in practice and this inquiry has shown nurses perceive ANPs as complementary to medical practitioners. For example, Felicity N worked with “really good doctors’” but she did not need to “compete with them” because she offered “something else”, which was talking to the clients.

The literature rarely examines career moves following a CNS post. The participants in this inquiry believed the specialist nature of their work could hinder career progression. This is because their skills may not be recognised or valued outside their small field. Whilst Daisy N was satisfied with this, feeling she was achieving most she wished to, Gem N was contemplating a sideways move into a bigger specialism which may offer enhanced career progression. There may be an assumption the CNS or ANP role is so fulfilling that no one would want to move on from one, but that is a dangerous assumption and could discourage ambitious nurses taking these roles. It is also contrary to the flexible profession Modernising nursing careers (Department of Health, Social Services and Public Safety, 2006) envisaged.

Nurses believe their work is important and Malliarou et al (2010) wrote nurses are idealistic and become frustrated if they cannot achieve the high standards they aspire to. Frustration is defined by Li et al (2011) as a perceived miss-match between the effort expended and the rewards gained. Stories of frustration include Trudy X, who was not allowed to deliver the care she believed was necessary and for which she had the required skills. Dee N described her role in research as a ‘*glorified secretary’* and felt the way their work was organised meant she and her colleagues were not allowed to give good care nor gain ownership of the studies, which caused a high turnover of staff. These were consistent with Flinkman and Salanterä (2015) and Dawson et al (2014), who all found nurses

who most wanted to leave were those reporting the most severe time constraints, rendering them unable to give the high-quality care they aspired to. Another source of frustration was described by Florence N and Mark X, who both experienced the frustration that they were not more involved with decision-making. DeCola and Riggins (2010) and Dawson et al (2014) all found a perceived lack of power or involvement in decision-making increased the risks of nurses leaving. Amber X was obliged to organise the discharge home of a client whom Amber X (see section 4.5) felt was vulnerable. This was discussed in the light of her decision to leave nursing and is consistent with Robinson, Murrells and Smith (2005), who found issues concerning professional practice were the most likely cause of nurses leaving.

Li et al (2011) regarded frustration as a sinister development, which often resulted in a job change. Consistent with this prediction, five out of twenty nurse respondents (25%) mentioned the words frustrate, frustration or frustrating, and these included three (Amber X, Trudy X, and Mark X, 60%) who had left and a fourth (Florence N) who was pondering early retirement. It was noted in the literature review (section 2.6) several research papers have examined the intention to leave, but this inquiry takes this further and talked to nurses who had left, thus confirming the importance of frustration.

Nurses may enjoy using their skills after they have left the profession. Thus, Alice X is proud of being “really good at fainting”. By this she means she is good at managing passengers who are taken ill, which is a valuable contribution to her job within a cabin crew. Another example is Mark X, who appreciated that he could contribute his clinical insights into his current role in emergency planning. This suggests nurses believe their skills are important to the wider society, but the survey did not fully endorse this. Just 61% of nurse participants agreed to some extent. This ambivalence is surprising because Rosie N, Tanya N, and Paula N all related thoughts about using their skills after leaving nursing or even after retirement. Older adults often see volunteering as a means of maintaining their

identity and giving their life meaning (Bogaarde, Henkens, and Kalmijn, 2014; and Connolly and O'Shea, 2015). A study specifically about retired RNs undertaking voluntary work (Cocca-Bates and Neal-Boylan, 2011) found these nurses did indeed find fulfilment and companionship through volunteering. The managers and educators did not support the notion that nursing skills are used after leaving nursing. The managers may be especially aware of the loss of staff resources when a nurse leaves.

The next aspect of their work nurses like is variety. Paula N and Margaret N had moved jobs simply to experience a change. Such simple reasons for changing jobs is rarely discussed in the nursing literature. If boredom is discussed, it is its impact upon the quality of nursing care. For instance, Cleary et al (2016) identified boredom can lead to clinical errors and poor care but did not discuss the influence of boredom on career decisions. However, it is recognised by managers and John M expressed concern nurses will move away from their Trusts, just because they want a change. One potential way of preventing this is to offer rotations between different clinical experience. However, John M found this complex to organise and often unsuccessful when nurses are obliged to move from a job they like. Instead, he tried offering nurses a change if they wanted it, on an individual basis. This is good practice because Dawson et al (2014) stated being denied the opportunity to work in a different field was the second biggest source of dissatisfaction amongst RNs, causing them to ponder leaving. John M's approach would have been endorsed by one London Trust which reported experiencing high vacancy rates and high staff turnover (*Nursing standard,* 2016). They found staff were unaware of other posts within the Trust, and further believed moving posts was difficult to organise. The Trust established a "career clinic", which helped 76 nurses transfer posts within the Trust over two years, and none had subsequently left. They estimated the clinic had saved them nearly half a million pounds in recruitment costs and agency staff (*Nursing standard,* 2016).

Moving staff within Trusts may be easier in the large London Trusts. Simply having these arrangements in place may encourage nurses to stay in their employing Trust, knowing they could readily move if their work becomes routinised, as Pitchie N feared. Paula N, Danni N, and Jess E all explained London offers more professional opportunities than elsewhere because London has more of the 'exciting stuff' (Danni N). The *Capital Nurse* project was established by Health Education England to support nursing careers in London (Health Education England, 2018). Its work acknowledges nursing in London has special challenges, most notably staff shortages and rapid turnover of nurses, but also offers jobs requiring a wide range of skills in a diverse and interesting population. John M further explained that London may offer more rapid promotion. Others, however, regarded this as a mixed blessing, because promotion could be gained too quickly (nurse respondent #5 and Jack N). According to John M, this can damage future career progression because the promoted nurse lacked the basic experience, qualifications, or knowledge a senior post would require.

Whilst the participants could not always articulate what they wanted from their careers, they could often iterate what they did not want, which was frequently an administrative role. In contrast to clinical skills, they complained about the ever-increasing amount of administrative work. Danni N was surprised and disappointed about the administrative burden, which was one reason she left relief work overseas. Jack N similarly disliked administration, which caused him to ponder a career move in the future, possibly even to a lower banded post (“band five”). Nurses dislike of paperwork does not appear much in nursing research and Coombes et al (2010) claimed NHS staff do not object to the bureaucracy within the NHS and suggested most have been trained within the NHS and so were tolerant of its ways. Yet, dislike of administration is commented upon in the nursing press (for example, Tuckett, 2016), suggesting this may be an overlooked influence on career decisions.

The findings of this inquiry contrast with much research in relation to nurses’ attitudes to management. Several researchers report nurses’ dislike some management approaches, prompting

them to ponder leaving (Walker, Clendon, and Willis, 2018; Price et al, 2013; and Dawson et al, 2014. This was less prominent in this inquiry, although there was some impatience with “micro-management” (Florence N) and the importance of “ticks” (Jack N). However, generally, these nurses were tolerant to the needs of management. It is possible these older and more experienced nurses understood the bigger picture and were sympathetic to the managers’ perspective. In contrast, much of the literature used in chapter 2 only involved student nurses and newly qualified RN’s.

The final, but very important, aspect of their work nurses like is learning. Nurses often opt to work where they believe they will be well-supported and have opportunities to learn. John M explained being able to assure newly registered nurses they would be well supported meant they would choose to work there and this was a sufficient reason for providing support. Demonstrating this, Josh N had even migrated to another country to seek opportunities to study and once here, moved jobs to one that would facilitate learning, an aspiration other migrant nurses may share (Adhikari and Melia, 2015). Consistent with Horn, Pilkington, and Hooten (2019, discussed in section 2.5.4) the participants tended to favour education they believed would enhance their practice, rather than seeking career advancement.

Induction to a new post is a form of learning some of the participants discussed. This is a series of events and meetings designed to ease the starter into their new role. The literature review (section 2.5.1) examined the considerable challenges of starting as a new registrant, when nurses are at a high risk of leaving the profession (Edwards et al, 2016) and a programme of professional support is a NMC requirement (Nursing and Midwifery Council, 2006). However, these stories included accounts of experienced nurses feeling frightened by the lack of supervision on starting a new job. Others agree induction is an important part of starting a new nursing post. Kamau, Medissaukaite, and Lopes (2015) found a good induction programme improved staff welfare and retention. Their programme was termed a job preparation course (Kamau, Medissaukaite and Lopes, 2015, page 307) and was

entirely about how to fulfil their role as mental health nurses. This would certainly have satisfied Jack N's need to know how to use the "bleep" system and would have reassured Rosie N she had the knowledge she needed to administer drugs. However, McCallin and Frankson (2010) found a good induction programme goes further, to clarify expectations and offer feedback and this should continue for at least several months. Paula N explained it took her about a year to settle into her senior role. Skimping on the induction programmes is counter-productive because Jack N left that post to return to his original employer when he did not feel safe. Similarly, Rosie N left the NHS because she felt no one had verified her ability to practice, which should have occurred as part of induction (she described this as being "signed off"). These quick departures are consistent with Kamau, Medissaukaite and Lopes's (2015) prediction that poor induction increases staff turnover.

This section now goes on to explore the decision to embark upon formal post-registration education. Consistent with Halfer and Graf (2006); Brand et al (2016); and Wilson et al (2008), this inquiry confirms this is a major decision and was much discussed by the participants. Most specialisms claim at least some of the nurses working in their areas should have post-registration education in their field (e.g. Braine and Cook, 2015; and Brand et al, 2016) to adapt and enhance their skills. Yet, pondering higher education may be exceptionally difficult for some nurses because the nurse participants did not consider themselves academic. Margaret N and Faye N had even been attracted into a profession where not being academic need not detract from having a good career. Nurses identify themselves as "knowledgeable doers" (Drennan and Hyde, 2008), but there may be some conflict between the relative importance of theory and practice. Jack N and other participants were more confident of their ability on clinically orientated courses. Sadie E was disappointed some nurses, who were suitable for studying at masters level, declined to do so. She explained they opted for the minimum amount of study allowing them to obtain the professional award they aspired to. Sadie E believed this was caused by nurses' low self-esteem.

The survey confirmed nurses can feel pressurised into embarking upon academic programmes. Such pressure was most keenly experienced by those nurses who are not graduates. The stories included some discussion of moving goalposts. Participants felt they were required to achieve ever-increasing academic qualifications. Spetz and Bates (2013) point out nursing is an unusual profession in it did not (at the time in the United States) require a degree, but they found studying for a degree benefitted the nurse and their patients. Consistent with this, Eizneberg (2011) found nurses who were graduates were more likely to engage in evidence-based practice.

Some participants in the inquiry, for example, Felicity N, demonstrated benefits from studying for a degree. The benefits of studying for a higher degree (MSc) are less easy to identify. These participants thought higher education would help them deliver better care, yet they did not see it as a route to career advancement, which is consistent with the literature (for example, Horn, Pilkington and Hooten, 2019; Koehler et al, 2016 and Booth et al, 2006). Yet, a higher degree is required for ANPs (or be working for one, Health Education England, 2017) and some of the participants thought their successor would need a higher degree. However, most of the participants did not currently hold a higher degree yet were successfully fulfilling the post. This could lead to the conclusion that further study can help career progression but may not be needed to successfully work at that level. However, Williams and Counts (2013) were able to show nurses who had studied their specialism at a higher level had improved knowledge, compared to those who had not. Sadie E stated the profession benefits from more research within health visiting and having more practitioners who could work at higher levels.

There is a difference between the transcripts of the nurse and ex-nurse participants compared to the managers and educators. The latter were painfully aware of the difficulty in obtaining funds or time to study in the NHS and believed this could discourage nurses from applying or cause them to leave, which is consistent with the literature (Flinkman and Salanterä, 2015; Tummers, Groeneveld and

Lankhaar, 2013; and Cleary et al, 2016). Yet, this was not prominent from the narratives of the nurses and ex-nurses, who seemed to accept the need to fund it themselves. For instance, Pitchie N explained he could work additional hours to pay for a masters' degree. Even Faye N, who felt resentment on behalf of a relative having to pay for her studies, was more concerned about the time this involved and the threat if she was not successful. This could provide evidence for Philippou's (2015) assertion that more senior nurses accept responsibility for their career development and contradict the findings of Cleary et al (2016), who found nurses resented the lack of support available for study and Brand et al (2016) thought the required investment in study may discourage nurses from embarking upon it.

5.3 The influence of finding the right role

This section starts by examining nurses' early plans for their careers and how they go on to identify a suitable post.

Some participants complained about the lack of quality or detailed careers advice before commencing their nurse education. This could explain why Dante et al (2014) found television was the key source of information about nursing careers, followed by personal contacts, whilst a careers service, universities, or employers featured barely at all. Other researchers have noted the plethora of television shows and novels about health care, which often portray a glamorised, "tidier" picture of health care, emphasising acute care rather than long-term care of the chronically unwell (Gillespie and McLaren, 2010; McCannn, Clark and Lu, 2010). Kukkonen, Suhonen and Salminen (2016) worried these affect nurses' self-perception and become a source of dissonance as nurses feel they are nursing for the wrong reasons and the world they aspired to does not exist. There was no evidence in this inquiry of participants basing their early career decisions on popular media. That is not to contradict the findings outlined above, rather this may reflect the participants were all experienced nurses and nurses who were disappointed in their career choice will already have left.

Nevertheless, even the participants in this inquiry admitted they entertained little idea of what a career in nursing was like when they embarked upon their pre-registration programme and had rather prosaic reasons for entering nursing.

Danni N may have hinted at another reason for entering nursing when she described her entry as being “by default”. Poor quality advice may mean nursing attracts some candidates because it is prominent and some may have failed to consider other, less prominent, occupations. This could be demonstrated by participants, such as Alice N and Jack N, who entered nursing following indirect exposure to nursing. Yet such plans were poorly formed and most of the participants entered the profession with minimal ideas of their future and any career planning occurred within the profession. McKenna, McCall, and Wray (2010) similarly found nurses have little idea of the career options open to them at the start of their pre-registration education. Wareing et al (2017) quantified this when they investigated the career plans of entrants to nursing education and found about 50% had some long-term career plans, although only 17% put the plan into action. Even that, however, is higher than found in this inquiry, where only one (5%) had a planned career; Rosie N wanted to be a health visitor, but she did not implement it, the reasons are explored in section 5.4 However, being flexible in their career plans is demonstrably helpful, since several of these nurses were in pioneering posts not existing when they entered the profession and so could not have been planned.

Clinical placements account for 50% of student nurses’ time and the lack of coherent information about job posts means they are especially important. Most of the nurse participants were able to identify the influence of these on their subsequent career decisions. This section of the online questionnaire triggered a high level of written responses, which again emphasises the importance of clinical placements to nurses (see appendix 4). Whilst all placements are important, the final one or two placements seem to be especially significant, which concurs with Mills et al (2016, see section 2.5.2.1). Wareing et al (2018) found over 60% of student nurses stated experiences in their third year

had “significant” influence on their career decisions, but the figure for experiences in their first year was less than 5%. In this inquiry, just one (Rosie N, 5% of nurse participants) took a post on her first placement whilst Margaret N, Mary N, and Daisy N (15%) all took jobs on their final placements. These figures, however, are not directly comparable to Wareing et al’s (2018), whose figures are for being ‘influenced’ (page 1180) by a placement in their final year, not necessarily commencing work there. The findings of this inquiry emphasise how important placements are because Rosie N did not even enjoy her placement on the ward where she worked. Similarly, Margaret N could not even explain why she had been so keen on working on her placement ward.

Much of the literature related to the influence of student nurse clinical placements, however, discuss the students’ exposure to types of work and in this inquiry, the clinical specialism influenced Pitchie N to choose to work there. This inquiry, however, has shown other ways in which participants were influenced by the clinical specialism. For example, the good relationships between the staff and between the staff and students (see section 4.2). Student experiences provided other means of influencing career decisions, namely witnessing other nurses at work. Thus, Melody N admired the work of a CNS and in due course was herself appointed as a CNS. This aspect of role modelling in nursing is rarely explored in the literature. Although role models are generally regarded as having positive outcomes on the recipient (Cleary, Horsfall, and Jackson, 2013) they tend to be examined in relation to modelling professionalism (for example White, 2018; and Felstead and Springett, 2016), which was not even mentioned by these participants. Instead, they spoke of other nurses modelling the role they were fulfilling. Melody N reported continuing to be inspired by role models after registration and Dee N also talked about the importance of role models even when, or perhaps because, her professional life was especially difficult.

Much of the discussion in the literature about the effects of clinical placements concerns newly registered nurses. For example, Mills et al (2016) looked at student nurse placements and their first

post as an RN and McKenna, McCall, and Wray (2010) examined how placements affected career plans whilst the nurses were still students. An unusual contribution of this inquiry is to show these early career influences had long-lasting effects, because only a few participants described significant changes in specialism during their careers. The effects of clinical placements may not be fully evident early in their careers because Felicity N described remembering her clinical placements ten years after qualifying and seeking work there.

What about areas they have not experienced? Daisy N noted she had not seen certain specialisms during her nurse education, leaving her with a small sense of wondering what might have been. Areas not offering placements to pre-registration student nurses are likely to be disadvantaged when they wish to recruit these nurses. For example, the Queens Nursing Institute (QNI, 2016) reported with alarm most community practices do not offer placements to student nurses. The nurses in the QNI survey described the professional opportunities in practice nursing as “fabulous” (pg. 23) and wanted such placements to be mandatory for all student nurses. Sarah M believed they all did get at least some community experience but the QNI (2016) did not share this confidence. Although all students must experience placements outside the acute sector, this can mean placements with health visitors or in clinics. Not having relevant experience can lead to nurses taking posts that ultimately leave them unsatisfied. Thus Rosie N was frustrated with her job in research and Faye N did not realise much care of sick children is undertaken by the children’s families. Nevertheless, it may be possible to interest student nurses in a field they do not directly experience, because Mark X was inspired by a lecturer to consider a field he could not have experienced as a student which was outside the nursing role. Mark X, however, was in a small field and it may not be possible to attract sufficient numbers into a large and expanding field such as community nursing.

In the online survey, the question about the importance of clinical placements was strongly phrased, to emphasise the ongoing influence of pre-registration clinical placements, yet still, the nurse

participants overwhelmingly agreed, but the manager \ educator participants were ambivalent. It is difficult to verify this, due to the low number of responses, but the transcripts from the interviews with the managers do seem to minimise the importance of clinical placements. Sarah M was confident any exposure to community nursing would be sufficient to attract nurses for whom this would be suitable. John M was keen to recruit students well before the conclusion of their programmes and before the final placement had even commenced. Although it is acknowledged this could relieve stress for students at a busy time, it may impact the quality of their career decisions and risks missing appointing students who have yet to encounter their favoured clinical area.

Registration means the end of structured career moves and nurses are left to build their careers. This time was characterised in the literature review as a time when newly qualified nurses seek their niche (Mills et al, 2016, discussed in section 2.4.1). Consistent with this, Jack N discussed seeking work in a specialist centre to "*see what they do*". This is rather unusual, however, and most of the career moves described were either in response to dissatisfaction with their existing post, a change in their personal situation, or the unexpected appearance of a new opportunity. Nurses often simply wait in their present posts for a job to become available near-by, which they can take without jeopardising their relationships. This is a contribution of this inquiry, rarely identified before. Career moves are not planned and nurses respond to the situations they are in or can see. A more coherent approach could be fostered by career mentoring. The importance of good mentoring was noted in the literature review (section 2.5.6). Mentoring was the theme of the review with few research papers dedicated to it, but was mentioned in several other contexts. Career mentoring has been reported to assist career progression, self-efficacy, and the ability to recognise their wishes and to act on them (Singh et al, 2010). In nursing, it appears having the right mentor can be crucial to career fulfilment, and is another aspects of good relationships, discussed above (section 5.1). Flinkman and Salanterä (2015) found a lack of mentoring could trigger newly registered nurses to leave the profession. It is important throughout a nursing career, because Booth et al (2006) noted the effectiveness of mentoring in the

development of consultant nurses and midwives. Several participants stated they would have liked to receive career mentoring and most of the managers enjoyed discussing the nurses' careers, regarding this as an important part of their role. Yet no nurse participants stated they received mentoring and thought they took their career decisions almost alone. Mentoring could be especially important for some and may partly explain the differential in career outcomes between white nurses and BME nurses, observed by David (2014) if, as Adeniran, Smith-Glasgow, and Bhattacharya (2013) suggest, BME nurses are less successful in obtaining helpful mentoring.

There may be an absence of formal mentoring, but this inquiry found nurses will informally advise their colleagues, perhaps encouraging them to consider entering a specialist field. Thus, Melody N listened as a young nurse expressed her dissatisfaction with ward work. Another source of mentoring is medical colleagues. Felicity N and Daisy N both described receiving teaching and encouragement from consultant medical practitioners who would have been invested in developing nursing staff to enhance the clinical team. Both Felicity N and Daisy N were working in new, developing fields where expertise was rather limited. The fast-developing nature of the nursing profession and the emergence of new roles may explain why these informal arrangements are important. Mark X compares this with other occupations, where the career hierarchy is more explicit. It seems likely, as these specialist posts become established, the informal arrangements will be less important because the career paths to advanced practice posts and elsewhere will be more apparent. Nevertheless, it is to be hoped nurses and other health practitioners will continue to encourage junior colleagues.

The ward manager (or ward sister, usually at band 7) post was identified by John M as critical to providing quality care, yet he explained these are challenging posts and increasingly difficult to fill, an observation confirmed by Pegram et al (2014). This is partly due to the lack of recognised preparation (Enterkine, Robb, and McLaren, 2013). John M described offering nurses the opportunity to act into a more senior role whilst the person appointed to that post is on leave. This helps suitable nurses to be

promoted into the post and facilitates a vibrant work environment, encouraging nurses to stay, perhaps believing they are on a good career trajectory. It also ensures an adequate supply of suitable staff ready for senior posts. Managers often then point out when a suitable post is available and help them prepare for the interview. This could be useful prompting because Sadie E suggested some nurses are unskilled in the formality of applying for a job.

Another aspect of this is the use of online resources available for nurses to contact potential employers and to learn of opportunities available. The nurse participants seem aware of these but do not exploit them for career gain and Florence N needed to advise nurses on how to use them. One reason for nurses not engaging with these could be the poor quality of published information available. This jeopardises the decision-making process (Adee, 2013). For instance, the professional press is dissatisfied with the plethora of job titles (see for example *Nursing Standard,* 2005). All this obliges nurses to obtain information from informal sources.

Nurses have a relaxed approach to career planning, which could explain why several thought they would be in their current posts at the end of their careers, yet some expressed disquiet about this. In particular, they were worried they may not always be physically able to do the job. They have good reason to worry, because Andrews (2005) found stress and lack of stamina caused some nurses' early retirement and Zubair, (2015) found just over half of all nurses reported experiencing back pain in a single year, including 23% who experienced chronic back pain. Nurses are more likely than other health workers to experience muscular-skeletal injuries (Zubair, 2015). The physical demands of nursing are one of the biggest concerns of older nurses and may cause them to leave bedside nursing (Spiva, Hart, and McVay, 2011; and Geiger-Brown, 2004). Sarah M recounted managing nurses who were obliged to leave due to a deterioration in their health as one of the worst aspects of her work. This problem could increase due to delays in the age of retirement (discussed at the end of this section). The effects of working longer on nurses' health are uncertain and unions have

expressed concern nurses may be obliged to continue arduous physical work beyond an ideal age (Sprinks, 2013).

Nursing is a human-facing occupation, and it may be inevitable aspects of their personal lives cause nurses to reconsider the nature of their professional role. Thus, Sadie M recounted the experience of receiving excellent health visiting care leads some nurses to choose to train as a health visitor. Others become disillusioned with caring for sick people and seek to promote health and prevent sickness in the first instance. Stevens, Brown, and Graham (2013) confirmed these sorts of insight often come with maturity and the result of nurses raising their own families. Tanya N chose to work in ED following the death of her daughter and then chose to work with complaints, despite having been the subject of a malicious complaint. However, the effect of personal life on their career choices is difficult to predict. Whilst some nurses choose to work with clients in a similar situation to themselves, others may seek to avoid work reminding them of their pain. For example, Alice X's brother's death may have discouraged her return because she could not face entering a hospital environment. Danni N had a child suffering from a genetic disorder, the very sort of disorder she was working so hard to avoid in others, and left her work in PIGD, perhaps wishing her son had benefitted from such a service. The research into nursing careers does not clarify this because it is rarely mentioned, although Redin (2011) did include this in a reflective account of her career. Career theorists readily acknowledge the importance of social background and personality on career decisions (for example, Vondracek, Ford, and Porfeli, 2014), but not of a single yet intense personal experience.

So far, several influences on finding a suitable professional role have been discussed. These are clinical placements, advice from friends and managers, informal visits, job adverts and electronic resources, and personal experience. However, if the informal advice they receive is of variable quality, the formal information unreliable and they do not plan their careers, it is not surprising many of the participant attribute their careers to luck or chance. This is like the findings of Luck, Wilkes, and

O'Baugh (2015, discussed in section 2.5.5) and is consistent with research in other occupations, for example, managers in industry (Hitler, 2011). For Pryor and Bright (2011), chance is central to career development, and they suggested the "butterfly effect" (where tiny, often unnoticed, changes become magnified as the effects are transmitted and culminate in an important event) means very early events can be disproportionately influential. Yet, that which the participants attribute to chance may not be truly random. The nurse participants acknowledged help, guidance, and encouragement they received in their careers. These informal, almost casual, arrangements are important, and it is a concern such guidance is delivered in a rather haphazard manner. The suspicion is those nurses who hear of attractive opportunities consider themselves lucky, whilst those who do not will perceive themselves as unlucky and may even leave the profession. Mills et al (2016) found careers advice was critical to retaining newly registered nurses. It is possible mentoring could help nurses find the right role, and they then describe themselves as "lucky'; but those who are not successful in obtaining mentoring are "unlucky".

Mitchell, Levin, and Krumboltz (1999) examined the role of luck in careers and developed the "Planned Happenstance" approach to career counselling. This states people who pursue successful careers are characterised by certain cognitive attitudes. These include a high level of curiosity; a willingness to take risks; an ability to adapt; persistence; and an optimistic outlook. This means happenstance (serendipity) can be created; the worker can plan to be where the opportunities are most likely to arise and are ready to exploit them. Writers such as Langelle et al (2016) are increasingly suggesting universities should teach such an approach to help their graduates seize opportunities when they occur. These participants had responded to the opportunities chance had provided. For example, Danni N described being offered a job when attending a conference; consistent with planned happenstance, she was at an event where career opportunities were likely to be apparent and responded positively.

There may be a second process at work here. The difficulty of articulating their career decisions could be explained by Kriekshok (2009) who described two, almost independent, decision-making mechanisms. They termed these systems I and II (Kriekshok 2009). System I is the logical, conscious application of deduction or induction; it is explicit and can be justified using logic and reasoning. System II uses intuition based on assumptions and biases, rendering system II less conscious and more difficult to explain. System II may be preferable when the decision is complex or not all the relevant information is known. Most career decisions are important but complex, so system II would be preferable. System II, however, requires time to ponder the choices, often subconsciously. This is sometimes termed "deliberation without attention" (Dijksterhuis et al, 2006) and may explain why Pitchie N did not even seem to recognise the concept of career decision because, when asked about them, he spoke of professional decisions relating to patient management. If the assumptions and biases used in system II are accurate, they can lead to brilliant deductions in the absence of full data but, if inaccurate, they can lead to dangerously bad decisions (Adee, 2013). Therefore, assumptions and biases can be useful, but the decider should remain ready to revise, discard, or replace them (Hofstadter and Sander, 2013).

Information may be valuable, but advice is often rejected. This may be because, although well-intentioned, offering advice is often not the client-centred activity Woolnough and Fielden (2017) state is a characteristic of quality career mentoring. Waddell et al (2015, part 1) noted even lecturers in nursing required additional training to enable them to provide careers advice and mentoring. The advice could also be inaccurate, and this inquiry included at least two examples of this. Further, nurses such as Jack N, were suspicious of advice being offered primarily with service needs in mind.

Some nurses choose to leave the profession. This is a momentous decision and Alice X shows it is a difficult one to reverse. An alternative approach would be to work for an employer who was willing to

provide support for maintaining their registration. This is what Mark X was still doing (see section 4.3) and Amber X had done whilst she studied for her PhD.

The nursing workforce is ageing, particularly in community posts (Leifer, 2005) and clinical nurses who joined the pension scheme before 1995 are entitled to retire aged 55 years (NHS Business Services Authority, 2008), a situation alluded to by Paula N, who referred to it as 'that bugger'. The effects of this ageing workforce may be partially offset by the equality act of 2010, which abolished the default retirement age, meaning workers cannot be obliged to retire on age grounds alone (Department for Business, Innovation, and Skills, 2011). This coincided with a staged postponement of the age at which individuals are entitled to their state retirement pension, possibly until 69 years ultimately (Age UK, 2013). Additionally, the closer a nurse gets to retirement; the less likely they are to wish to leave, because they have found a comfortable work-life balance and because they are concerned their retirement income will not be sufficient (Oxtoby, 2012). This is pertinent to the present study because it again emphasises that important career decisions are taken throughout a nursing career and career mentoring should be ongoing. For instance, older nurses may need guidance to be able to take advantage of flexible working arrangements (Harris et al, 2010). Further, several of these participants worried that they would not be well enough to work up to their retirement age. Yet, most of the participants rarely thought about retirement, even though some (Felicity N, Mary N, and Florence N) were within five years of being eligible to claim their occupational pension. Felicity N commented that nobody ever talks about retirement!

5.4 The influence of stress on career decisions

The discussion so far shows many nurses enjoy their work and successfully identify an area of healthcare they find interesting and fulfilling. However, this can come at a cost and Cooper and Baglioni (2013) claimed nursing embraces most of the hallmarks of a stressful occupation; the workload is variable and unpredictable; it is a person-centred, complex role; with extended periods of

concentration yet mistakes can be serious. Stress is much discussed in the literature and is defined by the NHS as “the body’s reaction to feeling threatened or under pressure” (Every Mind Matters, 2019) and stress at work is regarded as a serious public health issue (Despréaux et al, 2017). It causes cardiovascular disease, diabetes mellitus, unhealthy lifestyle, and even suicide ideation. This section examines the effect of stress on career decisions.

Stress is not always a negative influence, indeed, several of these participants reported they liked being busy and Dee N described herself as a “stress junkie”. Mary N described how, with good support, she had learnt to tolerate and even enjoy stressful work. This was noted by Wilkes et al (2017), who found almost equal numbers of nurses liked being busy as disliked it. Section 4.3 (above) identified good working relationships can compensate for a stressful environment, even contributing to the enjoyment of rising to the crisis.

Padilla-Forunatti and Palmereiro-Silva (2017) provide a model of burnout and say it is likely to occur when the worker’s effort is not matched by the reward and recognition they receive. It leads to feelings of exhaustion, with depersonalised and hostile attitudes to others, cynicism, and withdrawal of emotional involvement (Fida, Laschinger and Leiter, 2018). Padilla-Forunatti and Palmereiro-Silva (2017) claim it is quite common amongst nurses, with up to half of all ICU nurses affected. It could be caused by, and contribute to, the incivility discussed in section 5.1, above. Jones and Griep, (2018), describe an ideological psychological contract whereby the employer provides interesting work and the employee works hard. Asking too much of workers is a breach of the contract but initially, nurses will work even harder until eventually they cannot, and this leads to burn-out. The effect on some careers may be serious. Alice X left nursing but now regretted that decision. Rosie N was offered a job in the health visitors team, her “dream job”, but declined it because she was so exhausted by her role and could not contemplate an ambitious move. This was unfortunate because Rosie N was the

only participant who had plans for her career when she entered nursing, which was to be a health visitor, but was now one of the few participants rather dissatisfied with her career.

Lo et al (2018) found job stress was a major contributor to nurse turnover. They stated stress can directly cause nurses to leave but they also said it could indirectly cause nurses to leave through ill-health, including depression. This inquiry included none complaining stress had made them ill, but Dee N reported the catastrophic effect of stress on a colleague and Margaret N implied fears for her future health caused her to change jobs. Like much research on nurses leaving, Lo et al (2018) only documented nurses leaving their current posts and did not investigate what jobs they moved into. This inquiry can contribute because it involved nurses who had left previous posts through stress. Sarah M made the important observation that nurses move from management to matron (the equivalent of moving from a ward manager's post to a CNS post) to avoid burnout, but few move from matron to management.

Nurses know they are dealing with people's health and mistakes can be serious. This is ironic because stress, itself, may increase the likelihood of errors occurring (Daigle, Talbot, and French, 2018). These onerous responsibilities can influence career decisions because nurses worry about the possibility of an error or a complaint. The written and numeric responses to the online survey confirm this is a real concern for nurses and some appeared haunted by this. Occasionally, nurses do face disciplinary action which could result in their being temporarily or permanently removed from the register. However, nurses may over-estimate the risk to them of this happening because it is quite unusual. In the year up to April 2020, the NMC had over 700,000 nurses and midwives on its registers and handled complaints relating to 4650 of them (Nursing and Midwifery Council, 2020), representing about 0.64% of all registrants. Most complaints were dismissed but 1699 were fully examined. Of these, 380 had some sanction imposed. Only 127 nurses or midwives (around 6.5% of cases investigated and less than 0.01% of all registrants) were removed from the register. Yet in another

way, nurses are right to worry because Tanya N showed a complaint could have an unpleasant, potentially catastrophic, effect on the nurse's working life, even though it was not upheld.

Many of the participants were concerned about job security. Indeed, many nurses entered the profession believing it was a safe profession. Tanya N had chosen to remain in the NHS because she saw it as a reliable employer and Margaret N sought a secure income. Jack N would have liked a job as a lecturer-practitioner but felt these were the first posts to go if staffing needs to be reduced. This importance nurses attach to job security is consistent with the findings of other researchers (for example Kalandyk and Pendar-Zadarko, 2013). Nurses who work in the NHS for its security are probably right because redundancy is unusual in the NHS. Thus, most of these nurses would have spent their career free from concerns about job security, which enabled many to be relaxed about the future. Nevertheless, concerns about job insecurity could trigger career moves. These participants still discussed "the consultation", when two Trusts merged, three years earlier. None of the participants had direct experience of this but had observed it happen to others, which they found unpleasant and stressful. Nevertheless, the survey showed only modest concerns about job security, and it is poignant to note by the time of these interviews managers complained of being unable to recruit sufficient staff. It does appear clinical nurses in London need not worry unduly about the risk of redundancy.

The participants attitude to redundancy and complaints suggests they are quite risk averse. The exception was Paula N, who enjoyed talking about the career risks she had taken. This approach was consistent with Paula's personality; she liked variety and quickly became bored. Thus, to Paula N, risk-taking was enjoyable and not stressful. It is interesting to examine Paula N's experience in the light of Krieshock et al's (2009) theory. This states workers who are prepared to take risks experience greater career success and satisfaction. Paula N was happy to take risks and seemed to take delight

in the very fact that she was a rule-breaker, yet she was enjoying a noticeably successful career; she was the most senior nurse participant and also one of the youngest.

5.5 The influence of work-life balance on career decisions

Work-life balance refers to individuals' perceptions of how paid work and non-work roles fit together and are managed following their system of life values, goals, and aspirations (Casper et al, 2017). As Haar et al (2019) explained, achieving a work-life balance means achieving harmony between a worker's paid work and their multiple networks of roles including friendships, voluntary activities, sporting, and devotional life. Nevertheless, balancing the demands of family life with professional life is most discussed, both in the literature and in this inquiry. Someone must attend to the children and child-care duties fall disproportionally upon women (Homburg, Heigden, and Valkenberg, 2013). Becker and Moen (1999) found dual-earning couples with young children are rarely able to both aggressively pursue their careers. According to Haar et al (2019), individuals with a high workload and high levels of work-related responsibility will find a good work-life balance difficult to achieve, but supervisor support and a high level of autonomy can make it possible. Others are less optimistic, for instance, Gambles, Lewis, and Rapoport (2006) argued a healthy work-life balance is a myth and almost impossible to achieve, due to the "invasiveness of paid work" (page 51) in the digital age and financial pressures causing some workers to accept long hours. However, Gambles, Lewis, and Rapoport (2006) also acknowledged recent changes in the workplace have led to workers themselves becoming increasingly devoted to their work, which is inherently more interesting and satisfying than it was a generation ago. These changes include technological developments and mechanisation which have eliminated much drudgery, freeing the worker to engage with more intellectual work. This concurs with the inquiry, where all the participants found their work absorbing, interesting, and enjoyable, and they believed it to be worthwhile.

The enjoyment some nurses derive from a busy environment means each nurse must find the correct balance for themselves. If they do not have enough to do, they will become bored and frustrated. If

they have too much to do, this could impact their personal lives and they become resentful. This range of preferences regarding this balance can be seen here. Paula N described feeling completely satisfied with her job and allowed it to "consume" her. In contrast, Felicity N felt her personal life was important and being overly devoted to her work may not be "entirely healthy". Most workers try to accommodate family life, but nurses occasionally find this impossible and are obliged to leave the profession permanently (Homburg, Heigden, and Valkenberg, 2013), often, like Amber X, with regret (Brewer, 2008). John M described how this compromise between family and professional responsibilities could sometimes be impossible to achieve. It was impossible for Amber X, too, who gave up "before childcare really came in". More typically, participants described juggling their private and working lives. and most of the participants with children described altered priorities after their children arrived.

The needs of their families, especially children and frail parents, are a powerful influence on the career decisions. Much of the literature reports on this rather negatively, but some of the women participants with children had under-estimated the joys of bringing up children and were surprised at how much they had enjoyed that stage of their lives. Felicity N seemed to set out with the belief and wish that child-rearing would not alter her approach to her career but related how she "changed tack" to facilitate motherhood. She, Paula N, and Danni N all describe altering their approach to their work. In this inquiry, the compromises made were considered worth it and Felicity N and Paula N both seemed a little surprised at the enjoyment they derived from their role as a "Mum". Danni N alone seemed to resent the effect this had on her working life and would have "preferred" not to have to adjust. Workers changing their priorities during their life has been noted by other researchers. For example, several medical practitioners told MacDonald and Cawood (2012) that they chose their specialism initially for its perceived interest, enjoyment, and intellectual challenge, but subsequently flexibility and compatibility with family life had become more important. Thus, workers make early career decisions without considering how their chosen career will fit in with a future family life, but

then change their career paths to accommodate the needs of children and other dependants. Larsen, Leif and Frauendiest (2012) found perceived flexibility was important to nurses in choosing where to work.

One possibility is to exploit the 24-hour nature of the nursing service, which offers a variety of work patterns. Faye N found an arduous pattern but managed it. Felicity N found working 12-hour shifts impossible with children and had to be proactive in applying for a new job and asking for family-friendly hours. Her prospective employers had not even considered this before, yet found they were able to accommodate her wishes. This emphasises the importance of the nurse at least requesting (or the employer offering) appropriate hours. These can often be arranged so the nurse can continue to work at a level commensurate with their skills and experience, whilst also fulfilling the needs of their children and their wish for a family life. Sarah M stated the predictable hours in the community attract nurses to work there; community nurses do not work full night shifts and work one shift until they choose to change. This means their child-care requirements are predictable and they do not need child-care at night. Nurses who work at night usually rely on a partner for childcare. This could suit some, such as Faye N, but is challenging for single parents or those whose partners also work shifts. This latter was the situation Amber X was in, which she described as impossible. Other fields in nursing offer sociable hours. Jess E provided the example of cardiac rehabilitation which involves working with outpatients who have serious heart disease, to help them regain their strength. Nevertheless, this does not always work because Danni N requested, and got, a reduced working week with more days off, but she believed her senior medical colleague knowingly undermined this. She felt obliged to relinquish the job she loved, in cutting-edge research, and resented having this imposed on her.

Childcare was, or had been, a preoccupation for several participants and has become a feature of life in modern Britain. In 2019, an estimated 1.7 million children were receiving formal, paid childcare in

England (Department for Education, 2019). This compares with about 3.4 million under-fives in the English population (Office for national statistics, 2016). From this, it cannot be concluded half of children under the age of five receive formal childcare because some places are taken by children of school age (Department for Education, 2019). Nevertheless, the figures demonstrate formal childcare is part of the economic life of our country and Amber X was correct in believing the childcare may be available today. However, is this available to the children of nurses? The cheapest option is usually a childminder, and in London costs about £250 per full week, per child (Money Advice Service, 2020). This compares with take-home weekly pay of about £390.00 for a London nurse at the lowest rung of band 6 (without unsocial hours pay). This may mean two children requiring full-time childcare would take most of the income of a band 6 nurse; fortunately, there is some help available from the government and sometimes employers. Childcare is even more expensive and difficult if the family require irregular hours or hours different from the usual extended office hours, although childminders are sometimes willing to be flexible (Canter, 2016). These high costs may explain why few participants described paying for full-time childcare. Instead, they relied on a mixture of formal and informal arrangements. An interesting example was Mary N, who used reciprocal arrangements with other parents. This meant a friend who was also a parent would care for Mary N's children one day, but on a different day, Mary N (or her husband) would care for her friend's children. Faye N avoided child-care costs altogether by working at night when her partner cared for the children. For some, this constant juggling can be fun, and they are proud of how well they manage it. Yet, this is another positive aspect of family life rarely mentioned in scholarly sources, but social media does recognise the busyness of family life can be enjoyable (for example, Katelyn Fagan 2014).

Some of the apparent sacrifices made for the benefit of family life may not have been hardships. It is possible having a young family allows some nurses to decline challenging career opportunities. For example, Faye N seemed to appreciate family life gave her fewer career options. Although she seemed obliged to provide for her family financially to some extent, she also stated she did not need

to be so career orientated nor be as “driven” as she would otherwise have been. The demands of family life appear to have provided Felicity N with an “excuse” to give up a degree course she was not enjoying. This suggests one possible impact of family life on nurses' career decisions is to provide a route for them taking a less demanding career. That is to say some nurses may feel obliged to seek promotion and seniority despite not necessarily wanting to, but having a family enables them to opt for a quieter career.

Most of the participants came to accept their career or their family life must take second place, and it is always their careers. Not one participant stated they had allowed their career to have priority over their family commitments. The participants felt some adjustment to their career plans to accommodate their family responsibilities was inevitable, but instead of regretting this, they tended to speak of the enjoyment their families added to their overall quality of life. Only Danni N resented having to sacrifice her career for her family, yet still reported it was the right choice for her. Other researchers report family commitments postpone nurses’ entry into specialist training (Ng, Eley, and Tucket, 2016) or prevent them making advantageous career moves (Luck, Wilkes, and O’Baugh, 2015). This study showed little evidence of severe career effects, except Danni N. It is possible any such career disappointments were not revealed at the interview, but it is also possible these nurses had successfully found a work-life balance suiting them and, even if it involved compromise, this was not perceived as a sacrifice.

In any case, children usually prove just a short-term distraction from their careers and, once children are a little older, nurses can resume pursuing their career more energetically. Some of the participants described enjoying new-found freedom once their children became more independent and were proud of their continued professional achievements. This effect is predictable, and nurses can be encouraged to plan for such a time. Further, it is important to notice it is not just women with children who feel these conflicts. For example, Josh N left a job he loved to move to London to be

near his girlfriend. Similarly, Jack N felt responsible for his elderly parents, following the untimely death of his brother. This meant he was not free to, for example, move to another area to pursue his career. Dee N chose to work in a less onerous environment and moved into research nursing; although she did not have children, she nevertheless enjoyed the sociable hours.

Another possibility is to have children early and then progress with their career later. Some of the participants observed this pattern in others but none of them demonstrated it themselves. Paula N's career pattern is almost the opposite and shows having a young child need not cramp career ambitions. She had her child when she was in her 40's. By this time, some key career decisions had been made; she had completed her first and higher degrees and moved into senior management. Paula N's strategy was to achieve a senior post before risking compromising her career with child-care responsibilities. This is an increasingly common pattern (Liefbroer, 2005) but it is risky and, if it doesn't work out, the worker can end their career feeling bitter and disappointed (New scientist, 2015). Kroeger and Mattina (2017) speculated reproductive technology will offer women the possibility of postponing childbearing, but this inquiry suggests this may not be a positive development, because women may under-estimate the enjoyment of bringing up children and therefore postpone this positive part of their lives.

Pay is discussed here because of its contribution to family life. Most of the nurses were satisfied with their pay. The exception was Danni N. She had an unusual career, characterised by career moves between different specialisms. She moved quite early into international relief and from there to PIGD and then to ITU and finally into practice nursing. Here, her eclectic experience was useful, because she was involved in secondary prevention with clients affected by COPD and in women's health. Her career demonstrates clinical skills learned in one area can be valuable in others, yet she resented her pay band, which she believed did not reflect the broad range of experience she brought to her role as a practice nurse because she did not receive "credit for previous experience".

Some resentment may have been felt when they compared their pay to others. Gem N explained some of her nurses took home more than she did, due to the relatively generous unsocial hours payments. There may be another reason pay does not impact career decisions; even if they want more pay, they are unsure how to obtain it. Most nurses work for the NHS which offers standardised pay scales (see appendix 1), so changing employer for a pay increase or negotiating a pay rise is not usually a realistic option. Yet, Melody N's story shows if they want more pay, it is possible to achieve. She worked as a CNS on band 6 for two years, but like Danni N, felt her banding was not commensurate with her skills and successfully applied for a band 7 CNS post. This was at a different Trust and Melody N felt the work itself was similar, but on a higher band. Melody N subsequently informed the researcher she had been promoted to nurse consultant, which she had described during the interview as her 'final goal'. It is interesting that, for Melody N, wanting more pay did lead to a career decision, which suggests nurses who want more money can obtain promotion. John M (see section 4.3) provides a similar account, when he advised a junior colleague against moving simply for more money. John M believed the band was artificially high and the result of nurse shortages which ultimately did not help the nurse's career.

The online surveys appear to confirm nurses are indifferent to their pay, because 80% of nurses and managers or educators disagreed that nurses prioritise pay or were neutral. This concurs with Meadows, Levenson, and Baeza (2000). Yet, this disinterest in pay may be changing and other evidence contradict this inquiry. There is some anecdotal evidence (Karim, 2015) of nurses leaving the UK, not in search of adventure, but of better pay, conditions, and lifestyle. They are mostly migrating to work in Canada, USA, and above-all Australia, all of whom are welcoming UK nurses in increasing numbers (Pickersgill 2012). Further, Kalandyk and Penar-Zadarko (2013) found 97.7% of their nurse respondents stated low pay was a problem for them and Hackett (2020) stated over one third of nurses are pondering leaving, mainly due to perceived low pay. Further, the nursing press

repeatedly reports resentment (e.g. Gillen, 2013 and Kendall-Raynor, 2016) caused by perceived low pay.

The relaxed attitude of the participants to finances extends to their retirement. None of the participants was making additional pension contributions and some had withdrawn money from their pension funds when the rules permitted that. Despite all of this, the participants were mostly optimistic about their retirement. They were aware they (unlike some of their non-nursing friends) had a secure occupational pension scheme, which they trusted to provide a pension. Nevertheless, they were concerned about the size of that pension and John M and Gem N were both worried the pension may not provide enough to retire in London.

5.6 Conclusion to chapter 5

This chapter has discussed the narratives related to career decisions, identified from the stories. Nurses often enter the profession with high ideals but little understanding of what a career in nursing entails. The narratives influencing career decisions are relationships, which is largely overlooked in the literature. The second narrative is job satisfaction. This appears high amongst the participants, who want varied and interesting work with the opportunity to give good care and to learn and practice clinical skills. Most of these nurses appear to have achieved this yet, the third narrative was finding the right work and the participants often cannot provide a coherent account of how they managed it, often attributing their career success to serendipity. Nurses enter the profession without long-term career plans and there appears to be a paucity of good quality information within the profession. Most of the participants denied receiving careers advice or mentoring, yet several had made career moves at the suggestion of another nurse. The fourth narrative was stress and most nurses report this at times, although they varied in how much stress they find acceptable, and too much stress had often triggered a career move; yet some had moved to a quieter post, only to find they were now under-stimulated. The final narrative was work-life balance. The literature suggests this can be difficult to

achieve in modern Britain and several participants described putting their career second to their family life. Importantly, however, few resented this and were proud of how they had managed both a personal and professional life.

Having explored the data in the light of the existing knowledge, the next chapter will highlight the contribution of this thesis to our understanding of nursing career decisions and suggest some practical applications of these insights.

Chapter 6: Conclusion and outcomes of the inquiry

The two previous chapters presented and discussed the data. This was the stories of the twenty nurse participants. These were supplemented with insights provided by six educator and manager participants and results from the online surveys, all examined in the light of existing research. This final chapter evaluates the contribution of this inquiry to answering the research question: "what influences nurses' career decisions?". In answering the question this thesis offers some outputs of the inquiry. First, there are the stories themselves, all can be read in appendix 4. Rolfe (2006) said the value of qualitative research lies in its ability to illuminate the situations of others and Bell (2002) states a good narrative inquiry enhances the understanding of the participants, to this could be added the readers may also gain additional insights into their situations. Section 3.3.1 argued stories should be credible to the reader partly because they reflect the readers' own experience (Webster and Mertova, 2007). Therefore, the stories may have value in providing material for nurses to reflect upon, to help make sense of their own lives and potential careers. The stories recount career success in nursing and fulfilment (Dee N, Paula N, Felicity N, and Faye N), of working autonomously (Dee N, Daisy N, Felicity N, and Faye N), seeing through challenging projects (Daisy N) and accepting significant responsibilities (Florence N and Gem N). They also include accounts of nurses experiencing bullying (Paula N and Florence N) tragedy (Tanya N) and frustration (Mark X, Trudy X, and Danny N). Any of these could resonate with the readers' experience.

This chapter presents a new graphic, "careers in nursing" (see figure 6.1), which captures aspects of work this inquiry has revealed impacts on nurses' career satisfaction. This is accompanied by two tools (tables 6.1 and 6.2 in section 6.1). After presenting the graphic and tools, the chapter explains their development and how they could be used (section 6.3). It goes on to identify the unique contribution of this inquiry to our knowledge of nursing careers and the implications for the profession (section 6.4). The limitations of the inquiry are acknowledged (section 6.5) but then some

recommendations for practice, education, and research are outlined (section 6.6) and the objectives reviewed (section 6.7). The chapter concludes with a personal reflection on the author's journey in research (section 6.8). Reflexivity is an important feature of narrative inquiry (Finlay, 2002) and the researchers' reflections may guide future use of this methodology as researchers seek to understand careers in nursing.

6.1 Proposed graphic and tools

The graphic "career fulfilment in nursing" simply provides a structure for discussing careers in nursing. The five narratives are depicted in the graphic (figure 6.1). This could help nurses visualise their current role and may facilitate group or class discussions of careers in nursing. The graphic has been used to develop two tools. These are: "Reflecting on your career in nursing" (table 6.1) and "Reflecting upon nursing appointments" (table 6.2).

The first tool, "Reflecting upon career fulfilment in nursing" (table 6.1) helps nurses and their advisors think about their current post and their future aspirations. It has been noted nurses tend to only make career moves when they are unhappy, this tool has been designed to help them ponder their careers in the longer term. They are encouraged to review satisfaction in their current post and consider where this could lead them. The inquiry has shown nurses discuss career decisions, even if only on an informal basis, with family, friends, colleagues, and managers. This is to be welcomed and the tool will facilitate such discussions. This does mean, however, the role is often filled by someone not trained in career counselling, and this tool could provide a structure for their discussions. The second, "Reflecting upon nursing appointments" (see table 6.2) helps managers evaluate nursing posts and may be particularly useful if a post is likely to be difficult to fill.

The graphic and tools are presented below, followed by an account of how they were developed (section 6.2).

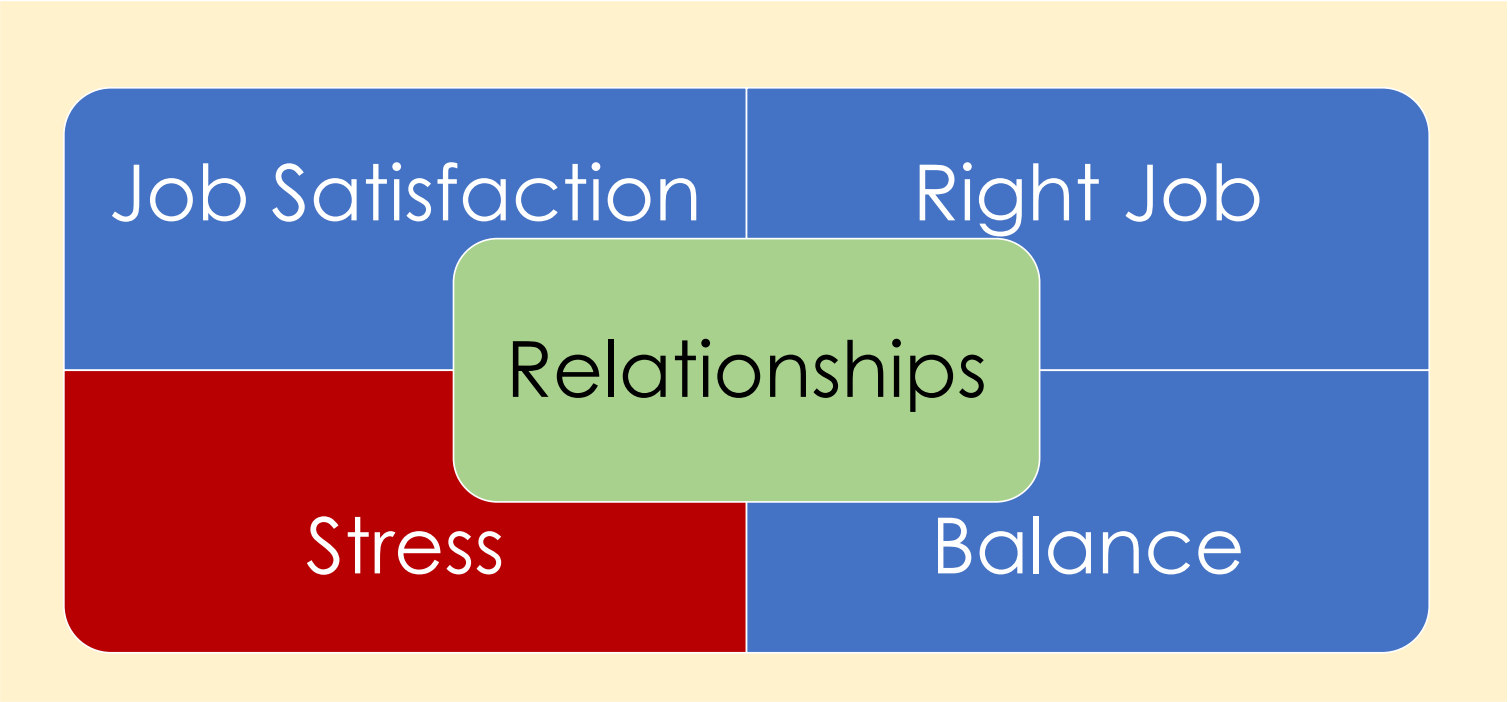

Figure 6.1: Career fulfilment in nursing

Reflecting on career fulfilment in nursing

Instructions for use: the first column suggests aspects of work nurses say make their work enjoyable. You can rate each one and then consider whether this aspect of your work could be improved. Towards the end of each section are "cautions" in red. These seriously undermine fulfilment at work and should be addressed if present. Remember this is your work, you should score your role as you find it.

Relationships

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	What would a five in this area look like? What actions would you need to take to reach that?
Camaraderie friendships and working relationships with nurses and professional colleagues		
Therapeutic relationships (i.e. with clients, their families etc.)		
Challenges: any bullying or harassment? What actions should you take?		

Job Satisfaction

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	What would a five in this area look like? What actions would you need to take to reach that?
Technical or clinical interest		
Opportunities to use clinical skills and a caring role		
Autonomy		
Variety		
Opportunity for career mobility and promotion		
Formal educational opportunities		
Challenge: Is there a risk of boredom or excessive routinisation?		
Challenge: Is there an unacceptable administrative burden?		

The right role

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	What would a five in this area look like? What actions would you need to take to reach that?
Is there career mentoring available?		
Do you get the chance to meet other professionals or to hear about new developments?		
Does your role complement aspects of your personal life?		
Challenge: is career information you receive up-to-date and reliable?		

Stress

Remember the amount of stress that is right varies between individuals. You may like a "buzz" or prefer a quieter role!

Aspect of role	Score out of 5 1= too much stress or not enough to do (boredom); 2=not quite right; 3=okay; 4=good; 5= excellent	What would a five in this area look like? What actions would you need to take to reach that?
Amount of responsibility		
Workload		
Freedom to work at high standards		
Job security		
Exposure to risk		
Challenge: is stress affecting your health?		

Work-life balance

Aspect of role	Score out of 5 1=bad; 2=poor; 3=okay; 4=good; 5= excellent	What would a five in this area look like? What actions would you need to take to reach that?
Adequate time for family		
Interaction between home and work		
Adequate time for work		
Journey to work		
Pay		

Thinking about your future (allow plenty of time for this!)

In this section you should consider your future and how you think this role is helping you achieve the future you would like.

What are you currently learning that could be relevant to future job moves?	
Are there any opportunities you could take to increase your career fulfilment?	
Is there anything from this tool you would like to share with a colleague or your manager?	
What sources of information can you access about careers?	
Is there anyone you admire, perhaps the way they work or the job they do? Can you contact them and ask to talk to them about their work or to "shadow" them?	

Table 6.1: Reflecting on your career in nursing

Reflecting on appointments and roles in nursing

Instructions for use: the first column suggests aspects of work nurses say make their work enjoyable. You can rate each one for the post you are considering and, in the third column, reflect on whether this aspect of the role could be improved. There are some suggestions for features of a nursing role that may help improve a score. At the bottom of each section are "cautions" in red. These seriously undermine fulfilment at work and must be addressed if present.

Relationships

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	Can the score be improved? What action can be taken
Camaraderie friendships and working relationships with nurses and professional colleagues		Effective leader Social, charitable or other events available
Therapeutic relationships (i.e. with clients, their families etc)		Support when dealing with needy clients Training in therapeutic relationships and opportunities to reflect
Challenges: any incivility (bullying, harassment)		Staff development or transfers, involvement of HR or outside agencies

Opportunities to learn about the role

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	Can the score be improved? What action can be taken
How well-known is the specialism?		Provide explanation of role that applicants may not be familiar with. Informal visits, role shadowing?
Students and visitors		Does the area /role take student nurses on placements **And / or** will students see or experience the role? Consider "micro placements" or electives. If impossible, could visits or lectures be organised? Ensure students and others made welcome, taught, and encouraged to consider returning as RN?
Induction		Provision of a programme offering orientation, discussion of expectations, feedback
Challenge: does the role lack prestige or status?		Increase status e.g. by encouraging contributions at Trust level or beyond.

Job satisfaction

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	Can the score be improved? What action can be taken
Technical or clinical interest		Identify those aspects of the work the nurse could be responsible for (for example) clinical developments, research, placements, teaching, discharge planning.
Supervision, professional support, mentoring, & Informal learning		Provision of study time, named career mentor, learning opportunities in (for example) other departments
Formal educational opportunities		Expectations for study for BSc / MSc made explicit? Realistic timeline and support in place?
Autonomy		Opportunity to contribute to management decisions, future strategy, and wider issues. Will the nurse have the opportunity to contribute to "something big"?
Opportunity for career mobility and promotion		Will they get the chance to act up, work in other departments, and hear of new opportunities?
Variety		Opportunities to work with other departments, rotation, variety in role
Challenge: Is there is risk of boredom or excessive routinisation?		
Challenge: Is there a high or unacceptable administrative burden?		

Stress

Remember the amount of stress that is right varies between individuals.

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	Can the score be improved? What action can be taken
Workload		Acceptable and clearly defined workload
Amount of responsibility		Clearly defined areas of responsibility, with provision to ensure and reassure nurse they are competent. Pay commensurate with responsibility
Freedom to work at high standard		Requirements of high standards are explicit, with arrangements for facilitating and ensuring these
Job security		Provision of job security. If new, temporary, or experimental, assurance of alternative employment in place.
Relationship with management		Opportunity to contribute to management and strategic decisions?
Challenge: Is there a high administrative burden? If so, is there appropriate support in place		
Challenge: Is this a very stressful role and, if so, is appropriate support in place?		

Work-life balance

Aspect of role	Score out of 5 1=absent; 2=low; 3=okay; 4=good; 5= excellent	Can the score be improved? What action can be taken?
Suitable for nurse with other responsibilities		Consider part time / job share / family friendly or flexible hours. Availability of workplace or other childcare arrangements?
Geographical location		Explanation of arrangements for public transport, parking etc. in place? Is there a need to consider travelling at unsocial hours?
Is the pay commensurate with responsibilities		Ensure pay grade correct and explicit. Consider arrangements for pay progression
Requirement to work unpredictable hours or risk of short notice changes		Possibility of regular (albeit unsocial) hours? Arrangements for changes in work hours to be provided in advance?

Table 6.2: Reflecting on nursing appointments

6.2 Developing the graphic and tools

Nurses should be familiar with reflection because this is part of the re-validation process, under the auspices of the NMC. Therefore, the graphic and two tools have been developed and are designed to encourage reflection and discussion, based on the stories.

The graphic simply depicts the five narratives influencing career decisions as revealed in the career stories. “Relationships” is shown prominently in the middle, and with a green background, to represent their significance. Relationships are key to career fulfilment and are always of paramount importance to all nurses. If they do not form them, nurses are at risk of drifting in their careers, changing jobs, or even leaving the profession. The other four narratives are arranged around relationships. Three are depicted with a blue background. Nurses may discuss what each of these means for them. The narrative of stress is depicted with a red background. This represents excessive workloads, unacceptable levels of responsibility, and an intolerable work-life balance can all lead to career moves. It is acknowledged nurses sometimes enjoy the “buzz” of being very busy, but they nevertheless often explain that it is not possible to work at such levels indefinitely. If the situation does not ease, they will often seek new work.

The vocabulary used in the graphic and tools is like that used by nurse participants and so is common parlance for nurses. The vocabulary should help nurses feel comfortable using the graphic and tools and to encourage them to share this with others. The content is expressed informally and encourages users to take time reflecting. This means the term “uncivil” has been replaced by “bullying”. This is the term used by the participants and is likely to be better understood by users of the tools. There are two other changes. Because the semi-structured interviews were designed to gather information about career decisions, job moves and finding the right role were discussed in the career stories and is one of the narratives. However, the inquiry found nurses do not move jobs readily and it was important the graphic and tools do not imply they should do so. Therefore, the tools include the simple title “right

job". Work-life balance has been replaced with "balance" for brevity in the graphic but is maintained in the tools.

The tools encourage reflection upon career mobility and whether a post facilitates promotion or offers the opportunity to work elsewhere. Such considerations were almost absent from the stories, yet the discussion (section 5.3) showed nurses can and do leave posts if they are denied the opportunity to work in different roles. This justifies the addition of an area not fully derived from the career stories. Further, the managers believed offering nurses the chance to work in a more senior role whilst the post-holder is on leave (to "act up") ensures a dynamic work environment. This encourages nursing staff to remain because of the good career opportunities and, in turn, helps ensure a pool of nurses suitable for promotion.

Both tools mostly comprise of simple, five-point Likert-type scales, which most nurses are familiar with (and was used in the online survey for this inquiry), meaning they can be adopted with minimal explanation. The descriptors for the scores are slightly different in the different sections, to make them easier to use. There are some questions, termed challenges, which cannot be scored because they are always unwanted. These are highlighted in red to alert nurses and their managers to ponder their presence and whether they can be mitigated.

The tools are presented mostly in dark grey text with a pale blue and cream background. The font used is Century Gothic. This formatting was recommended by the educational technologists as facilitating accessibility. If printed, the tool will use six sides of A4 (eight sides for the management tool) and could be in black and white to control costs. The graphic is slightly brighter, to facilitate its use in class, but sharp contrasts have been avoided.

The nurses' tool does not give advice for several reasons. Principle amongst these is because this was not the aim of the inquiry and there is insufficient evidence upon which to base careers advice.

This inquiry has found nurses are disinclined to take advice and if they seek advice there is plenty available. This is evident from tables 2.2 and 2.3 showing the high number of articles (183 out of 542 articles considered) excluded from the literature review because they were not empirical research papers. Many of these offered careers advice to nurses without providing the evidence on which this is based. Finally, although most nurses work for the NHS, the situation still varies locally and the CNS or ANP posts can arise due to local health needs. Instead, the tool encourages nurses to consider where they can turn for advice or mentoring. Nevertheless, some aspects of nursing careers are always malign, and these are highlighted.

6.3 Purpose of the graphic and tools

A significant motivation for embarking on this inquiry was to address the lack of evidence for educators in guiding student nurses. The graphic and tools depict aspects of their work nurses like and some they dislike and could now be used by educationalists. It could help student nurses anticipate some of the joys and difficulties to be found in their future careers. The graphic could provide the basis for class discussions or individual reflection to explore with student nurses' expectations of their careers and the positive and negative aspects of nursing they should consider. As nurses approach qualification, the tool "Reflecting upon career fulfilment in nursing" could be used to highlight influences nurses find important and to help the students review potential jobs. The tool (table 6.1) could provide them with a structure to help them to identify of aspects work they may value and should seek, as well as suggesting those they should avoid. Further, nurses rarely receive formal career mentoring, yet they do often benefit from informal guidance from kindly managers and colleagues. That means this important role is fulfilled by people not specifically prepared for it, and therefore a simple and relevant tool could assist nurses in their everyday conversations with nursing friends and colleagues. These contributions are important because helping other nurses was the motivation of many of the participants and others who contributed to the research.

Nurse managers, particularly in London, are interested in strategies to attract and retain staff. The tool "Reflecting on appointments in nursing" (table 6.2) could be used by managers considering nursing posts. It will be especially helpful for managers with a post that may be difficult to fill (for example, the ward sister/manager or team manager role) or less popular areas (for example, elder care). This tool could also be useful if the team dynamics are not effective. This tool also does not give advice but does include some ideas for enhancing a nursing role. For instance, the tool asks if there are mentors available because the ward sister/manager or team managers' post has the potential to be a rather isolated role, and most of the participants stated they would have welcomed mentorship. It also reminds managers about the importance of induction for new staff. As well as this, the inquiry showed nurses complain about the poor quality of information available about careers in nursing, and the tool "Reflecting upon appointments and roles" (table 6.2) encourages managers to consider the information available about the post under consideration and suggests a range of strategies.

In future, it may be possible for the graphic and tools to be accessed electronically and for them to be linked. This would mean the user could "click" on each area of the graphic and this would lead to the relevant section of the tool opening. If they were online, this would make them more widely available, and it could be used as part of an appraisal or the reflection component of NMC revalidation. The lockdown has demonstrated many workers are now comfortable working and collaborating online. This tool could facilitate discussions relating to appointments and appraisals for nurses.

6.4 Contribution to knowledge

This thesis opened with the observation the nursing profession offers a wide variety of interesting posts, yet too many nurses leave the profession early. This leads to nursing shortages, which puts strain on the remaining staff. This loss could also be disappointing to the nurses, who had envisaged themselves staying in the profession. Certainly, of the four ex-nurses involved in this inquiry, one regretted leaving. What has this thesis shown to illuminate or even relieve this problem?

Despite the completed inquiry, there remains no single answer to the question, “what influences nurses’ career decisions?”. Nevertheless, as they explored decisions in retrospect, many of the nurse participants were able to make sense of them in a manner they may not have been able to at the time. The approach of this inquiry contrasted with much of the existing literature (explored in chapter 2), which mostly discussed future career intentions, but these nurses recounted decisions which had already occurred. They reported responding to new, often unexpected, career opportunities and enjoyed adapting their skills to new situations. At the conclusion to this inquiry, five narratives are proposed which influence nurses' career decisions. They strive for specific sources of fulfilment in their careers and, often even more powerfully, sought to avoid others. Chapter 5 examined the narratives found in the career stories and compared these with the existing literature. Whilst some of the narratives are well-known, such as the effects of stress and workload, others are new. This chapter now goes on to review these and the unique contribution this inquiry has made to our knowledge about career decisions in nursing. Such contributions are the hallmark of a PhD thesis (Mackintosh, 2016). The discussion also encompasses concerns about nurse attrition explored in chapter 1.

There was some existing research concerning the progress of nurses in the first year or two after registration. It is therefore well-established nurses have difficulty adjusting to life as a registered practitioner and are at risk of leaving currently. Much less is known, however, about the career progression of established registrants and how they adapt their professional lives to developments in their own lives and perspectives. This inquiry only involved experienced nurses and ex-nurses and shows they tend not to anticipate future career moves or retirement. They do not plan moves or career progression, usually only seeking new work when actively unhappy. This suggests nurses who leave before retirement age have rarely made an active choice but have been driven away by problems at work.

The stories confirmed Jirwe and Rudman's (2012) findings that nurses obtain career fulfilment from several sources. The importance of relationships may be acknowledged by nurses themselves, but they are usually overlooked in career research, or perceived merely as an attractive bonus of work. This inquiry has shown relationships guide career decisions and nurses will be attracted to work in areas where there is good camaraderie available. It has confirmed the destructive effects of incivility but demonstrated this is rarely resolved within the team and often only end when the recipient leaves, without the causes of the disruption ever being addressed. Nurses who do not form good relationships are at risk of drifting between jobs and possibly out of nursing altogether.

There is, however, another aspect of relationships. As well as being enjoyable, this inquiry shows many nurses benefit from informal career guidance and encouragement from colleagues, particularly managers. This is a great advantage, although it may be under-recognised by nurses and most deny receiving career mentoring. Knowing how to move posts may be especially important to nurses, who often complain of boredom or excessive routinisation. This inquiry shows differentials in the quality of information available. Some participants benefitted from good advice and recounted help and encouragement they had received. Likewise, the managers were keen to "grow their own" senior nurses. Others, however, complained they (or others) received information and advice that was inaccurate or biased. Nursing does not have a clear hierarchy and so good quality mentoring assumes even greater significance. This raises the worrying possibility some nurses are leaving nursing believing the profession has nothing to offer them and unaware of potential posts available.

Planned Happenstance (Mitchell, Levin, and Krumboltz, 1999) proposes successful careerists display characteristics such as a high level of curiosity; a willingness to take risks; an ability to adapt; persistence; and an optimistic outlook. This inquiry found some evidence of these characteristics influencing nursing careers. Moreover, the formation of successful mentoring relationships could be part of this. It is possible these participants, who had all pursued fulfilling careers, had listened to

advice and made judicious use of it. Many of the participants attributed their career success to luck or chance, it is possible those who had received good quality information were the ones who felt they had been “lucky”. Planned Happenstance (Mitchell, Levin, and Krumboltz, 1999) suggests the worker can ensure they benefit from this luck, which is not random. Managers will want to ensure all their staff are “lucky” and receive good quality careers advice and mentoring. Similarly, HEIs may be able to teach some of the behaviours Planned Happenstance suggests can promote career success, although nurse educators may require additional training to fulfil this important role. Doing this will help the HEIs fulfil their responsibility of ensuring their students obtain the maximum career benefit from their studies.

Nurses enjoy learning and will seek to work where this will be facilitated. They especially value the opportunity to learn if they believe it will enhance the clinical care they provide. However, this inquiry has revealed that experienced nurses may leave if they fear being obliged to study for a degree (usually a BSc) or higher degree (usually an MSc). Nurses have a low opinion of their academic ability and may fear academic assessments and avoid them. Most clinical nurses do not believe studying for a higher degree will contribute to their effectiveness at work. Some of the participants did not hold a degree yet acknowledged their successor is likely to require one. They had mixed feelings about this: since they are demonstrably effective without a higher degree, is one necessary? Worse, is nursing losing something important, as the profession becomes more academic?

Most of these experienced nurses had achieved a good work-life balance, but for those with families, this almost always involved informal care for their children. This could be due to their needs for flexible childcare, outside usual office hours, or the costs of childcare. That nursing does not always take place during office hours can facilitate nurses working whilst also fulfilling parenting responsibilities. Nurses sometimes need to be proactive in arranging this because it is rarely offered or suggested. All the participants were emphatic the welfare of their children came first and they

would not jeopardise that. Further, it was not just women with young children who put their families first, men and participants who did not have children reported concerns for elderly parents or the effects of workplace stress on their relationships and marriages.

Participants reported concerns about ageing themselves. This is pertinent, given the ageing nursing workforce (see section 1.2) and the figures discussed in section 5.3 concerning injury to nurses. Some participants enjoyed a stressful and busy environment, but even they acknowledged they will not always be able to work at that level. Several participants expressed misgivings about their physical ability to continue working as they currently were up to retirement. Although often phrased in jest, this could conceal a genuine deterrent to continuing to work as a nurse and it is possible some nurses proactively choose to leave rather than face an ever-increasing struggle to continue working. Managers dread this situation but, more positively, nurses could be alerted to alternative roles or the possibility of flexible retirement. To this may be added the effects of working in London. Nurses like the professional challenge but can find the capital a difficult environment to live in. Some resolve this by commuting, but others find the resulting journey unacceptable. They often leave for local employment, possibly accepting a lower grade or a less interesting post.

Choice of specialism has been a popular subject for medical research, but the choice of nursing field is less commonly investigated. When it is researched, it is usually about attracting nurses into less popular areas. This inquiry provides evidence nurses choose their specialism for the intrinsic interest and rarely consider how any post could lead them to further career moves. The importance of clinical placements as students is recognised in some existing research but this inquiry adds this influence is long-lasting. This inquiry involved experienced nurses' and ex-nurses' career stories and they were often able to identify early influences, such as a friendship, with a long-lasting influence upon their career decisions. This was described as the butterfly effect (Pryor and Bright, 2011). Although the effects of clinical placements were regarded as a positive influence by the participants, it is possible

their enduring importance reflects the lack of information about careers available after they have completed their pre-registration education.

Section 2.5.3 explored contradictory evidence about the importance of pay to nurses. This inquiry agrees with researchers who say pay is less important to nurses. Nevertheless, they expect their pay to be fair and resent feeling they are paid at a lower level than their skills warrant. They also want their pay to be reliable and dislike job insecurity. Both these situations can cause them to leave. Interestingly, however, nurses wanting a higher income seemed able to achieve it without leaving nursing. Nevertheless, a request for a pay rise is rarely successful and nurses may have to leave for another Trust.

The importance of career mentoring has been reiterated throughout this inquiry, for a number of reasons. It is evident nursing does not, most notably at higher levels, have a clear career structure or formal arrangements for its practitioners' progression. This may be exacerbated because one of the strengths of ANP or CNS posts is they develop to respond to specific local needs, but that can mean it can be difficult to know how to obtain such a post. Chapter 2 suggested new nurses tend to prefer nursing clients with a single, acute pathology. This inquiry has shown nurses often develop an interest in preventive and secondary prevention as they mature. This is precisely the emphasis of many advanced practice posts and suggests these roles will become more attractive as nurses progress in their careers. Career mentoring will help nurses explore their maturing outlooks and priorities.

This inquiry has shown ANP and CNS posts are attractive but their appeal can make the ward sister/manager or team manager post appear relatively less attractive. The latter can be difficult to fill due to their complex nature and a large amount of staff management. They are usually paid at band 7, which makes them comparable to a CNS or ANP role. On the other hand, a disadvantage of the ANP and CNS roles is they are not perceived as a route into higher management and stepping out of such a role is likely to involve a step down. Although some of the participants in this inquiry were

satisfied with this, it contrasts with the flexible, mobile workforce envisaged by *Modernising nursing careers* (Department of Health, Social Services and Public Safety, 2006). One complication is the CNS role may appeal to nurses who fear burn-out.

There is some discussion in the literature (see section 2.5.2.2) about preparation for taking a CNS or ANP post. These posts can be highly specific, and it is unlikely there will be suitable MSc programmes available to meet all the diverse educational needs. Several of the nurses in this inquiry reported receiving training and encouragement from medical practitioners. This may not be sustainable, and the profession needs to consider how these nurses can be developed in future. This inquiry confirmed the findings of the literature (chapter 2); nurses rarely seek CPD for its own sake, or for career progression, but to enhance their skills so they can better meet the needs of their clients. In contrast to the literature review, this inquiry found nurses accept the need to invest in their post-registration education. The findings of this inquiry may reflect a more modern approach to further and higher education, where it is viewed as the responsibility of the worker – particularly for more senior practitioners.

6.5 Limitations

These findings are tentative and need to be tested on a wider and more diverse population. It was acknowledged from the outset nursing is a big, complex profession, and it was necessary to define just one, small part of it to study. Even having done so, however, it remained a challenge to recruit participants to fully reflect London adult nurses. There was no attempt to ensure the participants were statistically representative of the wider profession, but there were attempts to ensure as many perspectives as possible were included in this inquiry. The snowballing technique of recruiting participants lead to the danger that participants would be clustered in just a few specialisms, and indeed four of the 26 participants worked in one specialism, gastrointestinal health, which was therefore rather over-represented. The inquiry only involved London nurses, but even within London,

they may not have been representative. Of the 16 nurse participants who were still working as RNs, 6 worked for just one Trust. This may also have been an effect of snowballing recruitment. Similarly, it was difficult to recruit participants who worked in fields that were themselves difficult to recruit nurses to. One such area was represented, namely community health, but others, such as elder care, were not represented in this inquiry.

During the initial planning of the inquiry, it was possible there would be a shortage of suitable nurses willing to participate, a problem encountered by other qualitative researchers in nursing (Raymond et al, 2017). In this inquiry, that concern was not realised, and sufficient participants were readily recruited. However, these early concerns may have meant insufficient thought went into recruiting a varied sample, due to a reluctance to turn down potential participants, when in fact choosing between participants may have provided a broader range of experience. For instance, three of the participants had trained overseas, but two of these grew up and were trained in the same place, the Philippines. Whilst this does reflect the high number of Pilipino nurses working in the UK, it meant this inquiry did not take the opportunity to include a wider variety of overseas participants.

A striking feature of the findings is all but one of the participants were highly satisfied with their nursing careers (the exception was Trudy X). Using snowballing and personal knowledge, efforts were made to find some unhappy participants, to ensure a broad range of perspectives were offered. A few were identified and contacted by the researcher, but only Trudy X agreed to participate, and only using written responses. This may demonstrate this group can be hard to access for research purposes. However, the open invitation to several nurses meant both those nurses who were happy with their careers and those who were unhappy could have used the opportunity to discuss these issues. The general contentment amongst the participants could potentially restrict the applicability of this inquiry because the nursing press reports widespread dissatisfaction amongst nurses. On the

other hand, the data gathered for this inquiry could accurately reflect the feelings of London nurses and the nursing press over-report problems.

As other researchers have found, all participants had difficulty explaining how they had made their career decisions; they tended to have relied on system II, which is intuitive, rather than system I, which is explicit**.** Whilst this is, in itself, an important and interesting finding, it nevertheless made analysing the decisions difficult. However, a strength of narrative analysis is the opportunity to retrospectively make sense of their decisions and to develop coherent narratives. The contribution of the managers and educators was particularly valuable here because an objective perspective upon other people's career decisions helped build the picture. The qualitative research method allowed some narratives, apparent early on, such as the importance of relationships, to be explored more fully. Others were identified later in the research and may not have been fully explored. For example, how participants were able to fulfil their family as well as their professional commitments, and much of the discussion about childcare was speculative.

This inquiry confirmed nurses can provide a rich story of their career and experiences, and little prompting was required to gain illuminating data. The researcher's inexperience contributed to the interviews occasionally lacking focus. The researcher was much obliged to the participants, and sometimes treated the interviews as social conversations, rather than research interviews, and was consequently reluctant to direct the conversations. During the conduct of the inquiry, the researcher increased her skills at directing the conversation, whilst remaining courteous and keeping the participants' account at the forefront of the interview.

6.6 Implications for practice and recommendations

Whilst acknowledging the limitations, it is still possible to state some implications of this inquiry and form recommendations for practice, education, and research. These will be presented in that sequence.

Nurses rarely have career ambitions, but they do have concerns about the future. They worry about becoming bored at work, their health failing or being required to undertake further study. This is compounded by the opaque career structure in nursing, especially concerning moving into advanced practice and beyond. Published information about posts available can be unreliable. This is partly because many posts arise in response to local needs and the manner in which healthcare is organised locally. This flexibility must be retained, but possible career progression needs to be transparent. The holistic nature of nursing means many skills are important in a wide variety of different clinical areas, but the value of “soft skills” is sometimes underestimated.

6.6.1 Recommendations for nursing practice and management

- Nurses could review their post, particularly if they are not fulfilled at work. They should be introduced to the tool for reflection. This should enable them to identify the cause of their dissatisfaction and to review whether this can be revised or whether potential posts would provide fulfilment.
- Career mentoring should become an explicit part of the appraisal system. Nurses should receive feedback and ideas for career development.
- Routes to advanced practice need to be formalised, and career moves beyond advanced practice. It is important to continue allowing flexible role development to respond to local needs.
- Managers could consider using the proposed tool to review posts, and it may prove singularly useful in those posts that are hard to fill.
- Nurses may need to be reminded of the importance of soft skills, rather than procedural knowledge, to career progression and how their existing skills may have already prepared them for a potential new role.

- Employers should encourage nurses who fear boredom to consider other roles locally. More Trusts could consider career fairs or career clinics to help nurses who want to explore a different clinical area to still remain in the same Trust.
- Good team relationships must be fostered and successful teams only re-organised when absolutely essential.

6.6.2 Recommendations for HEIs and other education providers

- HEIs and Health Education England must provide good quality information about nursing careers to prospective candidates.
- HEI's could offer MSc's in nursing with an option of including highly specific skills, suitable for some CNS or ANP posts. These could be taught elsewhere (including on training programmes designed for medical practitioners), yet still form part of an academic award.
- HEIs should make expected career gains from their programmes explicit.

6.6.3 Recommendations for future research

The findings could now be more widely tested.

- A longitudinal study could measure the tool's ability to predict career moves for nurses. This could be achieved by asking nurses to complete the tool at a few stages in their careers and mapping this to career moves and job satisfaction.
- The tools could be tested by other groups of health professionals and nurses outside London, to measure its transferability.
- Once the limitations of the inquiry have been addressed, it could be repeated to capture trends amongst younger, less experienced nurses. This may illuminate current trends and provide an enhanced understanding of the future.

6.7 Review of objectives

The introductory chapter identified objectives for the inquiry (section 1-3) and the extent to which these objectives have been fulfilled will now be examined.

1. **Conduct a narrative review of the literature and appraise current research into nursing career decisions to identify any gaps in the literature and to help shape the interpretive lens used for this inquiry.** Chapter 2 showed there was some literature about why people entered the nursing profession and how they fared upon registering. The dearth of literature relating to careers of more senior nurses demonstrated the need for this inquiry. Chapter 2 includes reflexive commentaries highlighting contributions of existing research to the interpretation of the data gathered for this inquiry. Much of the existing research was based outside the UK.
2. **Identify the most suitable methodology to collect and analyse data to address the question.** Chapter 3 argued the nature of the question required a qualitative approach, which would contrast with the predominantly quantitative approach of much research into careers. This chapter briefly explored a range of potential qualitative approaches, particularly a case-study approach, but concluded a narrative inquiry was the most suitable because people readily construct their story to make sense of their lives, and a narrative inquiry allowed this to be used to enlighten career decisions in nursing.
3. **Present the data and appraise it to explore how nurses establish themselves in their profession, develop their careers, and seek further education.** Chapter 4 presented the data as a series of narratives and chapter 5 examined how this answered the research question. They showed many aspects of their work nurses value and are passionate about, and a few they seek to avoid. Nurses do not make career decisions in isolation. Instead, they juggle their professional and intellectual ambitions with a desire to meet the needs of their clients, their feelings of loyalty to their professional colleagues, and the needs of their families. It shows nurses are highly motivated to achieve a reliable, secure income but are less interested in the size of that income. It has shown nurses have only the vaguest plans for retirement yet are optimistic about it.
   The educators and managers in this inquiry were unanimous in stating they welcomed nurses seeking career advice and this is an aspect of their role they enjoy, even though some of their advice may not be evidence-based. In contrast, most of the nurse participants denied ever having received career mentoring. Yet it was apparent some had benefitted from occasional, informal discussions and encouragement about their careers. There is evidence nurses who leave the

profession early may do so with sorrow. Fostering good relationships within the team and good career mentoring could occasionally prevent this loss.

4. **Discuss the limitations of the research.** This chapter has acknowledged this inquiry involved just a small number of participants in a tightly defined situation, but the manner in which the data was collected, analysed, and presented should allow it to be related, with caution, to other situations.
5. **Examine the extent to which the data generated for this inquiry provides evidence of existing career theories and if not, propose a new approach.** Some findings about nurses' career decisions are consistent with other career researchers, who have shown the most superior decisions are made using a "deliberation without attention" approach, in a manner consistent with Planned Happenstance. The chapters examined the participants' accounts of their career decisions and demonstrated nurses were usually unable to account for most of these and none had a career plan they had acted upon. This inquiry has shown nurses can respond to unexpected career opportunities and enjoy applying their knowledge and skills in new ways. However, existing theoretical approaches do not adequately explain many career decisions in nursing. This led to the development of a new graphic, summarising the findings of this inquiry and highlighting the contributions made to careers research. The tools provide a practical way of using these new insights to help nurses build their careers and managers recruit to posts or areas. The new ways of thinking in career theory is particularly important in a PhD thesis, such as this, because it must demonstrate a unique contribution to knowledge.

6.8 Reflections upon an inquiry

This section reflects upon the whole of the research process and is written in the first person.

I pondered undertaking a major piece of research for several years and wanted to register for a PhD, which is widely regarded as a training for emerging researchers. I had initially assumed I would do this in the applied biological sciences because those were the subjects I taught and I had a track record of publishing in those areas. However, I believed my teaching was not hampered by a lack of research in these subjects. In contrast, I felt impeded by a lack of knowledge and expertise into careers and career guidance. I read around this and was dismayed to learn this deficit was widely shared.

I knew this would be a demanding process, but I may have under-estimated the difficulty of moving from a biological science background to an educational one. I was often told to “make my voice heard”, but struggled to ensure my analysis reflected the previous research and the participants’ stories. I had read extensively about the process of analysing qualitative data and I knew the analysis would be iterative and early analysis would alter subsequent data analysis. Initially, this felt "messy" but over time I came to see this “messiness” was empowering because it permitted me to dig deeper into new and unexpected areas. I felt these changes also enabled me to do justice to the participants because it allowed me to reflect their ideas and experiences in subsequent data gathering.

I developed several ideas from the data analysis but was not confident these truly reflected the feelings of the participants. Apart from relationships, there were no aspects of their career decisions that all participants were unanimous about. I wanted to be able to state how confident I was about my emerging ideas, and so I launched the survey. I expected to be able to claim a high proportion of my participants agreed with my findings and was disappointed this did not happen. One reason is some of my questions may have been interpreted differently by the participants compared to my intention, and also the response rate was poor. Being perceived as an “insider” meant the participants could talk freely with me, confident I would understand their jargon and be sympathetic to their dilemmas. Interestingly, this may also have applied to my “working mother” status because two participants asked whether I had children. They discussed their balancing acts and were perhaps reassured to learn that I, too, had struggled to fulfil both professional and family responsibilities.

Most participants seemed to enjoy the opportunity to reflect on their careers. I had excluded close colleagues and friends, yet after the interview, the participants and I often found a friendship had started. This had the potential to complicate attempts to be objective but served to reassure the research team the participants had not felt exploited or in any other way uncomfortable and the caring ethic (Costley and Gibbs, 2006) had been fulfilled. Their enjoyment also suggested Bell’s (2002)

requirement that a good quality narrative inquiry will enhance the participants understanding of their own lives had been fulfilled. Some of the participants had volunteered partly because they wanted to contribute to the careers of other nurses and were keen to tell me what this advice would be. I was careful to include these and ensure that macro-ethics (Kvale, 2007) principles had been adhered to and honouring the intention of the participants.

6.9 Concluding thoughts

The research objectives have been met. Through a narrative analysis documented in this thesis, London nurses' career decisions have been examined and the influences upon these have been illuminated. Whilst acknowledging the limitations of the inquiry, this chapter has presented a new graphic of nursing careers and tools for reflecting upon these. A series of recommendations have been provided; for practitioners, as they navigate their way through this complex but exciting profession, and for managers and educators as they seek to guide nurses, and for further research.

The overriding message is nurses can afford to be optimistic about their careers. All the participants remaining within the profession, and most who had left, had achieved interesting and fulfilling careers, and were justly proud of their contributions to the lives of their clients. They looked to the future with confidence and to retirement with equanimity. In their work, they had formed deep and lasting friendships, and it had brought them endless satisfaction:

***Faye N**: It's been quite a blast; I have to say!*

***Dee N**: You do get immense job satisfaction if you find, if you are lucky enough to find the type of nursing that you love, you couldn't wish for anymore!*

Appendix 1: Nursing grades, titles, and NHS salaries April 2020-2021

current nursing grades (Agenda for Change)	nursing grades prior to 2006	typical title	salary up to £ (Currently subject to 3-year pay arrangements)
band 5	Band D	staff nurse (newly qualified nurse) practice nurse	27,416
band 6	band E	senior staff nurse/ junior sister health visitor district nurse team leader	37,890
band 7	band F	ward sister/charge nurse nurse specialist community matron / team manager	44,503
band 8a band 8b band 8c band 8d	band G	modern matron director of nursing consultant nurse/ nurse practitioner	46,518 55,450 64,913 81,821
band 9	band I	regional director	94,213

Table ap 1.1 Nurses' pay titles and bands

In addition, nurses working in London receive additional payments that are intended to reflect the increased cost of living in London.

Area	
Inner London	20% of basic salary, subject to a minimum of £4,47 3and a maximum of £6,890
Outer London	15% of basic salary, subject to a minimum payment of £3,784 and a maximum payment of £4,822
Fringe	5% of basic salary, subject to a minimum payment of £1034 and a maximum payment of £1,791

Table ap 1.2 London weighting

Nurses may also receive payments for “unsocial hours”, which are paid for working during the night, weekends, and bank holidays, typically an additional 30%-60% on the hourly rate for the time worked.

Appendix 2: Search of the literature

The chart below summarise all the articles used in the review of the literature (chapter 2), they are listed alphabetically, by author. The chart provides the authors' names, year of publication, titles of article and journal, methodology, location of research and the sample size. The section on methodology is headed, in **bold and underlined** by the means used to assess the quality of the research. The section below each entry summarises the findings as they relate to career decisions in nursing.

Data extraction table

Authors name(s)	Year published	Title of article	Name of journal	Methodology	Location	Sample size
		Summary of findings / results				
Abrahamson, B.	2015	Nurses' choice of clinical field in early career	*Journal of advanced nursing*	**BMJ Survey** Paper Survey	Norway	290
		The tendency among undergraduate nursing students to choose care of older people after graduation increases as their score on altruism decreases, but is not correlated with their score on theoretical knowledge. The tendency to choose psychiatric fields increases with an increasing score on perceived practical skills and decreases with an increasing score on perceived theoretical knowledge.				
Adeniran, R.K.; Smith-Glasgow, M.E.; Bhattacharya, A.	2013	Career advancement and professional development in nursing	*Nursing outlook*	**CASP qualitative** Online descriptive survey	USA	200
		Significant disparities were noted in the role model function of mentoring and some professional development and career advancement measures. Mentorship is essential for professional growth. Sociodemographic characteristics of mentors are important because mentors are role models. BAME nurses may be less successful in obtaining helpful mentoring				

Alexander, R.K., Diefenbeck, C.A.; Brown C.G.	2015	Career choice and longevity in US psychiatric-mental health nurses	*Issues in mental health nursing*	**CASP qualitative** Descriptive phenomenology	US	8
		Three themes which encouraged nurse retention: Overcoming Stereotypes to Develop Career Pride, Positive Team Dynamics, and Remaining Hopeful. Nurse educators can inspire students' to pursue a psychiatric nursing career, while nurse managers and clinical specialists contribute to retention.				
Barron, D.N.; West, E.	2007	Tied to the job; affective and relational components of nurse retention	*Journal of health service research and policy*	**BMJ Survey** Exploratory cross-sectional postal survey	UK	2880
		Relationships with supervisors and managers have a significant effect on respondents' career intentions. Feeling valued by the Trust and by society was very important. Nurses able to distinguish between local problems that are the responsibility of the Trust and those, such as levels of pay, that could only be solved at the national level.				
Berkery, E.; Tiernan, S.; Morley, M.	2014	The relationship between gender role stereotypes and requisite managerial characteristics: the case of nursing and midwifery professionals	*Journal of nursing management*	**BMJ Survey** Survey	Ireland	410
		Female nurses and midwives did not gender type the managerial role, whereas males gender typed the managerial role in favour of men. Differences less pronounced for students.				
Booth, J.; Hutchison, C.; Beech, C.; Robertson K.B.	2006	New nursing roles: the experience of Scotland's consultant nurse/midwives	Journal of nursing management	BMJ Survey Postal survey	UK	16
		Key themes that consultant nurse/midwives considered important including mentorship, autonomy and clinical credibility. Barriers to work included lack of understanding of roles and the wide scope of some posts. Considerable variation in support, conditions of service and line management arrangements was found.				

Brand, M.C.; Cesario, S.K.; Symes, L.; Montgomery, D	2016	Journey to Becoming a Neonatal Nurse Practitioner	*Advanced in neonatal care*	**CASP qualitative** Semi-structured interviews	USA	11
		Conditions leading to choosing the NNP role include working in a neonatal intensive care unit and deciding to stay in the neonatal area, discovering the NNP role, deciding to become an NNP, and readiness to enter graduate school. Important aspects of readiness are developing professional self-confidence and managing home, work, and financial obligations and selecting the NNP program.				
Brown, J.; Nolan, M.; Davies, S.; Nolan J.; Keady, J.	2008	Transforming students' views of gerontological nursing: Realising the potential of 'enriched' environments of learning and care: A multi-method longitudinal study	International journal of nursing studies	**CASP qualitative** Longitudinal study involving postal surveys, focus groups & case studies	Scotland, UK	Variable numbers involved over course of project. 718 questionnaires and unstated number in focus groups
		Students may not enter nurse training with negative predispositions towards work with older adults, but they develop during their training largely as a result of clinical placements and paid work. Student nurses are often exposed to 'impoverished' environments of care in which they witness poor standards of care and negative attitudes towards older people. However, if they experienced 'enriched' environments they are far more likely to enjoy gerontological nursing.				
Burton, C.R.; Bennett, B,; Gibbon, B.;	2009	Embedding nursing and therapy consultantship: the case of stroke consultants	*Journal of clinical nursing*	**CASP qualitative** Focus groups	UK	24
		A lack of consensus about the nature of clinical expertise and a diverse range of pathways towards consultantship were identified. There are opportunities for consultants to be entrepreneurs but inflexible programmes to support aspiring consultants may limit the opportunities to develop these entrepreneurial skills.				

Candela, L.; Gutierrez, A.; Keating, S	2013	A national survey examining the professional work life of today's nursing faculty	*Nurse education today*	**BMJ Survey** Online, cross-sectional survey	USA	808
		Staff stayed through commitment to profession, admin support & belief that they were good teachers. Younger staff more likely to consider leaving.				
Carlson, E.; Ramgard, M.; Bolmsjo, I.; Bengtsson, M.	2014	Registered nurses' perceptions of their professional work in nursing homes and home-based care: A focus group study	*International journal of nursing studies*	**CASP qualitative** Qualitative analysis of focus groups	Sweden	30 RNs
		Nurses working in elderly care perceived their professional work as holistic and respectful nursing. Three categories of work that they valued were: long-term relationships, with clients; nursing beyond technical skills; balancing independence and a sense of loneliness. Contrasts with popular image				
Cleary, M.; Horsfall, J.; O'Hara-Aarons, Jackson, D.; Hunt, G	2011	The views of mental health nurses on continuing professional education	*Journal of clinical nursing*	**CASP qualitative** Semi-structured interviews	Australia	50
		All nurses had plans for CPD and valued education, particularly in-house locally based sessions targeting patient-related clinical skills enhancement. Work-based flexibility, the types of courses available and opportunities for study leave were also identified as important factors. Important for staying in the profession was: continuing professional development, collegial support amongst peers and management; and tertiary studies.				

Dawson, A.J., Stasa, H., Roche, M.A., Homer, C.S.E.; Duffield, C	2014	Nursing churn and turnover in Australian hospitals	*BMC Nursing*	**CASP qualitative** Survey with qualitative analysis	Australia	362
		Key factors affecting nursing turnover were limited career opportunities; poor support; a lack of recognition; and negative staff attitudes. The environment is characterised by inappropriate skill-mix and inadequate patient-staff ratios; a lack of overseas qualified nurses with appropriate skills; low involvement in decision-making processes; and increased patient demands. These issues impacted upon heavy workloads and stress levels with nurses feeling undervalued and disempowered. Nurses described supportive strategies: improving performance appraisals, responsive preceptorship and flexible employment options.				
De Groot, K., Maurits, E.E.M. & Francke, A.L.	2018,	Attractiveness of working in home care: An online focus group study among nurses	*Health & Social Care in the Community*	**CASP qualitative** Online focus groups	Netherlands	6 groups 38 participants
		The findings showed that home-care nurses find it attractive that they are a "linchpin", the leading professional and with the patient as the centre of care. Having autonomy is attractive: in decision-making about care, freedom in work scheduling and working in a self-directed team. Variety in patient situations and activities also makes their work attractive.				
Edward, K., Warelow, P., Hemingway, S., Hercelinskyj, G., Welch, A., McAndrew, S. Stephenson, J	2015	Motivations of nursing students regarding their educational preparation for mental health nursing in Australia and UK	*BMC nursing*	**BMJ Survey** Online survey	Australia and UK	249 Australia 146 UK
		The students on the comprehensive program represented in Australia were much less likely to indicate that mental health nursing was definitely not a career option, compared to UK student on a mental health programme. This would be expected in view of the different nature of the pre-registration programmes in the 2 countries. In both groups a higher level of motivation to work in mental health emanated from personal experience and/or work experience/exposure to mental health care.				
Flinkman, M.; Salanterä, S	2015	Early career experiences and perceptions	*Journal of nursing management*	**CASP qualitative** Content analysis of interviews	Finland	15
		Found 3 reasons newly registered nurses consider leaving their jobs or the profession: poor nursing practice environments; lack of support, orientation and mentoring, and nursing as a 'second best' or serendipitous career choice.				

Halfer, D.; Graf, E.	2006	Graduate Nurse Perceptions of The Work Experience	*Nursing economics*	**BMJ Survey** Longitudinal survey	USA	122
		Intent to stay for newly registered nurses is tied to aspects of scheduling, co-worker and physician relationships, professional growth opportunities, recognition, control, and responsibility. Some things improve significantly over 18 months: understanding leadership expectations, ability to manage job tasks, and awareness of development opportunities. Several variables worsened before they improved, reflecting a "honeymoon" period				
Hasson, D.; Lindfors, P.; Gustafaaon, P.	2010	Trends in self-rated health among nurses: a four year longitudinal study on the transition from nursing education to working life	*Journal of professional nursing*	**BMJ Survey** Longitudinal, paper survey	Sweden	1114
		A small but significant and continuous decline in self-reported health among nurses during 3 years of follow-ups, starting from their last term of nursing education and continuing 3 years into their working life. The most pronounced decline seems to occur in the transition between student life and working life and is most explicit among the youngest nurses. However, the long-term effect on SRH when entering into working life seems to be more pronounced among the older nurses.				
Hickey, N.; Sumsion, J.; Harrison, L	2013	Why nursing? Applying a socio-ecological framework to study career choice of double degree nursing students and graduates	*Journal of advanced nursing*	**CASP qualitative** Interviews and focus groups	Australia	68 34
		About half graduated without deciding upon career. Showed importance of employers' recruitment and marketing strategy in persuading those participants to work for them!				
Homburg, V.; Heigden, B.; Valkenburg,L.	2013	Why do nurses change jobs? An empirical study on determinants of specific nurses' post-exit destinations	*Journal of nursing management*	**BMJ Survey** Cross-sectional analysis of secondary data	Netherlands	318
		Nurses' intention to leave is determined by their general satisfaction with management and leadership quality, their satisfaction with pay and benefits, their job satisfaction and work-to-home interference issues they have to deal with, but not by career development opportunities.				

Horn, K.; Pilkington, L.; Hooten, P	2019	Pediatric Staff Nurses' Conceptualizations of Professional Development	*Journal of paediatric nursing*	**BMJ Survey** Correlated study	USA	74
		Most nurses' main motivation to seek Professional Development opportunities was to provide safe, quality care. Mostly understood as courses and committee involvement, research, and professional organization membership were ranked as relatively unimportant.				
Hovey, S.L.; Dyk, M.J.; Kim, M.; Reese, C.	2018	The effect of first clinical assignment on prelicensure nursing students' attitudes towards older adults	*Contemporary nurse*	**BMJ Survey** Observational design study	USA	53
		Students with exposure to long-term and then the acute care setting showed linear improvement in their attitudes toward older people. This study showed students may start not recognising the differences in acute and long-term nursing care				
Koehler, A.R.; Davies, S.; Smith, L/R.; Hooks, T.; Schanke, H.; Loeffler, A.; Carr, C.; Ratzlaff, N.	2016	Impact of a stand-alone course in gerontological nursing on undergraduate nursing students' perceptions of working with older adults: A Quasi-experimental study	*Nurse education today*	**BMJ Survey** Experiment to investigate effect of course	USA	266
		A course designed to put elder care into a positive light yielded an overall significant increase in positive perceptions of working with older adults among nursing students. Most participants reported having previous experience with older adults and those that had showed higher perception scores at pre-test than those without, but after the course there was no difference				
Koskinen, S.; Hupli, M.; Katajisto, J.; Salminen, L.	2012	Graduating Finnish nurse students' interest in gerontological nursing — A survey study	*Nurse education today*	**BMJ Survey** Structured Questionnaire	Finland	254
		Students who had prior elder care work experience, women, and students who had learned about elder nursing through an independent course were the most interested in working in elder care. The factors that enhance interest are the quality of nursing, the challenging aspects of the field and the opportunities for career advancement, the elder nursing education and practical training.				

Larsen, R., Leir, L.; Fraundienst, R.	2012	Baccalaureate nursing students' intention to choose a public health career.	*Public health nursing*	**BMJ Survey** Descriptive correlations	USA	354
		Newly registered nurses were unlikely to choose a career in public health, but this does increase the longer that they have been registered. The top three recruitment strategies ranked by students were comparable wages, flexible scheduling, and tuition reimbursement.				
Lea, E.; Marlow, M.N.; Altmann, E.; Courtney-Pratt, H.	2018	Nursing students' preferences for clinical placements in the residential aged care setting	*Journal of clinical nursing*	**CASP qualitative** Statistical analysis of student nurses' online placement requests	Australia	6610
		Requests for clinical placements analysed, just over 10% related to aged care: of those, 66.1% were students requesting not to be allocated residential aged care for next placement, primarily due to previous experience in the sector; 17.1%, referred to aged care in a neutral manner, focusing on conflict of interest, but 16.8% were a request for an aged care placement.				
Luck, L., Wilkes, L.; O'Baugh, J.	2015	Treading the clinical pathway: a qualitative study of advanced practice nurses in a local health district in Australia,	*BMC nursing*	**CASP qualitative** Semi-structured interviews	Australia	27
		4 influences on career progression experiences: moving up the ladder, changing jobs for career progression, self-driven and the effects of institutional environments. Much influenced by luck because economics and politics affected the opportunities available.				
Mackintosh, C.	2007	Making patients better.	*Journal of Clinical Nursing,*	**CASP qualitative** Semi-structured interviews	UK	16
		Nurses who worked in surgery had chosen an area where patients were basically healthy and would be reluctant to transfer to a specialism where patients were more needy.				

Mauro, A.M.P.; Escalier, L.A.; Rosario, M.G.	2016	New careers in nursing scholar alumni toolkit: an innovative resource for transition to practice	*Journal of professional nursing*	**BMJ Survey** Survey	UK	20 newly qualified nurses from 3 schools
		Devised a 6-chapter document (which especially targeted non-white nurses) to help ease transition to registered nurse status. Used feedback in revising it and feedback stated that it was helpful.				
McCann, T.; Clark, E.; Lu, S.	2019	Bachelor of Nursing students career choices: A three-year longitudinal study	*Nurse education today*	**BMJ Survey** Longitudinal survey	Australia	88
		Students commence their course with a predominantly lay-informed image of nursing, and few had plans for their own careers. This may be tempered by favourable curricular influences towards the mental health field. However, the curriculum discourages students from pursuing a career in aged care and midwifery.				
McKenna, L.; McCall, L.; Wray, N.	2010	Clinical placements and nursing students' career planning	*International journal of nursing*	**CASP qualitative** Focus groups interviews	Australia	13
		Survey of effects of clinical placements upon student nurses: 1. Confirmed for them that this was the right career; 2. Provided opportunities to think about future career, including areas they had not previously considered; 3. Offered chance to consider geographical location and other practical arrangements				
Mills, J.; Chamberlain-Salaun, J.; Harrison, H.; Yates, K.; O'Shea, A.	2016	Retaining early career registered nurses: a case study	*BMC nursing*	**CASP qualitative** Case study: Interviews, focus groups	Australia	35
		Identified 6 areas of focus for newly registered nurses retention: 1) well-planned, supported and structured transition periods; 2) consideration of rotation through different areas with a six month minimum for skills development; 3) empowering decision making; 4) placement opportunities and choice in decisions of where to work; 5) career advice and support that considers their personalities and skills; and 6) encouragement to reflect on career choices.				

Ng, L.; Eley, R.; Tuckett, A	2016	Exploring factors affecting registered nurses' pursuit of postgraduate education in Australia	*Nursing and health sciences*	**BMJ Survey** Survey and factor analysis	Australia	568
		The analysis identified a three groups of factors that explained much of the decision to enter post-registration education. These were: "facilitators," (improves knowledge; increases confidence in clinical decision-making; enhances careers; improves critical thinking; improves nurses' clinical skill; and increased job satisfaction.) "professional recognition," and "inhibiting factors" (stress, costs, workload)				
O'Connor, T.	2015	Men choosing nursing	*The journal of men's health*	**CASP qualitative** Qualitative interpretation of Interviews	Ireland	18 men
		Little encouragement is given to men to join the profession, and for men who have chosen to nurse attempt to distance themselves from traditional motivations for choosing nursing such as caring and vocationalism.				
Pajic, , S.; Keszler, A.; Kismihok, G.; Mol, S.T.; den Hartog, D.	2018	Antecedents and outcomes of Hungarian nurses' career adaptability	*International journal of manpower*	**BMJ Survey** Cross-sectional survey	Hungary	314
		Demonstrates positive relationships between nurses' adaptive readiness (proactive personality and conscientiousness), career adaptability, adapting behaviours (career planning and proactive skill development) and adaptation outcomes (employability and in-role performance).				
Philippou, J	2015	Employers' and employees' views on responsibilities for career management in nursing	*Journal of advanced nursing*	**BMJ Survey** Cross-sectional survey	London, U.K.	871
		Showed temporal dimension to career management responsibilities. Short-term responsibilities for securing funding and time for development lay with employers. Medium-term responsibilities for assessing nurses' strengths and weakness, determining job-related knowledge and skills and identifying education and training was shared. Long-term responsibilities for developing individual careers and future development plans lay with employees.				

Price, S.; Paynter, M.; McGillis- Hall, L.; Reichert, C.	2013	The Intergenerational Impact of Management Relations on Nurse Career Satisfaction and Patient Care	*Journal of nursing administration*	**CASP qualitative** Focus groups	Canada	185 participants in 18 focus groups
		Students wanted a supportive environment to enable successful transition to practice. Early-career nurses expected effective leadership at the unit level, effective communication, and positive working relationships to enable best care outcomes. Mid- to late-career nurses were most dissatisfied with management.				
Read, E.; Laschinger, H.K.S.	2017	Transition experiences, intrapersonal resources, and job retention of new graduate nurses from accelerated and traditional nursing programs: A cross-sectional comparative study	*Nurse education today*	**BMJ Survey** Descriptive, cross-sectional comparative study	Canada	998
		Few significant differences between new graduate nurses from accelerated and traditional programs. Both had high levels of intrapersonal resources, positive transition experiences, were satisfied with their jobs and their choice of nursing as a career, and their intentions to leave were low.				
Sayman, D.M.	2014	Fighting the Trauma Demons: What Men in Nursing Want You to Know	*Nursing forum*	**CASP qualitative** Semi-structured interviews of male RNs		
		Men in nursing repeatedly learn that theirs is a female-dominated profession; they are excluded, had to work extra hard and were often expected to deal with difficult patients. They have to work to make their identity yet are more likely to leave.				

Schmidt, N.; Brown, J. M.	2019	The Effect of a Perioperative Nursing Elective on Nursing Career Paths	*AORN journal*	**CASP qualitative** Descriptive study	USA	23
		Twenty-six percent of nurses who had taken the elective went on to work in the perioperative specialty, and the majority indicated they continued to consider perioperative nursing as a career choice.				
Stevens, J.; Browne, G.; Graham, I.	2013	Career in mental health still an unlikely career choice for nursing graduates: A replicated longitudinal study	*International journal of mental health nursing*	**BMJ Survey** Survey, longitudinal, repeated over 3 year	Australia	203 189 160
		Confirms previous studies showing that mental health nursing is one of the least desirable career choices for most nurses at the start of their course and remains so as they approach graduation. The reasons change but the outcome remains the same. The current system in Australia does not encourage nurses to consider a career in mental health nursing.				
Stevens, J.A.	2011	Student nurses' career preferences for working with older people	*International journal of nursing studies*	**BMJ Survey** Longitudinal surveys	Australia	150
		8% of the students began their course wanting to work with older people. Overall the ranking of 'working with older people' for commencing students was 7 out of ten. This decreased throughout their course to become the least desired career choice of graduating nurses with only 3 of the 150 participants stating a desire to work with older people. Career choices divide along the lines of 'high- tech' and 'low-tech'. Nurses are influenced by socialising factors within the education process, negative clinical experiences and the ageist bias within the broader community.				
Thongpriwan, V.; Leuck, S.E.; Rhonda L.; Powell, R.L.; Young, C.; Schuler, S.G.; Hughes, R.G.	2015	Undergraduate nursing students' attitudes toward mental health nursing.	*Nurse education today*	**BMJ Survey** Descriptive, online survey	USA	251
		All students had similar knowledge of mental illness with negative stereotypes and low interest in mental health nursing as a future career, even though they believed that psychiatric nurses provide a valuable contribution. Negative stereotypes were less in students who had mental health nursing preparation either in class or in clinical practice compared to students who had not and they were less anxious. They were more likely to express an interest in a future career in mental health nursing if they had prior mental health experience.				

Tummers, L.G.; Groeneveld, S.M.; Lankhaar, M.	2013	Why do nurses intend to leave their organization? A large-scale analysis in long-term care	*Journal of advanced nursing*	**BMJ Survey** Survey of a subset	Netherlands	9982
		The most important reason for nurses' intention to leave is insufficient development and career opportunities. Secondly, a negative working atmosphere. Third, partly context dependent, when nurses in home care felt that their autonomy was reduced, this strongly influenced their intention to leave.				
Waddell, J.; Spalding, K.; Gaitana, G,; Navarro, J.; Connell, M.; Jancar, S.; Stinson, J.; Victor, C	2015	Integrating a career planning and development programme into the baccalaureate nursing curriculum – part 1 Impact on students' career resilience	*International journal of nursing education scholarship*	**CASP qualitative** RCT of intervention with questionnaire and focus groups or telephone interviews	Canada	72
		The program offered students the tools and resources to become confident, self-directed, and active in shaping their engagement in their academic program to help achieve their career goals, whereas control group students continued to look uncertainly to others for answers and direction.				
Waddell, J.; Spalding, K.; Navarro, J.; Jancar, S.; Gaitana, G,;	2015	Integrating a career planning and development programme into the baccalaureate nursing curriculum – part 2 outcomes for new graduates' nurses 12 months post-graduation	*International journal of nursing education scholarship*	**CASP qualitative** RCT of intervention with questionnaire and focus groups or telephone interviews	Canada	72
		Including structured and progressive curriculum-based CPD opportunities in academic programs, has positive outcomes that accrue to students and the benefits extend to newly registered nurses as they transition to their first professional nursing role.				

Waddell, J.; Spalding, K.; Navarro, J.; Gaitana, G,;	2015	Integrating a career planning and development programme into the baccalaureate nursing curriculum – part 3 Impact on faculty's career satisfaction and confidence in providing student career coaching	*International journal of nursing education scholarship*	**CASP qualitative** Qualitative analysis of effect of training upon staff	Canada	9 volunteers
		Academic staff who participated in the intervention CPD intervention group reported an increase in confidence in their ability to provide career coaching and education to students and that their own career development served to enhance career satisfaction.				
Walker, L., Clendon, J. & Willis, J.	2018	Why older nurses leave the profession	*Kai Tiaki Nursing Research*	**BMJ Survey** Questionnaire	New Zealand	495
		Study of "intention to leave" relate to the intensification of nursing (higher acuity and bed occupancy), and the need for sufficient nursing resources, flexible management and better support for older nurses.				
Wareing, M.; Taylor, R.; Aileen Wilson, A.; Sharples, A.	2017	The influence of placements on adult nursing graduates' choice of first post	*British journal of nursing*	**CASP qualitative** Descriptive analysis	UK (east England)	35
		The working environment: the level of support provided by mentors and clinical staff; the opportunity to make a difference to patients' lives and the variety of placements, were key influences on nursing students' decision regarding their first staff nurse post.				
Weaver, R., Furguson, C., Wilbourn, M.; Salamonson, Y	2014	Men in nursing on television	*Journal of advanced nursing*	**CASP qualitative** Qualitative and quantitative textual analysis	USA	5 shows
		Men were portrayed in ways that engaged with explicit and implicit stereotypes. They were often subject to questions about their choice of career, masculinity and sexuality and their role usually reduced to that of prop, minority spokesperson or source of comedy even though they often sought to expose common stereotypes about men in nursing, they nonetheless often reinforced stereotypes in more implicit ways. So TV can both contribute to and challenge stereotypes.				

Wilkes, L.; Doull, M.; Ng Chok, H.; Mashingaidze, G.	2017	Developing a tool to measure the factors influencing nurses' enjoyment of nursing	*Journal of clinical nursing*	**BMJ Survey** Questionnaire, online and paper	Australia	124
		Found 16 determinants of enjoyment. Of these, four were perceived by over 80% of the nurses to negatively impact their enjoyment. In contrast, nine items showed a positive effect on enjoyment with educating others, connecting with others, variety of work, doing and sharing with others, supporting others being the most positive. Three items were considered neutral: criticism, busy workload and changing policies.				
Wilson, B.; Squires, M.; Widger, K.; Crawley, L.; Tourango, A.	2008	Job satisfaction among a multigenerational nursing workforce	*Journal of nursing management*	**BMJ Survey** Postal survey to all eligible nurses.	Canada	6541
		In overall job satisfaction and five specific satisfaction components, Baby Boomers were significantly more satisfied than Generations X and Y. Definitions of generations differed from other researchers'.				
Xiao, L.D.; Shen, J.; Paterson, J.;	2013	Cross-Cultural Comparison of Attitudes and Preferences for Care of the Elderly Among Australian and Chinese Nursing Students.	*Journal of transcultural nursing*	**BMJ Survey** Cross-sectional questionnaire	Australia and China	256 Australian 204 Chinese students
		The percentage of students more likely to care for the elderly was significantly higher among the Chinese group than the Australian group. Work experience with older people and being under the age of 20 were found to be positive predictors, whereas factors such as prejudice toward the elderly and beliefs that elders should live in separate housing were negatively associated with an intention to care for the elderly				

Table ap2.1 Data extraction. Shows essentials of articles with relevant findings outlined

Appraisal tool and outcomes, Qualitative research

	Are the results valid?						What are the results?			
	Was there a clear statement of the aims of the research?	Is qualitative method appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issues	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Will the results help locally (with this inquiry)?
Alexander, R.K., Diefenbeck, C.A.; Brown C.G. 2015	Yes, but very broad	Yes	Yes	Cannot tell	Yes	Cannot tell	Not discussed	Cannot tell	Yes	Somewhat
	2 researchers independently coded the meanings in transcripts. Participants provided with gift voucher upon completion of survey, which may have affected recruitment of participants in favour of those who want or need additional income. Interviewers kept questions to the minimum to encourage free flow of information, but data may have lacked focus yet authors had specific question (why do nurses choose and then remain in mental health nursing?) so a danger of extrapolating from a general discussion to a specific topic						3 themes clearly identified; how interest developed, personal relevance and validation of potential			Only examined decision to enter mental health nursing
Brand, M.C.; Cesario, S.K.; Symes, L.; Montgomery, D 2016	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
	Some danger that interviewing own students the participants may not be honest in presence of an authority figure, although this lessened because were asked about experiences prior to becoming students. Provided unusual amount of detail of analysis, which was done by attributing each line of transcript to an action then conducting cross-comparisons with other transcripts.						Only included nurses who were training (and only nurses on the course that the lecturers were involved in, so difficult to generalise from this) but omitted to include those working in the specialism but not undertaking training as a practitioner. This was unfortunate, as one of the stated aims was to examine the barriers that prevented nurses taking up much-needed training.			Difficult to generalise, but some specific, practical problems identified that prevented RNs taking clinical post-reg education

Burton, C.R.; Bennett, B,; Gibbon, B.; 2009	Yes	Yes	Yes	Yes	Yes	Un-clear	Yes	Yes	Yes	Probably not
	Was an explanatory study, which is appropriate given the immature nature of this occupational group. Included all the nurses in the population. Data was collected at two points. Everyone who was invited to participate in the study (N = 13) took part in the first data collection exercise. However, only 11 participants took part in the second data collection exercise. The drop out of two participants is not explained.						Ethical approval granted. Informed consent obtained from participants before focus groups. It would have been helpful to have provided information on how the authors attempted to exercise control over what participants may subsequently communicate outside the group. No statement of approach to data analysis, merely referring to 'established procedures'. Nevertheless, two people were involved in the analysis of the data.			A key issue is that it is difficult to extract the nursing data from the therapy data.
Brown, J.; Nolan, M.; Davies, S.; Nolan J.; Keady, J. 2006	Clear	Yes	Yes	Yes	Probably	Yes	Possibly	Cannot tell	Yes	Probably yes
	An ambitious project. A mixed methods study; used multiple different ways of measuring students' attitudes to elder care. A high number of participants for qualitative research, but all came from just 2 cohorts at the same Scottish university. Due to multiple types of data used, lacks details about how this was managed. An element of action research, because students contributed to curriculum design. Longitudinal design						Authors stated that no formal approval required for all stages. Minimal details of analysis given due to large amounts of different types of data. Attitudes develop mainly from clinical placements with classroom teaching less important			Detailed information about how attitudes to elder care can develop,
Carlson, E., Ramgard, M.; Bolmsjo, I.; Bengtsson, M 2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes
	Researchers did not know participants and ensured a respectful approach to them at the commencement of the groups. Homogenous sample. Researchers made several different attempt to ensure that the participants' voices (who often not heard) was prominent.						The transcripts were analysed to identify "meaning units" (page 764), although there was no information about how these were derived. Anonymity assured. Main advantage was deep relationships with clients			Clear account of multiple benefits of working in elder care,

Cleary, M., Horsfall, J., O'Hara-Aarons, M., Jackson, D. & Hunt, G.E., 2011	Yes	Yes	Yes	Limited	Yes	Yes	Permission granted	Cannot say	Yes	Possibly
	All participants were nurses working in just one hospital. Researcher was independent to local area. Participants were encouraged to talk freely about wide range of topics						No discussion of confidentiality, consent etc. No details of analysis provided			CPD, thought of as normal part of career
Dawson, A.J., Stasa, H., Roche, M.A., Homer, C.S.E.; Duffield, C	Yes, but quite broad	Yes	Cannot tell	Cannot tell	Cannot tell	Cannot tell	Permission granted	Possibly not	Yes	Possibly
	Wide range of participants (in Australia). Collected large amounts of data from heterogenous (geographic, qualifications and experience), but details of the analysis almost absent. No audit trail of how model was derived						Provided a neat model of 3 groups of factors (working environment, workload, career dissatisfaction that causes nurses to leave). Was based in Australia, where it is possible to move to a different employer to get different terms.			Identified many factors, but no discussion of which most important, although suggestion that each contributes to others
De Groot, K., Maurits, E.E.M. & Francke, A.L. 2018	Yes. Wanted to show that educational level impacted upon satisfaction – not able to	Yes	Yes	Yes	Probably	Possibly not researchers acted as moderators, effects of this not explored	Discussed, but stated permission not required	Minimal details, but did involve different researchers	Yes	Yes
	Participants recruited though wide variety of means. Details of "interview guide" provided, but minimal details of management of groups and experience of doing it online. Responses were written and a-synchronous. Authors acknowledge that only positive aspects explored, so disadvantages may have been under-stated.						Identified role of 'lynchpin', which lead to variety and autonomy.			Clear evidence of positive aspects of elder care

Flinkman, M.; Salanterä, S	Yes	Yes	Yes	Yes	Yes	No	Yes	Cannot tell	Yes	Yes
	Advertised widely yet only recruited 15 RNs who had left. No account of how participants were selected, are likely to be all who responded to adverts. Potentially awkward as were interviewing nurses who had left – relationship between participants and researchers not explored in article, but assurances provided to participants about confidentiality of data						Transcripts were reduced to "analytical reading", a 1-page summary and this was coded. No summaries or details of coding provided. Conclusions supported by direct quotes. New nurses left due to stress from environment, lack of support or in wrong career!			Useful to examine why some had left as well as intention, but not attempt to compare intention to leave with actuality.
Hickey, N.; Sumsion, J.; Harrison, L 2013	Yes	Yes	Yes	Yes, but no discussion of who chose to participate	Yes	Not discussed	Yes	Cannot tell	Yes	No
	Longitudinal study. Also considered initial degree choice. Sequence of analysis apparent but no discussion of how themes derived nor how prominent they were.						Showed uncertainty about career, but not easy to apply to UK which has few or no "double degrees"			Included because were RNs, but double degree meant they could choose other occupation
Lea, E.; Marlow, M.N.; Altmann, E.; Courtney-Pratt, H	Unclear	Yes, given nature of data	Yes	Yes	Yes	No	No	Yes	Yes	Maybe
	Clever use of readily available data. Analysed written requests relating to care facilities for older adults, made by student nurses. Qualitative analysis of students' own words. May have overstated their claims because they analysed and reported just a small proportion of all requests. Of over 6000 comments, only 401 related to residential care. So important claims about student nurses interest in elder care may be over-stated, as so many appeared neutral on this subject. Also, student nurses' requests in relation to placements relate to their perceived learning needs, and may not relate to their career plans, which is what the authors suggest.						No discussion of permission from students to use data. Research done on own students. Data was extracted by independent 3rd party, lecturers only had access to anonymised data			Analysis may exaggerate students feelings toward elder care

Luck, L., Wilkes, L.; O'Baugh, J.	Yes Broad aim as novel topic	Yes	Yes	Yes	Cannot tell	Not discussed	Yes	Probably	Yes	Could apply to one specific group
	Researchers targeted specific group of nurses in one state. Advertised and sent emails and continued to recruit until data saturation achieved, so no further selection of participants. Minimal details given of tools, but method appeared consistent with aims.						No details of analysis given, but procedure included 2 researcher coding transcripts independently and research team verifying this. Showed stages in obtaining AP post, but most claimed was luck, although also described themselves as self-driven, which was necessary because institution applied many constraints.			One of only a few articles investigating senior nurses. Tended not to move on from AN post
McKenna, L.; McCall, L.; Wray, N.	No – stated area of general interest	Yes	Yes	No	Yes	No – is possible that participants knew researcher	Permission granted	Cannot tell	Yes	Possibly
	Part of a larger study about quality of student nurses placements. Described as purposive sample, but not apparent what was the aim of the selection. This small study took an unstructured approach and allowed students to respond to questions about career choice and placements in their own words.						Identified 3 effects of placements on career choice: confirmed initial choice to enter nursing, informed choice and helped them feel confident about choice of clinical area. They also considered geographical area.			Only interviewed students – no information on how plans worked out.
Mackintosh, C. 2007	Yes, very specific	Yes	Yes	Not discussed	Not discussed	No	Permission granted	Cannot tell	Yes	Possibly
	Minimal details provided of procedure nor analysis. Qualitative methods suitable for examining motivation.									Often choose to work in surgical areas for gratification of seeing clients recover

Mills, J.; Chamberlain-Salaun, J.; Harrison, H.; Yates, K.; O'Shea, A.	Yes	Yes	Cannot tell	Yes, but just one hospital involved	Cannot tell	Not discussed	Not discussed	Cannot tell	Yes	Uncertain
	Minimal details of instrument, procedure or analysis discussed. Theoretical approach identified (open coded and grounded theory) but not discussed or justified. Good response rate, but only involved one hospital, and no details of the nature of that hospital. Broad definition or early career (First 5 years).						Data collected by telephone interviews and focus groups, but no discussion of different nature of results. Results in themes: advice; (lack of) choice;			Not apparent how themes were identified. Insufficient details given to be able to apply to London nurses
O'Connor, T.	Yes	Yes	Yes	Not described	Yes	Not discussed	Ethics approval granted but issues not discussed	Cannot tell	Yes	Yes
	Interviewed men working as staff nurses from just one hospital. Recruitment strategy not described but could have involved all adult male nurses in one hospital. Authors used own experience to design the study but does not consider if this affected perspective. Used NVivo to code transcripts. Initial interviews used to form categories to shape subsequent interviews, so participants helped form the basis for analysis.						Quotes used to support claims			Sympathetic approach to difficulties men experience being in minority

Price, S.; Paynter, M.; McGillis- Hall, L.; Reichert, C.	Stated, were highly specific	Yes	Yes	Not discussed – only 8 hospitals in whole of Canada!	Not justified, but acceptable way of assessing experience	Not discussed	Yes	Not discussed	Not discussed	Yes
	Analysis of quality of relationships. Used focus groups, appropriate for examining experience, but itself could have been affected by relations within the group! Focus groups involved nurses at different stages in their careers, including students. These are analysed separately, although it is not possible to identify how many of the participants were students and how many were qualified nurses. Title of research confusing, because generation often means birth cohort, but in this study it referred to career stage (student, early career or mid/late career).						Details of analysis of transcripts very brief, but made important claims			Much data excluded, e.g. students' relationships with managers & management impact upon nursing care. However, the data on the impact of management upon career satisfaction was important to this review.
Sayman, D.M.	No	Yes	Yes	Used range of sources, as well as participants	Data collection complex	No	Not stated	Cannot tell	Yes	Yes
	Instead of question, had clear problem and statement of purpose. Due to variety of data needed to adopt different strategies to analyse it, but this is not fully explored. Research and interviews done by woman researcher, and account provided of reflexivity to ensure trust-worthiness.						Used theory of symbolic interactionism to analyse interviews of men, who were purposively chosen, but it is not apparent what characteristics she was wishing to have represented, although there was a good spread of ages.			Experience of men working with negative stereotypes.

Schmidt, N.; Brown, J. M.	Yes	Yes	Yes	All eligible were contacted	Yes	No	Yes	Cannot tell	No	Possibly
	Acceptable response rate (46%), but population of just 50 meant that results difficult to generalise from. Although not stated, is likely that they were approached by staff involved in the elective. Few details of the elective are provided, although this has been written up separately.						No details of analysis, except for some statistical analysis of proportion working in perioperative field. All participants had experienced same elective, so results could have been influenced by the particular arrangements.			Pre-reg elective encouraged nurses to consider career here, although only about ¼ did
Waddell, J.; Spalding, K.; et al	Yes, in all 3	Used qualitative and quantitative appropriately	Yes, although not described as such was action research	Yes	Yes	No, conducting research on own students.	Permissions granted, but I had concerns	Yes, but small numbers	Yes	Possibly
	Outcomes in part 1 used questionnaire to measure career decidedness and qualitative measures to assess participants' career confidence. Outcomes in part 2 only quantitative analysis of participants career preparedness, so no qualitative findings related to longer-term outcomes. Statistical analysis problematic in view of only 33 in intervention group and 39 in control group. Also experienced high drop out of intervention group, so additional students were recruited. Statistical analysis showed that two groups similar at outset but showed differences in their approach to careers by the end. Part 3 qualitative analysis only, interviewed 9 academics involved in the research, 3 had additional preparation and 4 did not.						Control group missed additional material to help careers, which was provided to experimental group by the research team. Proposed modest and realistic curriculum changes that could enhance student careers.			RCT of pre-registration activities designed to increase career resilience. Demonstrated that improved self-efficacy but no follow-up to measure effects on longer-term career.

Wareing, M.; Taylor, R.; Aileen Wilson, A.; Sharples, A.	Precise aim stated	Yes, supported by statistical analysis	Yes	Yes, but only 1 cohort involved	Yes	Not discussed	Yes	No	Yes	Yes
	Title showed single aim, but objectives were broader than this. Response rate of 57% low, considering this was a survey carried out on the last day of students' programme Small survey of just one school. Described as a pilot study, but main study not identified for this search. Implications of surveying own students not discussed. Tools not validated, but adequate details of the tool provided so could be replicated. Mixed methods approach had potential to be powerful tool for examining first career choices						No account of any statistical tests and no explanation of qualitative analysis. Results presented as series of 4 themes, put into context of wider literature, but with minimal statistical evidence			Discussed influences upon early career decisions: variety, support, learning opportunities, staffing levels. Confirmed preference for acute areas
	Yes	Yes	Yes	Not discussed	Yes	NA	NA	Cannot say	Yes	Possibly
	Content analysis of popular (in U.S.) T.V. shows. No discussion about which were included or not, precise details provided, but no justification. Textual analysis of plot etc involving men – details not discussed, but at least 2 researchers viewed each episode included						Minimal details about how content was classified or analysed			Exposed contradictory attitude in these shows

Table ap2.2 Appraisal of the quality of qualitative studies ("the CASP tool")

Appraisal tool, questionnaires

Research question and study design	
What information did the researchers seek to obtain?	1
Was a questionnaire the most appropriate method and if not, what design might have been more appropriate?	2
Were there any existing measures (questionnaires) that the researchers could have used? If so, why was a new one developed and was this justified?	3
Were the views of consumers sought about the design, distribution, and administration of the questionnaire?	4
Validity and reliability	
What claims for validity have been made, and are they justified? (In other words, what evidence is there that the instrument measures what it sets out to measure?)	5
What claims for reliability have been made, and are they justified? (In other words, what evidence is there that the instrument provides stable responses over time and between researchers?)	6
Format	
Was the title of the questionnaire appropriate and if not, what were its limitations?	7
What format did the questionnaire take, and were open and closed questions used appropriately?	8
Were easy, non-threatening questions placed at the beginning of the measure and sensitive ones near the end?	9
Was the questionnaire kept as brief as the study allowed?	10
Did the questions make sense, and could the participants in the sample understand them? Were any questions ambiguous or overly complicated?	11
Instructions	
Did the questionnaire contain adequate instructions for completion—eg example answers, or an explanation of whether a ticked or written response was required?	12
Were participants told how to return the questionnaire once completed?	13
Did the questionnaire contain an explanation of the research, a summary of what would happen to the data, and a thank you message?	14
Piloting	
Was the questionnaire adequately piloted in terms of the method and means of administration, on people who were representative of the study population?	15
How was the piloting exercise undertaken—what details are given?	16
In what ways was the definitive instrument changed as a result of piloting?	17
Sampling	

What was the sampling frame for the definitive study and was it sufficiently large and representative?	18
Was the instrument suitable for all participants and potential participants? In particular, did it take account of the likely range of physical/mental/cognitive abilities, language/literacy, understanding of numbers/scaling, and perceived threat of questions or questioner?	19
Distribution, administration and response	
How was the questionnaire distributed?	20
How was the questionnaire administered?	21
Were the response rates reported fully, including details of participants who were unsuitable for the research or refused to take part?	22
Have any potential response biases been discussed?	23
Coding and analysis	
What sort of analysis was carried out and was this appropriate? (eg correct statistical tests for quantitative answers, qualitative analysis for open ended questions)	24
What measures were in place to maintain the accuracy of the data, and were these adequate?	25
Is there any evidence of data dredging—that is, analyses that were not hypothesis driven?	26
Results	
What were the results and were all relevant data reported?	27
Are quantitative results definitive (significant), and are relevant non-significant results also reported?	27
Have qualitative results been adequately interpreted (e.g. using an explicit theoretical framework), and have any quotes been properly justified and contextualised?	29
Conclusions and discussion	
What do the results mean and have the researchers drawn an appropriate link between the data and their conclusions?	30
Have the findings been placed within the wider body of knowledge in the field (eg via a comprehensive literature review), and are any recommendations justified?	31

Table ap 2.3: key to questions about quality of questionnaires ("The BMJ tool")

Outcomes of appraisal of questionnaires

	Question & study design				Validity reliability		Format					Instructions			Piloting			Sampling		Distribution, administration & response				Coding & analysis			Results			Conclusion & discussion	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Abrahamson, B. 2015	Stated	Yes	Used	No	Few claims made	Few claims made	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Yes	Unknown	Unknown	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
	Used national database for questionnaire				A longitudinal survey, but quite a small sample		Details of instrument not discussed, nor its distribution					Details not disclosed			No pilot, is assumed that had been used previously			Only 2 colleges involved		71% response rate				Concentrated upon less favoured specialisms (elder or mental health care)			how knowledge, altruism and choice of field related			Only discusses elder and mentla health care	
Adeniran, R.K.; Smith-Glasgow, M.E.; Bhattacharya, A. 2013	Stated	Yes	Utilised	Not discussed	Established tool	Confident	Not discussed	Several types	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Probably	Online	Self-administered	No	No	Power analysis	Not discussed	no	Yes	No	No	No	Yes
	Used established psychology tools to show differences between differently-trained nurses				Authors confident that tool would reveal differences, do not entertain the possibility that inability to show this could be result or inappropriate tool		Several instruments (4) were used, all had been previously validated, but this has not bee verified for this thesis. The experience of completing the questionnaires for the nurses was not discussed, but it is likely to have been a lengthy process					Survey appeared very complex & only 200 of the 483 responses were usable, suggesting that the sample is not representative (only included those with motivation to complete it).			No piloting deemed necessary, since tools were established. A pity, because this may have identified & addressed the difficulty in completing the questionnaires			Power analysis conducted to establish required sample size, but this not verified for this thesis. All participants worked in one US state		Was widely advertised, through several different types of media No attempt to examine the cause or effect of low completion rate. Had calculated the number required & did achieve this, despite high non-completion rate				Statistical tests applied, but the appropriateness of these have not been examined for this thesis			Drew important conclusions about career profiles of nurses trained overseas, yet only about ¼ (i.e. about 50) were international nurses, so is not safe to generalise from this. No quotes used			Authors believe differences present, in spite of minimal evidence	
Barron, D.N. West, E. 2007	Broad aims	Yes	Utilised	No	Yes	Yes	Cannot say	Cannot say	Cannot say	Cannot say	Cannot say	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Yes	Cannot say	Cannot say	Cannot say	Cannot say	Logistic regression	Not discussed	No	Yes	Yes	NA	Yes	Yes
	Adapted a previously existing US questionnaire						Minimal details provided of instrument, could view original details of instrument, but has been adapted by present authors					High rate of unusable responses.			A pilot may have helped identify who such poor successful completion			UK research, mostly based in London		Omitted any that stated they did not have career plans but also if they were incomplete. No discussion of effect upon quality of data.							Showed complexity of nurses' job satisfaction & that 55% planned to leave employment			Pay and respect important in retention	

Berkery, E., Tiernan, S. & Morley, M., 2014	Stated	Yes	Utilised	No	Yes	Yes	Yes	list of attributes	Cannot tell	Not discussed	Cannot tell	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Yes	Variety	Cannot say	No	No	Factorial analysis	Cannot say	No	Yes	Yes	NA	Yes	Yes
					Tools been successfully used frequently before		Participants provided with 92 characteristics commonly associated & asked if they applied to men, women or successful managers					High rate of unusable responses suggest tool difficult.			No pilot, pity because it may have shown up problems with tools.			Included midwives & unable to separate these results.		70% response rate. Paper survey distributed at conferences, so likely to include high number of proactive nurses & midwives						Men but not women report gender stereotyping of managers, but ldifferences less pronounced for students			Danger of 2-tiered profession	
Booth, J.; Hutchison, C.; Beech, C.; Robertson K.B. 2006	stated	yes	None known	Some	Not discussed	No claims made	Not discussed	Both	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	yes	Yes	Post	participants	Yes	No	yes	None	no	Cannot say	Descriptive	None	Yes	Yes
	Questionnaire unvalidated & based upon experience of a small group (4) from the population, so may have omitted to ask about issues that were important to other nurses.				Small population but high response rate, so gained contributions from 81% of consultant nurses\midwives in Scotl7		Details of instrument not discussed					Details of instrument not discussed			No pilot			Sample involved all consultant midwives & nurses in Scotland					Descriptive stats. Open-ended questions analysed independently by 2 different researchers			Mostly evaluated the positive impact of these newly-created posts on client care, but also discussed the effect of the availability of these new posts on the post-holders.			Showed variability of posts – in nature of work & pay and inconsistent approach to career development	

Candela, L.; Gutierrez, A.; Keating, S 2013	Stated	Yes	Not discussed	No	Limited	Limited	Not discussed	Online survey Liker-type	Not discussed	Not discussed	Cannot tell	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Comprehensive	Yes	Email	Cannot say	Yes	No	Statistical	Not discussed	No	Yes	Yes	Not discussed	Yes	No
	Questions were based upon a literature search but the tool had not been validated & statistical analysis suggested that well over half (29) items did not yield valid data. This suggests that & so their results can only be generalised with caution & may not be replicable.						Was a survey using mostly liker-type scales, with two questions requesting free text responses. Was a 45-question instrument, with 2 open-ended which seems quite daunting							No pilot			Authors claimed that their sample was statistically representative, but they do not provide figures to support this nor fully illuminate which factors they checked for being representative.		Although they do not state population size, involved all HEIs in America, yet they received only 808 replies which is a low response rate.				Checked for outliers (were none) then Pearson step-wise analysis used. Statistical approach not justified & I do not have the competence to discuss this . The analysis & results from free text questions not discussed			Results surprised the authors & this was examined.			Used data to examine sources of satisfaction & dis-content amongst academic staff.	
Edward, K., Warelow, P., Hemingway, S., Hercelinskyj, G., Welch, A., Mccrew, S. Stephenson, J 2015	Stated	Not entirely	Not discussed	No	No claims	No claims	Not discussed	Not discussed	Not discussed	Not discussed	Cannot tell	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Variable	Yes	Not stated	Not stated	33%	No	Frequency	Not stated	No	Yes	Yes & yes	No	Yes	Yes
	Used a tool that was developed for the purpose of this study & had not been validated, so cannot be sure of its validity or reliability. Survey unable to fully illuminate attitudes,						Survey of 9 closed & 3 open style questions, plus demographic questions							No pilot			Used different approaches in different schools so may not be consistent. Authors discuss limitations of purposive sampling		Distribution discussed, but may have taken different approaches in different hospitals. Different response rates from Australia & UK reported				Statistics only reported, no reporting on free test responses, this may have informed discussion but not apparent			An (unsuccessful) attempt to demonstrate that the different arrangements for student nurses in Australia & UK lead to different attitudes to mental health nursing.			Showed that individuals' exposure to mental health issues more important than formal teaching.	

Halfer, D.; Graf, E. 2006	Unclear	Unclear	Unclear	Not discussed	Few claims made	No claims	Unknown	Unknown	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Cannot tell	Cannot tell	Not stated	Not stated	Not stated	Not stated	Cannot tell	Not discussed	None	Yes	Yes	Yes	Discussed	Discussed
	A survey to describe the experience of newly qualified nurses – may not be the best way to analyse perceptions				Too few details to assess these		They were surveyed (using an instrument designed for this & not validated) at 3, 6, 12 & 18 months after graduation. Instrument of 21 statements for agreeing\disagreeing & 4 open questions											84 Nurses all worked in paediatric care in one hospital.		Not all nurses completed all surveys, return rate varied 28-46%. it is not explained how nurses who left that hospital's employment were accounted for.				Descriptive statistics & how these developed over time .Unusual longitudinal study to examine how experience develops			Leaving due to poor rotas, relationships with others. Staying helped as understanding of leadership develops			Authors speculated on the meanings of attrition from the survey.	
Hasson, D.; Lindfors, P.; Gustafaaon, P. 2010	Stated	Yes	None known	Not discussed	Satisfactory	Discussed	Not reported	Likert-type	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Yes	Was suitable	Post	Self-completed	Fully reported	Not discussed	Probably	Good	None	Fully reported	Yes	no	Discussed	Discussed
	To study how the transition from higher education to working life influences self-rated health in nurses. Objectives were to elucidate possible trend differences in SRH between the whole cohort & those working as a nurse at all follow-ups. questionnaires are an appropriate method of capturing data about self-rate health in nurses.				The self-rated health item is very widely used in high income countries. For example, it is one of the Patient-Reported Outcomes Measurement Information System (PROMIS) global health items. It is generally believed to have satisfactory validity & reliability.		The questionnaires included wide-ranging questions pertaining to socioeconomic status, demographic factors, health-related factors, & lifestyle factors. In relation to self-reported health, participants were asked to provide self-ratings of health using a Likert scale.			The questionnaire was not made available as a supplementary document.			There is no reference to the questionnaire being piloted			The cohort for the study was based on a total population of all final semester nursing students in the autumn of 2002 in Sweden (n = 1,648). This population should be able to manage the questions		Response rates fully reported for each time point Potential response biases have not been discussed			Statistical tests performed but I do not have the requisite knowledge to comment on the appropriateness of the stat tests performed. Procedures for non-response follow up described. Mechanisms to maintain the of statistical data are not specified. Procedures for non-response follow up described. . SRH analysed over time, & according to age & gender.			Objectives a little misleading: *to elucidate possible trend differences in SRH between the whole cohort & those working as a nurse at all follow-ups*. This should mean the authors were to compare & contrast SRH amongst those who had stayed in nursing & those who had left nursing. They don't do this			Nurses' health deteriorates in early career, but then improves	

Homburg, V.; Heigden, B.; Valkenburg,L 2015	Not stated / Probably / Used / No	Discussed / No claims	Unknown / Unknown / Unknown / Unknown / Unknown	Unknown / Unknown / Unknown	Not discussed / Not discussed / Not discussed	Not discussed / Not discussed	Not discussed / Not discussed / Not discussed / Not discussed	Statistical / Not discussed / No	Yes / Yes / Yes	Yes / Yes
	Used previously validated tools. Unusual because surveyed nurses who were in process of leaving, they also measured intention to leave, which is much a more common approach, so offers rare insight into what has actually impacted nurses' career decisions.	Good response rate (47%) suggesting results are reliable, but all nurses started off in one hospital, so may not be generalisable.	Details of questions shown, but not how they were presented. Reader could verify the nature of the survey from previous research	No discussion of this, but nurses likely to be comfortable responding to online surveys	No pilot identified	Response rate of 47%, all from one hospital, but from wide variety of specialisms, no attempt to achieve representative sample	Few details of distribution provided	Statistical analysis using standardised techniques – I am not qualified to comment on appropriateness of this, tested for fit to model	Discussed fit to model, & showed most job changes triggered by dissatisfaction, which is consistent with much other work. Was unusual in that it asked nurses who had actually moved, rather than just pondering doing so	Authors were aware that career moves can occur within one hospital (which is very common in the big London trusts) so moves between departments were also included.
Horn, K.; Pilkington, L.; Hooten, P	Stated / Cannot tell / unknown / Not discussed	Weaknesses acknowledged / Weaknesses acknowledged	Unknown / Mixed – few details / Unknown / Unknown / Unknown	Unknown / Unknown / Unknown	Not discussed / Not discussed / Not discussed	Restricted / Suitable	Stated / Not discussed / Yes / No	Unknown / Unknown / No	Probably / Not reported / No	Discussed / Yes
	3 research questions about relationship between nurses & professional development (PD) + 1 about the tool	Acknowledge that only 1 hospital involved did not define PD	33-item survey done online or on paper. New tool, not validated nor reproduced in article, but was developed by paediatric nurses. There is a danger that the tools reflected the researchers' won beliefs e.g. they were asked to rate how important certain barriers were, yet we are not told how those barriers were chosen	Paper surveys were completed with researchers present, but online were not – no discussion about whether this affected the ease of completion	No pilot – preparation was in haste to be in time for PD fair, so even expert review was limited	100 invites & 74 participants, which is small for quantitative analysis. Were partly recruited from PD fair, so likely to be more interested than most	Paper & online. Used broad-brush approach to recruitment but only in 1 hospital	Some statistical testing of veracity of new tool, but I am not competent to assess this; the authors claim that it shows validity	Nurses keen to undertake PD, but multiple barriers to doing it. Statistical analysis not reported for significance	Discussion shows few unexpected findings, but does put work into context

Hovey, S.L.; Dyk, M.J.; Kim, M.; Reese, C. 2018	Unclear	Possibly	Utilised	Not stated	Limited	Limited	Not stated	Not stated	NA	Cannot say	Cannot say	Not stated	Not stated	Not stated	Not discussed	Not discussed	Not discussed	Yes	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Yes	Not stated	No	Yes	Yes	NA	Uncertain	No		
	Statistical analysis of different attitudes of students towards elder care depending upon sequence of experience. Attitudes measured using pre-existing tool.				Not clear how different types of experience (acute or chronic) were classified.		Not advised of populations size. 73 students initially expressed an interest in the study, 62 signed consent form but 9 did not complete questionnaire form correctly. Students were unequally distributed to 2 groups (35 & 18),							No pilot, but instrument was previously validated			All students in cohort invited to participate		Few details of distribution provided, but likely to be straight-forward as were in same cohort				Statistical comparison of two groups results in questionnaire. I am not able to comment on appropriateness of tests.			Only small differences found, may not justify authors' recommendations for nursing curricular			Suggests sequence of elder care placement s significant.			
Koehler, A.R.; Davies, S.; Smith, L/R.; Hooks, T.; Schanke, H.; Loeffler, A.; Carr, C.; Ratzlaff, N. 2016	Stated	Yes	Utilised	No	Yes	Yes	Unknown	Described	Cannot say	Quite short	Cannot say	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Yes	Yes	Email	cannot say	Yes	No	Yes	Cannot say	No	Yes	Yes	NA	Yes	Yes		
	Evaluation of course				Findings relate to one course – no attempt to generalise		Was a total of 20 statements for students to express agreement or disagreement. Not stated, but appeared to be online questionnaire.							No pilot, but used existing questionnaire (with one additional question)			Highly specific population		Students advised or study by email prior to commencement of course. Good (85%) response rate.				Straight-forward comparison of students before & after course			No control group & post-test was done immediately after the course with no follow-up.			Measured short-term impact upon interest, but not long-term impact on career decisions			
Koskinen, S.; Hupli, M.; Katajisto, J.; Salminen, L. 2012	Clearly stated	Possibly	Not discussed	Not discussed	Discussed	Discussed	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Yes	Yes	Yes	Yes	Probably	Described	Described	Unknown	No	Correlations	Not discussed	Cannot say	Yes	Yes	None	Discussed	Discussed		
							Used 100 point scale, which seems quite complex, & reasons not explored							Only minor, technical changes made following pilot			All participants were from Finland		Distributed in class by researcher. Response rate not discussed				Compared attitudes to elder care with known influences			Factors that influenced interest in elder nursing. Findings rather predictable						

Larsen, R., Leir, L.; Fraundienst, R. 2012	3 questions	Yes	Not discussed	No	Yes	Yes	Described	Closed	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Yes	Yes	In class	Cannot say	Yes	Cannot say	Linear regression	Cannot say	No	Cannot say	Cannot say	NA	Uncertain	Yes
	Consulted with 5 "public health experts" to design tool				Specific area of interest		15 aspect of job satisfaction participants asked to state importance of each, & likelihood of undertaking public health nursing / health visiting. Not apparent, but probably a paper survey.								No pilot			2 contrasting universities		Distributed & completed in class, along with information about study. No account of how data collected after graduation Claim 100% response rate				descriptive statistics + attempt to find links between career choices & experience			Asked 1 year prior to graduation & each of 2 years after, to indicate reasons for choice from a pre-selected list.			More likely to choose this the longer been qualified, attracted by bonus & internship	
Mauro, A.M.P.; Escalier, L.A.; Rosario, M.G. 2016	Stated	No	Not discussed	Yes	Few claims	Few claims	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	NA	NA	NA	No	Yes	Email	self-administered	low rate	No	Described	Not discussed	No	Discussed	Yes	NA	Yes	Yes
	A pilot survey, but was primarily a means of evaluating new toolkit.				Sample too small to be generalisable,		Most of the article devoted to the development of a toolkit. Aim appeared to be using the feedback to further develop the toolkit rather than conducting empirical research.								Was a pilot in itself. No main study traced			Low numbers, surprising since 3 schools involved		20/29 recent nurse graduates Participants provided with toolkit & asked to respond to online survey				Comparison of different parts of toolkit			Were able to identify those parts of toolkit that most useful				
McCann, T.; Clark, E.; Lu, S. 2019	Not clear	Yes	Utilised	No	Convenience sample	Discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	Not piloted	Not piloted	Not piloted	Limited	Yes	Not discussed	Not discussed	Not discussed	Not discussed	χ^2 normality homogeneity	Not discussed	None noted	Yes	Yes, slight	None	Discussed	Yes
	Used pre-existing questionnaire, but this had not been used for a longitudinal survey before				Authors acknowledge difficult to generalise		Minimal details provided. All closed questions					No details given						Single cohort involved		Very different response rate each year – no discussion. Appears that they could not track individual students				I am unable to comment on suitability of stats			Confirmed existing notions about student career expectations			Unsurprising	

Ng, L.; Eley, R.; Tuckett, A 2016	Stated	Yes	Yes	No	Discussed	Discussed	Unknown	Described	Cannot say	Probably	cannot say	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Yes	Probably	Email	Cannot say	Yes	No	Factor analysis	Cannot tell	No	Yes	Yes	NA	Discussed	Yes
	Survey based on a questionnaire devised by one of the authors on a previous occasion . Most research into feelings at least offers some chance of free-text response, but this did not, so cannot verify whether this tool captured nurses' feelings.				Statistical verification of validity. Used factor analysis to find correlations between biographical factors & nurses' attitudes to post-graduate education.		Adequate response rate of (36%). % demographic & 14 attitude questions, latter using Likert-type scales This quantitative methodology to explore feelings, yet the factors were pre-chosen by the researchers & may or may not reflect nurses' true feelings. No open questions All online, no details of format provided							No pilot, but instrument had been developed (but not validated) previously			Used a previously developed database. Response rate of 35.6%		All nurses on database were emailed, & was all done online				Factor analysis to find correlations			Reported registered nurses' attitudes to post-grad education			An unusual approach that could be useful for understanding career development	

Pajic, , S.; Keszler, A.; Kismihok, G.; Mol, S.T.; den Hartog, D.	Stated	Well established methodology	Used these	Not discussed	Theoretical approach explained &	Few claims	Not stated	Variable	Unknown	Not discussed	Unknown	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Unknown	Probably	Unknown	Unknown	Unknown	Unknown	statistical tests	Unknown	No	Probably	Yes	Probably	Yes	Yes
2018	Used well-established psychology tools, so is likely to be valid, except that survey was translated into Hungarian for the purposes of the study, & details about this process are lacking. Aimed to find correlations between psychological traits (particularly in relation to adaptability) & career success.				All the students were part-time, which is unusual in the UK, so findings may not be applicable. All participants & supervisors were from one hospital, which could affect reliability & generalisability		3 instruments used with a total of 44 questions, all using a scale for participants to explain how much they agreed, but the scales differed depending upon the instrument they derived from (e.g. some required a numeric response & some required a choice of descriptors					No discussion of paper or electronic format or how it was distributed			no pilot			Detailed account of how participants were identified, but not of why these were chosen, all from one hospital		No discussion of how the questionnaire was distributed				Extensive statistical testing, techniques not justified & I am not competent to assess			Allowance made for possibility that people have more experience & that part-time nurses may be older & more or less adaptable as a result of experience.			Findings rather predictable, only acknowledged one other explanation (i.e. that supervisors rated the performance of nurses that they liked as higher than others) but do not explore the possibility that mutual liking between nurse & supervisor could genuinely affect the nurses' performance.	

Philippou, J 2015	Stated	Yes	No	Yes	Yes	Yes	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	No pilot	No pilot	No pilot	Yes	Unknown	Cannot tell	Cannot tell	Yes	Cannot tell	Probably	Not discussed	No	Yes	Yes	NA	Yes	Yes
	Participants rated the responsibility of the manager & the nurse on a scale of 1-10 for 7 aspects of career development. The 7 aspects were identified earlier from interviews with 41 participants, but this was not reported here.				Authors acknowledge this done at time of severe upheaval in NHS which may have coloured views on career development.		I was unable to establish how many questions there were, how the questionnaire was distributed, how long it would have taken the participants to complete nor how it was returned.							Questionnaire developed from previous interviews			Authors tool particular care to recruit participants were from a wide range of clinical specialities & geographical areas.		Good (52%) response rate. Good details of participants biographic & professional details				Wilcoxon signed-rank test used to identify differences between actual & ideal career responsibili- ties; the Mann–Whitney test to identify differences in responses between the nurse employees' & employers' groups; & the Kruskal–Wallis test to identify differences between independent variables from participants' demographic, employment & academic profiles. I cannot comment on the suitability of these			The authors do not report directly on the outcome of the original interviews			This study could be relevant because it is quite recent & placed in an NHS context	
Read, E.; Laschinge, H.K.S. 2017	Stated	Yes	Utilised	Not stated	Possibly	Yes	Not discussed	Open & closed	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	No pilot	No pilot	No pilot	Yes	Yes	Cannot tell	Cannot tell	Yes	No	X^2	cannot tell	No	Probably	Yes	Yes	Yes	No
					Used previously validated questionnaire but do not acknowledge controversy around concept of self-efficacy or how it can be measured.		Used 2 instruments previously developed (12 + 9 items), & 1 developed by authors – insufficient details given of latter, but it collected mostly descriptive data. Not stated by authors, but I assume that was all done online								No pilot described, but did use mostly previously validated tools			High number of participants & was a nation-wide study		Adequate response rate (27.9%), impressive for a postal survey, & the two groups were similar in most ways except, as expected, graduates from accelerated programmes were about three years older. No incomplete data reported.				Simple statistics designed to show differences between 2 groups			Authors looking to confirm that nurses from post graduate programmes would display greater self-efficacy. Were unable to show this			Much discussion about why they expected differences but little about why they could not show this.	

Stevens, J.A. 2011	Yes	Yes	Not discussed	No	Yes	Yes	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Yes	Lectures	Cannot say	Yes	Yes	Statistical	Not discussed	No	Yes	Yes	Yes	Yes	Yes
					Longitudinal study with potential to show changes		Format not discussed, but as distributed in class is likely to be paper. Offered 10 career choices, which participants ranked, could provide written rationale for most & least favourite.											All students in one state involved		Paper questionnaires distributed during lectures. Acceptable response rate (68%)				Wilcoxon rank some test used to show changes in preferences. Free text used to illustrate			Most of the results (6/10) showed statistically significant change			Elder care becomes less popular during nurse eduation	
Stevens, J.; Browne, G.; Graham, I. 2013	Stated	Yes	Utilised	No	Yes	Yes	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Yes	Lectures	Cannot say	Yes	Yes	Statistical	Not discussed	No	Yes	Yes	Yes	Yes	Yes
							Tool was simple; as list of potential careers & participants were asked, on successive occasions, to rank their preferences								No pilot, but note that study above could have contributed as pilot for this study			Narrow population - 3 faculty in one state		Paper questionnaires distributed during lectures. Good response rate (68%; 76% & 80%). Increased during study				Wilcoxon rank some test used to show changes in preferences			Relied on students estimate of how long they had spent in different clinical areas			Showed reasons for not choosing mental health change	
Thongpriwan, V.; Leuck, S.E.; Rhonda L. Powell, R.L.; Young, C.; Schuler, S.G.; Hughes, R.G. 2015	Unclear	Yes	Utilised	No	Yes	Yes	Dem&ing questionnaire	Variable	Unknown	not discussed	Unknown	Unknown	Unknown	Unknown	Yes	Yes	Not discussed	Yes	Yes	Yes	Cannot say	No	No	statistical tests	Unknown	No	Yes	Yes	NA	Yes	Yes
							10 demographic questions + 26 questions with sub-scales + 10 questions requiring Likert type response. All online						Some information on how electronic instructions distributed			Was piloted in different geographical area. Used to check validity			all undergraduate nursing students in 1 state		All online, sent emails via each college. Low response rate (18.8%) & high number (9%) failed to provide demographic details. These & non-respondents not discussed				Non-parametric analysis used because data not showing normal distribution, but I am not competent to assess this.			Some slight differences in who expressed an interest in a career in mental health nursing			But differences quite small	

Tummers, L.G.; Groeneveld , S.M.; Lankhaar, M. 2013	Stated	Yes	Used existing data	No	Yes	Yes	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	No pilot	No pilot	No pilot	Yes	Yes	Cannot tell	Cannot tell	Cannot tell	Cannot tell	factor analysis	Not discussed	No	Probably	Yes	NA	Yes	Yes
	Investigated the impact of 6 factors that lit search showed could be important in leaving employer				Well-established survey		Conducted own analysis of selected participants.								No pilot, but bigger survey professionally carried out at regular intervals			High number of participants from wide variety of work-places, all in elder care.		Details not discussed & not controlled by these authors					Verified validity by statistically checking for consistency in responses.			Found correlations between 6 factors known to cause dissatisfaction & intention to leave – no discussion of other factors, nor whether they did leave.			Started & finished with strong theoretical discussion.	
Walker, L., Clendon, J. & Willis, J.	Stated	Yes	Not discussed	No	Uncertain	Uncertain	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Probably	Yes	Online	Self	Yes	No	Not discussed	Not discussed	Not discussed	Yes	Yes	Probably	Yes	Yes
	To compare New Zealand nurses intention to leave with international literature				Intention to leave closely related to actually leaving, but not demonstrated		No details of any sort provided					again, no details provided			Was described as a pilot and exploratory study			Survey included only member of professional association – not discussed whether all nurses would be members, as in UK		30% response rate – is acceptable				Minimal details of analysis, excpt how and why some were excluded			Reasons for leaving – were unsurprising but do quantify this. Some nice citations included			Was discussed alongside international literature	

Wilkes, L.; Doull, M.; Ng Chok, H.; Mashingaidze, G. 201&	Stated	Yes	Utilised	No	Yes	Yes	Not discussed	Paper & online	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Paper & online	Unknown	Yes	No	Discussed	Cannot say	No	Yes	Yes	None	Yes	Yes
	Main aim to develop new tool. This provided quantitative evidence to support qualitative research (not reported here) which used interviews to identify the factors now included in the survey.				Claimed that questionnaire could illuminate enjoyment of nursing, which is known to influence staying in post.		23 factors asking how greatly (using a Likert-type scale) the different factors increased or decreased their enjoyment of nursing. The tool was based on factors had been previously identified from interviews with nurses, but this research is not reported here, making it difficult to be sure of its validity & difficult to replicate					No discussion or instructions or how parity was ensured between electronic 7 paper versions.			No pilot, but was based on previous work, which is discussed but not referenced.			No selection of participants, but were a more mature sample. Nurses responded to advert		Potential participants responded to adverts, no discussion as to how representative this was, but are likely to be nurses who feel strongly about the topic				interaction of factors affecting enjoyment analysed using chi-square analysis. Cronbach's alpha was calculated for the items in the survey 7 exploratory factor analysis with varimax rotation of items I am not qualified to assess this			Some qualitative results discussed, but from previous research			Showed that questionnaire a valid means of assessing enjoyment of nursing	
Wilson, B.; Squires, M.; Widger, K.; Crawley, L.; Tourango, A. 2008	Stated	Yes	Utilised	No	Possibly not	Possibly not	Not discussed	Postal	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Yes	Yes	Postal	Self	No	No	descriptive	Not discussed	No	Yes	Yes	None	Yes	Yes
	Sought to demonstrate generations fundamentally different, but assigning participants to their generation appeared rather idiosyncratic, 7 others assign differently						Used well-established tools, Would expect most nurses to be able to complete these ssatisfactorily								No pilot			Large sample, part of a bigger survey into nursing workforce		High response rate (65%) but no discussion of non-responders 7 unusable papers not discussed				Straight-forward statistics of differences between generations						Demonstrate that year of birth linked to attitudes	

Xiao, L.D.; Shen, J.; Paterson, J.; 2013	Stated	Yes	Utilised	Not stated	Yes	Yes	Not discussed	Described	Not discussed	Not discussed	Not discussed	Unknown	Unknown	Unknown	Not discussed	Not discussed	Not discussed	Yes	Yes	Unknown	Unknown	Unknown	Yes	Discussed	Not discussed	No	Yes	Yes	Table only	No	Yes
	To compare & contrast Australian & Chinese student nurses' attitudes to elder care				But differences between 2 groups modest whilst similarities were marked		9 items participants ordered preferences +16 item participants expressed degree of agreement.								Was part of a bigger survey, which may have been piloted. Lack of pilot a potential problem as questionnaires required translating into Chinese					High response rate (79% & 70%). Study designed to illuminate bias in nurses				Fractional invariance used to show differences in groups			Designed to capture feelings at start of nurse education with no intention to follow how they developed or translated into career decisions.			Surveys of student nurses' attitudes to & career intentions regarding, elder care.	

Table ap 2.4 Appraisal of quality of research using questionnaires

Appendix 3: Interviews

Interview schedules and prompts

Points to note:

- These are guides for the researcher; they are intended to indicate the type of material to be covered, and to act as a prompt.
- It is not necessarily expected that all the questions will be used, and not necessarily in that order
- The interviews will be audio recorded, and later transcribed
- The interviews are expected to last about one hour, and must be finished by 90 minutes

Nurses – first set

I'd be interested to know why you applied for this post; did you consider any others?

Reflecting on why you applied for this post, have your hopes for it been fulfilled?

What about your post before this one; and the one before that.....?

What do you feel about the information you had about possible posts?

Did you receive any help or guidance at any point in your career?

Have you received mentoring – how was it?

One of the key things in the literature is the extent to which workers are free to make their own career choices. To what extent have you been able to make your own career choices and to what extent have you been constrained by other factors?

Have you ever had to compromise in your career progression\aims?

Can you remember why you entered nursing originally, and to what extent has this been fulfilled?

What do you most enjoy about your work?

What motivates you?

What is your greatest source of satisfaction in your work?

How do you know when you have done a good job?

Is there any way that you have altered the role or the way you do it? How or why did it change?

Would you recommend nursing as a career, or your particular role?

What do you feel about opportunities for professional development?

Do you have any ideas as to what your next decision will be (including staying put)?

Do you have any long-term goals?

Have you ever made the wrong career decision?

Is there anything you know now that you wish you had known 20 years ago?

Looking forward, how will you know if it is time to move?

What might you be looking for in your next post?

Very many thanks for your help and time

Nurses – final set

- What are nurses looking for in their careers?

  Why did you enter nursing originally, and to what extent has this been fulfilled?

  Why did you apply for this particular post/ for this type of work, and to what extent has this been fulfilled?

  What do you most enjoy about your work?

  What motivates you?

  What do you feel about the pay you receive?

- What decision making styles are they employing and do these change?

  Reflecting on your career decisions, how do you go about these?

  Have you changed the way you make career decisions?

  Can you remember any career decision (eg the last one) and how did you go about it? What was going on in your life at the time?

  Do you have any ideas as to what your next decision will be (including staying put)?

  How do you commonly make decisions about your career? Do you act quickly or ponder it?

  Has this changed over your career?

  What factors do you consider when you make a career decision?

  Do you check on jobs eg NHS jobs or press, or put your CV online, LinkedIn?

- How far into the future are they planning?

  Reflecting on the roles you had did you plan a few years ahead?

  Do you have goals for the future?

  Have you thought about retirement – are you doing anything to prepare for it?

- Do they have to compromise on what they really want and what is achievable?

  Have you ever made a wrong decision, have you ever thought you had?

  To what extent are you free to make your own decisions?

- Have they received mentoring and how has these impacted on their career decisions?

  Have you had career guidance or mentoring which has had an impact on your career decision?

  What was it and why?

  Where do you go for help and guidance with your work, and is this sufficient?

  Is there anything you know now that you wish you had known 20 years ago?

- Very many thanks for all your help and sincere appreciation of your time

Managers, educators (first and final set)

What qualities make a good nurse?

What attracts nurses into this field?

What qualifications, attributes or experience do you like in nurses you employ?

What do you think your nurses find is the greatest source of satisfaction in their work?

How do they know when they have done a good job?

What are the most difficult aspects of their work?

To what extent are they prepared, in advance, for this work?

Once they are working for you, what opportunities for professional development are there?

What skills and attributes do you expect to see developing as they work here?

To what extent do they plan their own work / negotiate with other / work as a team member

To what extent do you guide them in their work, and to what extent are they expected to work without guidance?

Are there are other sources of guidance available to them?

What sort of roles (etc) do they move onto from here?

Many thanks for all your help

Decision tree showing that this inquiry did not require full IRAS ethics approval

National Research Ethics Service

Does my project require review by a Research Ethics Committee?

National Research Ethics Service

Does my project require review by a Research Ethics Committee?

This algorithm is designed to assist researchers, sponsors and R&D offices in determining whether a project requires ethical review by a Research Ethics Committee under the UK Health Departments' Governance Arrangements for Research Ethics Committees (GAfREC), a harmonised version of which came into effect on 1 September 2011. It encompasses the requirements for ethical review under both the policy of the UK Health Departments and legislation applying to the UK as a whole or to particular countries of the UK.

Researchers requiring further advice should contact their R&D office in the first instance. Further advice may also be sought from a REC office or the NRES Queries Line at nres.queries@nhs.net by

sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location.

GAfREC is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126474. This updated version of the algorithm takes account of paragraph 2.3.8A of GAfREC which was re-included in February 2012 following publication of an erratum.

In this document the term “Research Ethics Committee" means a REC within the UK Health Departments" Research Ethics Service, i.e. the National Research Ethics Service (in England) and the equivalent Research Ethics Services in Scotland, Wales and Northern Ireland. It does not include other RECs such as university RECs.

1

A. Is the project research?

A1	Is the project classified as research, or is it another type of activity such as clinical audit, service evaluation, public health surveillance, case study, satisfaction survey or equipment/systems testing? *Please refer to our leaflet “Defining Research” at http://www.nres.nhs.uk/applications/is-your-project-research/* *Specific guidance on the classification of post-market surveillance of CE marked medical devices is available within our guidance on approval for medical devices research at http://www.nres.nhs.uk/applications/guidance/guidance-and-good- practice/?esctl1507888_entryid62=66940*

If the project is not classified as research, review by a REC is not required. Host care organisations may have other arrangements in place to review the activity. Please seek advice from the R&D office or clinical governance office in the first instance.

If the project is research, proceed to Section B.

B. Is there a legal requirement for REC review of this research?

The requirements in Section B apply *whether or not* the participants are patients or service users within the services for which the UK Health Departments are responsible.

The requirements apply to the whole of the UK except where stated.

2

Ref.	*Question*	*Relevant legislation*
B1	Is the research a clinical trial of an investigational medicinal product? *Refer to the MHRA algorithm at*	Medicines for Human Use (Clinical Trials) Regulations 2004

	http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Clinicaltrials/Isaclinicaltrialauthorisation CTArequired/index.htm#1 to determine whether the trial is subject to the Clinical Trials Regulations. Contact the MHRA Clinical Trials Helpline for further advice.	
B2	Is the research a clinical investigation of a non-CE Marked medical device, or a device which has been modified or is being used outside its CE Mark intended purpose, conducted by or with the support of the manufacturer or another commercial company to provide data for CE marking purposes? *Refer to our guidance on approval for medical devices research* at http://www.nres.nhs.uk/applications/guidance/guidance-and-good- practice/?esctl1507888_entryid62=66940 or MHRA guidance at http://www.mhra.gov.uk/Howweregulate/Devices/Clinicaltrials/index.htm *Contact MHRA Devices Division for further advice.*	Medical Devices Regulations 2002
B3	Does the research involve exposure to any ionising radiation?	Ionising Radiation (Medical Exposure) Regulations 2000

	Refer to our guidance on research involving radiation at *http://www.nres.nhs.uk/applications/guidance/research- guidance/?esctl1428683_entryid62=67014*	

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B4	Will the research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in the study following loss of capacity? *An adult is any living participant aged 16 or over. Intrusive procedures are those requiring consent in law, including use of identifiable tissue samples or personal information.* *Applies in England, Wales and Scotland only.*	Section 51 of the Adults with Incapacity (Scotland) Act 2000 Sections 30-33 of the Mental Capacity Act 2005
B5	Will the research involve storage of relevant material from the living or the deceased on premises without a storage licence from the Human Tissue Authority (HTA)? *Relevant material means any material from a human body consisting of or including cells, except for hair or nail from the living or embryos outside the body.* *Includes storage of imported material. Does not include „storage incidental to transportation" or temporary storage pending extraction of aceullar material for research provided that residual relevant material is*	Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations 2006

	disposed of within hours or days (or at most a week). *Applies to England, Wales and Northern Ireland only.*	
B6	Will the research involve storage or use of relevant material from the living, collected on or after 1 September 2006, and the research is not within the terms of consent for research from the donors?	Section 1(9) of the Human Tissue Act 2004

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	Does not include imported material.Applies to England, Wales and Northern Ireland only.	
B7	Will the research involve analysis of DNA in material from the living, collected on or after 1 September 2006, and the analysis is not within the terms of consent for research from the person whose body manufactured the DNA?	Section 45 of the Human Tissue Act 2004
	For further guidance on B5-B7, refer to http://www.nres.nhs.uk/applications/approval- requirements/ethical-review-requirements/requirements-for-ethical-review-under- legislation/human-tissue/ or the HTA Code of Practice on Research at http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice.cfm *Guidance on defining „relevant material" is available from the HTA at* *http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/policiesandpositionstateme nts.cfm*	

B8	Will the research involve either of the following: . (a) organs retained from a post-mortem examination carried out on the instructions of the Procurator Fiscal . (b) organs, tissue blocks or slides retained from a hospital post-mortem examination, or tissue blocks or slides retained from a post-mortem examination carried out on the instructions of the Procurator Fiscal, unless lawful authorisation has been given for use in research?	Human Tissue (Scotland) Act 2006

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	Applies in Scotland only.	
B9	Will the research involve access to, or processing of, the confidential information of patients or service users by researchers outside the normal care team without consent? *Applies in England and Wales only.* *In addition to REC review, application must be made to the National Information Governance Board"s Ethics and Confidentiality Committee (NIGB ECC). Refer to http://www.nigb.nhs.uk/s251 for further guidance. Specific advice may be sought from the NIGB http://www.nigb.nhs.uk/contact-us*	Health Service (Control of Patient Information) Regulations 2002 Section 251 of the NHS Act 2006

B10	Will the research involve processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers without consent? *Authorisation for the research is required from the Human Fertilisation and Embryology Authority (HFEA). A favourable opinion from a REC is a required condition of authorisation. The NIGB ECC advises the HFEA on applications for authorisation. Please contact the NIGB for further advice http://www.nigb.nhs.uk/contact-us.*	Human Fertilisation and Embryology (Disclosure of Information for Research Purposes) Regulations 2010
B11	(a) Will the research involve patients (or information about patients) receiving treatment in or for the purposes of an independent hospital or independent clinic?	The Independent Health Care (Wales) Regulations 2011

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	Applies in Wales and Northern Ireland only. (b) Will the research involve patients (or information about patients) receiving treatment in or for the purposes of an independent medical agency? *Applies in Northern Ireland only*. *(Note: The Private and Voluntary Health Care (England) Regulations 2001 were revoked by the Health and Social Care Act 2008 (Commencement No. 16) Transitory and Transitional Provisions Order 2010 (SI*	The Independent Health Care Regulations (Northern Ireland) 2005

	2010/87)	
B12	Will the research involve residents (or information about residents) at a residential care home or nursing home? *Applies in Northern Ireland only.*	Residential Care Homes Regulations (Northern Ireland) 2005 Nursing Homes Regulations (Northern Ireland) 2005
B13	Is the research a clinical trial involving the participation of practising midwives?	Nursing and Midwifery Council (Midwives) Rules Order of Council 2004

If the answer to any of the questions in Section B is Yes, application for ethical review should be made to a Research Ethics Committee within the UK Health Departments' Research Ethics Service, except for research recruiting through the UK Armed Forces or otherwise within the remit of the Ministry of Defence Research Ethics Committee (MoDREC).

Specific requirements apply to the allocation of certain types of application. Further guidance is available from

http://www.nres.nhs.uk/applications/booking-and-submitting-your-application/ or from the NRES Central Allocation System or Local Allocation Systems (see link for contact details).

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If the answer to all the questions in Section B is No, please proceed to Section C to check whether any other policy requirements for ethical review apply to

the study.

C. Is there a policy requirement for REC review of this research?

The requirements in Section C apply to the whole of the UK.

Ref.	*Question*	*Explanatory comments*
C1	Will the research involve research participants identified from, or because of their past or present use of, services for which the UK Health Departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?	The relevant services are: Adult and children‟s healthcare within the NHS/HSC (UK-wide) Adult social care (England, Wales, NI) Children‟s social care (Wales, NI) Refer to Supplementary Note 7 below for further guidance on social care research. • • •
C2	Will the research involve research participants identified because of their status as relatives or carers of past or present users of these services?	

C3	Will the research involve collection of tissue or information from any users of these services, including those who have died within the last 100 years?	Tissue means any material consisting of or including cells. Includes tissue or information collected in the course of normal care, where research use is intended at the time of collection.
C4	Will the research involve use of previously collected tissue or information from which the research team could identify individual past or present users of these services, either directly from that tissue or information, or from its combination with other tissue or information in or likely to come into their possession?	Tissue means any material consisting of or including cells. Refer to Supplementary Notes 1-3 below for further guidance on circumstances where REC review is not required for secondary use of tissue or information previously collected in the course of normal clinical care.
C5	Is this a health-related research project involving prisoners?	A prisoner for this purpose means a person in the custody of the National Offender Management Service (i.e. the Prison Service in England and Wales), the Scottish Prison Service or the Northern Ireland Prison Service?
C6	Does this research involve xenotransplantation?	Xenotransplantation means putting living cells, tissue or organs from animals into people.
C7	Is this a social care research project funded by the Department of Health?	

If the answer to any of the questions in Section C is Yes, application for ethical review should be made to a Research Ethics Committee within the UK Health Departments‟ Research Ethics Service.

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Where research approved by the Ministry of Defence Research Ethics Committee (MoDREC) continues within the services for which the UK Health Departments are responsible following transfer of participants into their care, it does not then require separate REC review.

Specific „flags‟ apply to the allocation of certain types of application. Further guidance is available from http://www.nres.nhs.uk/applications/booking-and-submitting-your-application/ or from the NRES Central Allocation System or Local Allocation Systems (see link for contact details).

Information for participants

Appendix 7a: Sample Email invitation to a potential participant known to researcher

From: Coutts, Alison

Sent: 29 June 2013 14:04

To:

Subject: interview

Hello …….

I don't know if you remember meeting me at the ……. You were kind enough to express an interest in my PhD research, which is about nursing careers; at the time you said you were willing for me to interview you about your career.

I am now commencing these interviews, and am wondering if you are still willing to participate. I would come to you at your convenience, and it will take no more than 90 minutes. One other thing, at the moment I am only interviewing nurses who gained their registration between 1998 and 2008 - I don't know whether that includes you?

If you think you may be willing to participate, I can send you more details before you finally decide.

I look forward to hearing from you.

Best wishes

Alison Coutts

Senior lecturer, City University

Email sent by alumni office on behalf of researcher

On 21 May 2013 15:13, Rees, Sue <Sue.Rees.1@city.ac.uk> wrote:

Dear……

I hope that you are well. I am hoping that you will be willing to participate in some research.

One of our lecturers, Alison Coutts, would like to interview you about your career to date. She is looking for adult nurses (and ex-nurses) who obtained their first nursing qualification between 1998 and 2008. The interview will take about an hour, and definitely no more than 90 minutes. In order to participate in the study you need to be under 60 years of age, and also not be a current student at City, nor an applicant.

If you would like to participate or need more information, please contact Alison Coutts on her email address: alison.coutts.1@city.ac.uk

Thank you

Sue

Sue Rees
Head of Alumni Relations

Development & Alumni Relations
City University London
Northampton Square
London, EC1V 0HB

T: +44 (0)20 7040 5558
E: sue.rees.1@city.ac.uk
W: www.city.ac.uk/alumni
Support the City Future Fund

Follow-up email to respondents who have expressed an interest

From: Coutts, Alison

Sent: 15 May 2014 21:03

To:

Subject: RE: Nursing research

Hello …..

Thank you very much for your interest in this research. I have attached some information about the study; if you decide to participate it will involve my interviewing you for 60-90 minutes.

I normally come to you at work to conduct the interview, but if you prefer you could come to the university, or we could meet somewhere neutral or we could do it over the phone.

I hope to meet you sometime soon.

best wishes, Alison

Invitation to complete online survey

From: PG-Coutts, Alison

Sent: 25 May 2017 14:57

To: Coutts, Alison

Subject: FW: careers research

Attachments: Story Pitchie.docx

From: PG-Coutts, Alison

Sent: 12 January 2016 10:55

Subject: careers research

Hello ....,

I hope you do not mind me contacting you again. You may remember kindly allowing me to interview you about your career, over a year ago! I have now completed the data collection. As part of my data analysis, I have written a summary of the career decisions each of my participants, calling it their story. I attach a copy of yours ("Pitchie"). I would be very interested in any comments you have on this: the factual record; what you think about anything you said, and also any "updates". Your interview suggested that you were beginning to think about your long-term future. If you have anything to add please reply to this email.

From all the interviews, I have some provisional findings; I have converted these into a short questionnaire, and would be interested to know the extent to which, from your experience of your career, you agree or disagree with these statements. If you feel able to do this, please click on the link below, I estimate it will take up to 10 minutes.

Thank you, and best wishes

Alison

https://www.surveymonkey.co.uk/r/XYJ3DVV

Information Sheet: study into nursing careers

Title of study: What influences nurses' career decisions?

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of the study is to explore the processes you have gone through in making career decisions; what has helped or hindered you in this, and how your personal attributes have contributed to your choices

Why have I been invited?

I am recruiting about twenty nurses (adult branch) who obtained their registration between 1988 and 2007. I believe that your insights into your career (your previous and present posts) may assist me in building a picture of nursing careers.

Do I have to take part?

Participation is voluntary, and you may withdraw at any stage. You may also choose not to answer questions, for instance if you feel they are too personal or intrusive.

Your participation in this study will not affect your future career, nor your relationship with City University

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. Even if you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

- You will be invited to a single interview,
- I suggest that we meet at your place of work, but if you prefer we could meet elsewhere. You may prefer to be interviewed by telephone. This would be particularly suitable if you are no longer living or working near London, but you may prefer it for other reasons.
- The interview will be recorded, usually using a voice recorder, but if you prefer the interview can be recorded by my taking written notes.
- The recorded interview will take about one hour, certainly no longer than one and a half hours.
- Allowing time for organizing and finishing the interview, I am asking you to allow up to two hours for this.
- Once the interview is complete, I will write up exactly what has been said, and will forward a copy to you in order to give you opportunity to comment on the accuracy of this record, before it is used further in the study.
- This interview and the others will be analysed, looking for any common themes relating to nurses career choices and what has influenced these
- I am hoping to use some original quotes from these interviews in the final report; the source of any such quotes will only be identified by a pseudonym

Expenses and Payments (if applicable)

If we meet anywhere other than your place of work, I can offer modest travel expenses, but I am not able to offer any financial or other reward.

What do I have to do?

The interview will be about your career, and how you feel about it, please see the attached for an outline of the questions we will be exploring

What are the possible disadvantages, advantages and risks of taking part?

There should be no risks involved in joining this research project, indeed I hope that you will enjoy the opportunity to reflect on your career.

What will happen when the research study stops?

The recording (or hand written notes) will be destroyed once there is a word-processed record of the interview. This record will be kept for ten years after the completion of the study, and then destroyed.

Will my taking part in the study be kept confidential?

Only one researcher will have access to the original record of the interview, and only she will know whose interview it is. The recording may also be heard by a professional transcriber.

The interview transcript will be fully anonymised before anyone working with the researcher sees it. For this purpose you will be asked to choose a pseudonym, and your contribution will be referred to using that name throughout the remainder of the project.

Furthermore, any names you use in the interview, for instance of colleagues or employers\places of work, will be removed and not appear in the transcript

The only possible exception is in the unlikely event that you reveal unreported criminal activity or professional misconduct, which the investigator feels obliged to report.

The transcripts will be stored, in a locked cabinet within City University and will be shredded after ten years.

What will happen to results of the research study?

The research is being undertaken as part of a doctoral course, and will be written up to in support of an application for award of PhD. It is also hoped that a much briefer account will be written up in the nursing or educational press.

Throughout this your chosen name will be used to refer to you and that name will be used to identify any of your quotes that are used in the report; that means that you should be able to recognise your contribution to this research, but no one else will be able to. Additionally the names of people you have worked with and the names of the places you have will not appear in any form.

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

You are free to withdraw from the study at any time. You can also ask, at any time, for your transcript to be removed from the analysis so that it does not contribute to the final research report.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team> If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study you need to phone 020

7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform then that the name of the project is: *what influenced nurses' career decisions?.*

You can also write to the secretary:
Anna Ramberg, Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V OHB
Or email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may feel you have grounds for legal action

Who has reviewed the study?

This study has been approved by City University London the MA/PhD programme management committee which incorporates the Research Ethics Committee for student projects.

Further information and contact details

Researchers name	Email address	Telephone number
Alison Coutts	a.m.coutts@city.ac.uk	020 7040 5797
Dr. Pam Parker	P.M.Parker@city.ac.uk	020 7040 3047

Thank you for taking the time to read this information sheet.

CITY UNIVERSITY LONDON

EST 1894

10. Consent Form

Title of Study: *What influences nurses'*?

Please initial boxes

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve an interview by the researcher allowing the interview to be recorded use of a computer to write up and analyse the data possible use of anonymised direct quotes from my transcript	
2.	This information will be held and processed for the purpose of the research projec I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. Any identifiable data will not be shared with any other organisation.	

	I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____ _____ _____

Name of Participant Signature Date

_____ _____ _____

Name of researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix 4: Results

Career stories

These are told using the participants' own words as far as possible. They are mostly told in the present tense, because that is how they were described, although the participants did discuss past events. The quotes are verbatim, including the researcher's (Alison) encouragements. They are in italic without speech marks, unless they are quoting themselves or another person. The same convention has been used as in chapter 3.

symbol	[]	()	…	-
meaning	material omitted to guard confidentiality	unintelligible	omitted for brevity	interruption

The extracts here are complete, with all the idioms of speech included

Name	Year of registration	Current post	Gender	Age
Alice X	2008	Airline cabin crew member	Female	40s

Alice was born in England but brought up in South Africa. She entered nursing because she liked working with people. Furthermore, her father had been in hospital and the teenaged Alice was interested in everything she saw. *I like to travel and I thought it was quite a good idea, you know it gave you - it was a job that gave you - scope and also it was job - it was a job for life, I could look as a career*. She had a couple of years after school when she did some additional A' levels, then trained in London.

She stayed in London, working in an intensive care unit in a teaching hospital: *that was a nice environment, I worked with really nice people, it was challenging, but yes - I really enjoyed* (it). She then stopped nursing to travel, taking several trips, returning to work in a high-dependency unit in Scotland, believing that her long-term career may be in intensive care. This post she did not enjoy, as it was too stressful, yet she remained there for two years: *I didn't realise, I think that the environment was highly stressed, I think people in that unit were highly stressed. I don't think I am really - but it really rubbed off and you got to the point when you are worried about going to work because when you got something wrong…they really came down on you*.

She moved to Australia and worked there, which she initially enjoyed and *I thought I could stay there, but they nurse differently, there - within three months you are like - you run the whole ward - I wasn't enjoying it*. She returned to the UK and worked with an agency, *but bank nursing wasn't helping me feel part of the unit, and that's when I enjoyed nursing, when I was part of the unit. Actually, you know - it's staff that make it. Well I suppose you pull together and you have a team here kind of friends* and she was at a loose end: *I didn't know where I was going in nursing*.

She saw the cabin crew posts advertised, which appealed to her desire to travel, and applied. This was not part of a long-term plan, rather: *I just wanted to break and - yeah that's what happened to be*.

Alice is proud of using her nursing skills in caring for people during flights – *and I will tell you another thing people get sick, quite a lot in the air. You know what, I mean fainting - I am really good at fainting, what you know from nursing but you know your first aid your first aid is really good. I felt that my first aid is better here than it was as a nurse.* However, she is aware that she has a high level of nursing skills that she is not using: *I quite used to feel guilty when I first left as I thought: I was trained so I should be giving these skills. Sometimes you hear about the nurses in NHS hospitals, and bringing them in from other countries.* She can also find the trivial nature of some of the problems difficult*: pleasing people, you know after when I joined here, these people get on make it - so, annoyed about the smallest things, and coming from nursing that was like: somebody who I have looked after major transplant just got more grace than you will ever have moaning about your boarding, you know, but that's human nature isn't it?*

She commented that her current job is not stressful, and wonders if that is one of the things she likes about it*: it's not stressful job, unless something's going to go wrong on the plane, but it is not really a stressful job there's no pressure Maybe that's me, because I felt the pressure in nursing; although I like the challenge of being in a high dependency unit and looking after someone…. I don't know if I am one of those people who just don't want the responsibility and I don't think it is a good trait (both laugh).* Asked whether she enjoyed all the travelling, Alice said that now she really appreciates being at home; indeed, for several years she did not even travel on holiday! She does, however, like to be out and about: *I like getting out there, I like, I don't like being closed in, I like to be out seeing what is going in the world - interacting. Yes, just life. Yeah. This job sometimes can be you are going somewhere that is really nice; so, yes that motivates me*. She appreciates occasional stop-overs in her work, and also 10 days off a month: *so, I mean that's bonus of it – it wouldn't happen in nursing! (laughs). Do you know what scary I found, almost to the day that I started here I got paid more money as well (Alison: yes); from the day I joined here, I was earning more than hospital nurse. And when I () that's a sad, sad fact as well.*

(Alison: You are being paid more now than-) Definitely now but when I joined (Alison: As soon you joined your payments went up?) Yes, maybe slightly but now it is more, I mean I don't know what nurse gets paid now; but definitely paid more which is sad, a sad fact. She also appreciates the flexibility of her work*: I can put in a request for the type of work I like to do (Alison: Why?) So I can choose to be home every night or I can choose to go away for a few nights we have a lot – er - of choice of what type of work we do. (Alison: and that's not on a moment by moment basis? I want to be away a lot this month but I want to be at home next month, you don't even have to commit to a lifestyle forever?) So, I can choose to be home every night or I can choose to go away for a few nights we have a lot - er - of choice of what type of work we do*. She also enjoys the teamwork and the social aspects of her work*: you know, when we get down we have a glass of wine, it is a quite a sociable job and that's another similarity to mention it is quite sociable. and you just put it into a computer you might not get 100% of what you want but they aim to give you - er - 60 %*

She now sometimes regrets not nursing now and certainly regrets not keeping her NMC registration active: *I mean we have a lot, well not a lot, but we have quite a few nurse cabin crew here, it is not uncommon - I have lost my registration (Alison: right, so they have kept their registration?) Some of them do, because you can reduce your hours here, we have got some male midwives, people who can do intensive care, people from A&E - it is kind of normal for nurses to come here. So it is more then, I can think of my few in my head here actually and*

some do still nurse. As well as working here – yeah - To keep up the registration… I didn't know where to go in nursing and I saw an interview for this - that changed and I gave up and I should have kept my registration but I didn't. The airline, in common with many employers, like to have registered nurses on the staff, and would have facilitated her undertaking the clinical or other work that keeping her registration active would have required. She is also aware that she has lost her confidence, and this is significant to her: *Just because when move around you don't gain that confidence and I think. That's is really important in nursing, to be confident in the kind of your skill and that way it have to be how it would be for me, or how I envisage it would be*. So far, she has made two attempts to regain her registration, but has not been successful. The first attempt was in Scotland: *I was working full time here and the course was there - there was couple of days in the university and then you were just left to try and get this placement done and this essay which you got given a sentence say, I am not the most academic person and it was - how do you find information, when there is no one to help you and they came back and said you didn't ask us enough but, they didn't really help you, you given a sentence and got to try and make an essay out of it, I found that incredibly hard, and so I gave up.* The second attempt was quite recent, in England: *they mentioned 14 funded places; so, but then I think she got a lot of people that were back in and basically I was on a holiday for the first round of interviews and so I missed that, so I don't know if she recruited, she did interview me and then said we don't know with your commitment with [] but to be honest I have to work full time to live, I know it would be tough for a few months - but I wanted to do it you know, and it was convenient near to my home and I probably could have taken some time off, you know, but she didn't let me on the course. So, I should get back in touch and try again, you know.* However, she knows that if necessary she could re-gain her registration - or even work as a care assistant - which means that she will always be able to earn her living, and this is important to her. She would recommend flying, but only for a short time: *so, I would say take a year off nursing, fly for a year, and see the world and then go back to nursing and that wouldn't be what I would do that year, but that would be what I would recommend someone to do, just if you are a bit jaded or anything, come and do this!*
It's the little things people could get very upset, it does give you a sense of what's important, this job, that your family and your friends and that's what, I think nursing did that as well kind of thing. In the interim I lost my brother and that probably stop me nursing as well he died very suddenly from cancer, (Alison: oh my goodness) that would have - I probably might have gone back in a bit earlier, but I backed I backed away - for few years and I think, maybe I would have tried to nurse, but he died unfortunately a year and after I left nursing that probably was – yeah - And gives you that maybe made me look at nursing differently
She is aware of other career possibilities, management and rostering of cabin crews, or aviation medicine, although that involves a demanding training with repeated updates.

Name	Year of registration	Current post	Gender	Age
Amber X	1989	Senior lecturer (non-nursing)	Female	40s

Amber became interested in nursing young, working as an unqualified assistant in a care home. She was employed to work in the kitchen, but occasionally helped out with patient care: *and I actually remember looking after a patient... and I had great pleasure in telling her that I was going to become a teacher and she said to me 'don't you dare become a teacher, you have to become a nurse!' and it was the first time I had actually contemplated it. I had already applied to university, I was accepted, to do a degree and I was going to do my teacher training... and it all changed! To the utter horror of my family, who stated that nurses were '2 a penny*'. They saw that she had potential and did not want it wasted. But when they saw that her mind was made up they were supportive, pleased when she started her BSc, were the proudest of parents at graduation. Her father felt that she had exceeded all expectations when she commenced PhD, but sadly died shortly before it was complete.
The sudden decision to enter nursing has been the right one for her: *it felt a privilege, actually, to be a nurse, and I have always felt that. And to be present at moments in people's lives in terms of distress, but happiness, joy the whole remit, it's always just been a pleasure, and I have loved every single bit of it.*
Amber trained and worked in London, and then worked in America as a nurse before returning to the UK, still working as a nurse. She met her husband whilst planning the move to the USA. This was a difficult time because she was tempted not to go, and also because her departure date was continually postponed due to problems with her visa. Once there her work was initially unsatisfactory because at the private hospital she was placed in; she planned to give some care but was sent away because the patient was on a business call. She spoke to the agent that had recruited her, who stated '*I know exactly the place for you*' and moved her to a public hospital, which she much preferred. *Being in LA was like being in a gold-mine without a shovel, we were surrounded by great and conspicuous wealth, but could not partake in it; we were accommodated in a plush apartment but could not afford to do much in it. And what made it worse was that the local nurses were paid more!* In the end she enjoyed her time in America, and her (now husband) was able to spend some time there with her. At that time, she worked and he had an extended holiday.
I do miss being a nurse I mean I will always be a nurse, erm, and it's still the first thing I tell people about myself (Alison: so I suppose the obvious question is why did you leave?) because I had my family... at a time before child-care really came in, so there wasn't much child-care, and my husband was also doing shifts, so between the two of us it was almost impossible! But she also felt that healthcare was changing: *having a 24 bedded unit and being told that you had to get 3 lots of patients into the same bed during the day, so actually you were nursing sometimes 36, 38, 40; and then running a ward and just finding everything being so stretched. I had already started to feel really frustrated, just finding everything being so stretched, and the one thing that I remember really vividly was working in a hospital and on a Sunday of a bank holiday weekend I was asked for a blind lady to be discharged back to her home, and she was frail, she was single, and it just made me question everything.*
Amber's initial decision to teach and then to enter nursing were done without much thought, but since then she has put a lot of thought into her career decisions; for instance she was offered two lectureships and was in a dilemma as to which to take*: it actually made me ill, making, trying to make the decision, because they were both amazing opportunities, one post was more prestigious and also nearer her home but and then I met her and just, I don't know, (sighs) I went with my heart! um (Alison: mm hm) I went with my heart, we just clicked (Alison: mm hm) and, yeah, no, it just felt right, but the - my head was telling me that I should have taken the position in []; it would have been much better for my career (Alison: oh right!) academically because at the end of the three years I would have ended up with papers, I would have - and it was very research-based. It would have been 20 minutes from my house (Alison: yes!) I wouldn't have had to travel up and down to London! But I think this, this particular role gave me autonomy, um, and a little bit of flexibility and, you know, and I could still see that there was room to continue doing something medical, and I knew that [] was also working in a brain-injury clinic. So, one of the*

first things she said, she said 'you would be perfect for doing that', so I think that also sort of swayed it as well. However, she knows the person who did take it and is now happy that she took the correct post. She does not regret any of her career decisions, but continues to ponder issues related to her career, such as her pursuit of clinical work that she loves: *I have been reflecting on whether I am a good academic, because, whereas probably I should be coming away from the clinic - so, the thing that suffers the most is me getting papers out, which is actually the currency of my academic profession - that I am not a good academic.* She also feels that the less academic nature of her current institution means that she has more difficulty obtaining research grants: *but it would be nice to have a little bit more academic kudos, yeah, if I'm honest.*

She has recently moved, with her department, to a new site, and that was the last time that she actively considered moving jobs: *there was a difficult transition period, urm when we weren't really feeling connected within the department….. and it's a very different philosophy, but again I think that's because academics, academia has now become quite ruthless and people are fighting for, like the number of hours, like they're trying to reduce their hours so they have more time to do papers. There is also pressure to generate an income for the university.*

Amber kept her registration until after her PhD in neuropsychology, indeed she used it then to give patients drugs. Amber is happy with the way her career is working out, and enjoys the way in which her teaching and research complement each other. She does miss nursing and values her clinical time but is aware that the way she works may not be best for her career prospects.: *the only thing I would like is an occasional day on the ward, to run a ward - (Alison: To get them all sorted out!?) and get - yeah (both laugh) oh dear, yeah! But what's really interesting is I work as a [] so I still see patients. I do miss being a nurse. Deep down - I will always be a nurse; it's still the first thing I tell people about myself.* She feels that she is lucky that she can devote time to it, but that does mean that she does not get as many publications as her colleagues, *which is actually the currency of my academic profession.* She laughs because, after all, she has ended up teaching and worries that enjoyment of her job means that she sometimes takes on too much. Looking to the future: *I probably will have to give up some of my teaching in order to carry on because - we also do a lot of research, and we also do a lot of other things, and we just get to the point we realise we cannot do all of it, as much as I would like to*. She is also training to be a CBT therapist (and has since completed this training).

Amber's husband retired relatively early, but Amber has no retirement plans at present. This means a role reversal for them, as Amber had time away from work to care for the children, and it is now him who has more time for *the family and home; this has worked because: so it has always been the two of us trying to do the best for the children, the best for each other and taking time, we have just completely swapped roles (Alison: mm) we just completely understand each other, and I think that has always been a really good support the whole way through everything because he understands my job and I understood his job.*

Name	Year of registration	Current post	Gender	Age
Daisy N	1993	8A nurse colposcopist. RCOG\BSCCP accredited	Female	40s

Daisy came from a family of nurses, and decided to be a nurse herself quite early. She opted to take her A' levels as part of a pre-nursing course; she did well and was encouraged to apply for her nurse training in London, believing that she would receive the best nurse education. She didn't get the A levels needed for the degree programme but did the Diploma. Her first post was with the same health trust that she trained with, and she has been there ever since: *I've found it very welcoming... and - I didn't ever want to work anywhere else, I just found the community here to be such a nice community.* She worked on a gynaecology ward in her third year and found the work interesting and satisfying: *we helped them through the process and sent them home <u>well</u>*. She liked the team; they suggested that she return to do some bank work whilst she completed her training, and she opted to return there for her final student placement, and was appointed to her first post there too. During that time Daisy benefitted from encouragement from both senior nurses and also senior medical colleagues: *so, they basically 'I'm going to being to do this lady's surgery for this and this would you like to come and watch me do this operation?' ... if thing's were looking quiet at [] the sister from there would ring the sister from here and say 'would you like Daisy to come across to do some chaperoning and assisting for you?'.*

Daisy continues to value the team spirit *That was the team - oh, it was lovely*! yet she also takes a pride in the independent nature of her work and the fact that she does it to a *high standard I'm an independent practitioner, I provide a good level of care to the women that attend and see me - you know, I'm a key worker for a lot of women. there's an awful lot of paperwork (Alison: ohhh) lots of paperwork, lots of computer work, but you do - when you're doing a clinical sessions - when you've got ten, twelve women booked for an afternoon or a morning you do actually need to have a break from the constant (Alison: yes) one on one and doing examinations and doing a lot of talking about HPV and cervical abnormalities. You do actually need to have this!* Daisy's role in unusual for a nurse: *I do like runnin' my own service and knowing that that is - before I took it on - it was always a doctor's role*. She was working in outpatients, assisting in thousands of procedures, going on to train as a nurse colposcopist - an initiative taken by medical practitioners. She was aware that nurses could do this role from the professional press, yet was still surprised when they suggested it. The training was the same as that undertaken by medical practitioners, and took four years; longer than normal because of the volume of her work, and the fact that she was fulfilling multiple roles. The pioneering nature of her work means that her nurse manager does not fully understand her work, so she is more likely to turn to a medical colleague for help in her clinical role. Nurses doing this work are now increasing in number and Daisy, in turn, supports nurses following in her footsteps. However, she worries that younger nurses may not have her patience*: people don't just give time to settle in - get to know a place and work they're all just (snapping her fingers) 'I wanna move, I wanna move up, I wanna move up!'... they don't seem to understand; you get the experience; you get the knowledge; that's the time to move up.* She can see the impact she has made: *looking at statistics, the DNA rate, it's a lot better than it used to be... So, the women are happy coming back; they feel comfortable coming back.* She is aware that she has no succession plan in place. She has a close nurse colleague who is busy running the outpatient department, and Daisy feels that these roles require single-minded commitment. Daisy also took an initiative that has led to her department having a research link. This meant that Daisy undertook a lot of data entry work, mostly in her own time, which she does not regret*: the information we've now got out of there, the reassurance I can now give women - from that data - is brilliant!*

Daisy has difficulty in explaining career decisions she has made, as they were based on the fact that she found she liked her student placement: *you know you do sometimes wonder 'well I never got to see what cardiac nursing was like - I never got to see what - you know we only had a short exposure to midwifery' and it does - yeah - so it does make you wonder, I might have more interested in one of those*. She has never had a career plan, although she knew what she did not want*: I think you take steps along the way and I think you have to make it as something comes up. You just think - I was offered when I was D grade - in fertility, as an E grade and I just went 'I don't want to*

be working in fertility, I'm not gonna take advantage of becoming an E grade in fertility because that's not where I want to go'... I was then asked to apply for the E grade on the gynae ward. And I thought 'fantastic- that's the next, that's what I wanna do'. She contrasts her own career, which is characterised by staying in the same Trust, with others: I *do just feel nowadays that they don't... people don't just give time to settle in... get to know a place and work they're all just (snapping her fingers) "I wanna move, I wanna move up, I wanna move up!" But I just, they don't seem to understand; you get the experience; you get the knowledge. That's the time to move up... there are so many people just moving around the [] system just having no idea what they're dealing with.*
Nevertheless, she has made some career decisions, such as when she wanted to become a sister in gynaecology. *I'm gonna have to look, to see what opportunities there are and at the that point they'd moved general gynaecology over from the [] and they were looking for a junior sister and it was very… it's not gynae oncology, it's not outpatients but it is a job doing gynaecology and it's a more, it's a junior management position, I'm gonna gain experience and it's only across the corridor from where I was working. So, you know - so I took that opportunity.* Daisy then talked about another career decision which was when the sister from women's outpatients got pregnant. *She went on maternity leave, they said well the only person that's experienced enough to just take over, erm is Daisy so I came over here - s'posed to just fill in for maternity leave, she decided not to come back and, um, I then was asked to apply for the full-time F grade over here. So yeah, I think you make career decisions along the way as opportunities come up.*
Daisy has always found learning highly motivating: *I then had another fantastic leader in [] taught me loads of things; taught me how to manage; give me more management experience... doing things like rotas and all of those jobs that you don't do until you're a sister.*
She is unsure about her next move, as there is no career structure: *I think when you do get to a certain level in colposcopy... that's where you are. The only other things you can do is to go into more of the protocol side and that - I'm already in that slightly... I don't see it as an avenue of being someone that wants to work up to being a senior nurse - deputy head of nursing for a trust that sort of thing.*

Name	Year of registration	Current post	Gender	Age
Danny N	1991	Practice nurse	Female	40s

Danny had obtained a place at University to read botany but declined this; she really wanted to study alternative medicine *but there wasn't any such thing in 1987 and I fell into nursing by default basically and I - my plan was to do nursing, get the basic physiology, you know pharmacology then go to do alternative medicine* Meanwhile she was working in a care home, initially as a cleaner and worked up to care assistant, and enjoyed it, so she decided to read nursing in order to study life sciences and then go to do alternative medicine - *and then I never did, and I've stuck in nursing and other healthcare things ever since; never done anything else. Alison: Yes, that must be very satisfying. Um, what motivates you?*
Danni: ah! Umm, just being able to help people really,
Danny trained as a nurse and then as a midwife. She has moved around extensively: *I think that's one of the good things about nursing, and when I was younger I was able to move, you know I did my nurse training in [], I did my midwifery training in [] and then went over to [] and worked in women's health over there for a while*. *I used to do a fair bit of that: worked for a while, go abroad for a while, just a bit travelling; come back do a bit more work, then – nursing's good like that.* Her first overseas post was in women's health in Africa. She then heard of a job in another African country: – *I'd travelled prior to getting that job I'd travelled all around Africa for over a year, um and ended up in Kenya and then Tanzania and then went back to Kenya and I stumbled into that job, completely; I was talking to somebody in a bar and they said 'you would great person to come and work for us' and they gave me just an address.* She enjoyed travelling for the variety and excitement, but it wasn't always what she expected: *it was more bureaucratic and administrative than I was hoping; as a nurse I wasn't expecting that at all, the things that I really enjoyed was the clinic visits and the training of the healthcare workers, that's what I was signed up to do, I didn't expect to spend nearly a week every month doing reports! Yeah, yeah, it drove me mad, it's probably a large reason why I didn't stay.* She never worried about getting a job: *it used to be a lot easier than it is now, you know, I used to be able to – you know – I'd have a pick of jobs.* She decided to move into humanitarian relief, but was careful*: they gave me three choices: Afghanistan; Somalia; Cambodia: Afghanistan in 1999 no, no no no; Somalia was also a little bit on the unstable side as well*. So, she settled on Cambodia. She then decided *I wanted to sort of move other things in life, so, yeah, I think it's one thing either you do it for a short period of time, a year's a short period of time, and then come back or there were some of the people on team I had been there forever; there was one of the doctors and she'd made her life out there*.
On her return to the UK *I was at a conference and got talked into a job in London; came down to London with a five year plan. (Alison: Five year, as in you were going back after five years?) Danni: yeah, yeah, that was long time ago (laughs) (Alison: so what was it that attracted you to London?) Danni: erm, ooh, well the particular job that I got recruited to do you could only do in London (Alison: mm) um, and so it was a very specialist area, it was taking the job that I was doing an extra step, um and, ooh there were just lot of things about London, obviously there is - I mean I'd been to London a thousand times before, I wasn't one of these people that never been to London. (Alison: so you knew it?) Danni: yeah, I never, I wasn't somebody that'd never spent any time – in fact I was in, at a conference in London when I was working in Manchester and got asked to come down "oh, come and have a chat with our clinical director, she'd love to meet you and blah" when I got there it was basically a case of "right, we're interviewing you and this is the job"* This post was in pre-implantation diagnostics, which she found fascinating and completely absorbing. During this time, she allowed her midwifery registration to lapse, as she could not devote the time to it that re-registration would have required. Then everything changed: *I - realised that actually I'd - it was the sort of job that took over your life and you know you were - my son's first Christmas - he was born in July, he was about six months old I was called into work on Boxing Day; I was supposed to be off, but something had gone wrong and I was the person that was rung when stuff went wrong and I realised then "I can't continue doing this" if I want to have a family, yes so I came out of that floundered a bit about what to do and decided something completely different went into intensive care started at the bottom worked my way up again.* She suspects that her colleagues did not help her in her part-time role: *I worked Tuesday, Wednesday and Thursday instead of full time, my consultant wanted me there full-time, he would ring me on a Monday and the Friday, when I was home with my son… he was an astounding person to work for but, he did have a slightly, um, archaic, view of how nurses should, should be, so yeah, yes, so family got in the way of my career really. … As I say, my consultant made I very difficult for me to work part time already, and so, but I was teetering with that, and I was coping just about with that, but then once these, these problems started to come to light it was, yeah, this isn't this isn't gonna work. He has long term health problems (Alison: ahh) yeah, he has a genetic condition actually, which the irony, the irony of that just never, it never, yeah.*

She has known other people do things differently: *she had her children much younger (Alison: mm hm) than I did, and she worked - she's a midwife she worke*
d on nights the whole way through when her children were young, and then over the past five years, her children are now she's got 18 year old twins and a 16 year old, the past five years she's gone boom, (Alison: yes) worked her way right up and she's now head of midwifery, the trust that she works in.
Commencing her family also prevented her returning north, as she originally intended yet, she felt she needed to move out of London: *we were living in a one-bedroom basement flat and we wanted to move out to the house and we needed to be somewhere with a direct train line into London... it was just a one-bedroom basement flat with a shared garden; we bought a three-bedroom house with a decent garden!* Initially she worked in a hospital near that house, but missed the buzz *because all the really exciting stuff getting shipped to London*. Indeed, one of the best parts of her job was nursing people in the ambulance during their transfer to London, because this role involved *quite a lot of autonomy*. She therefore moved to work in intensive care in London. *I worked 12 hour shifts (Alison: which I think would help) so I was only 3 or 4 days a week but even that is um – and I'm really sorry I forgot to offer you a drink - (Alison: that's quite all right, thank you) mm, three or four hours – um three or four days a week but twelve and half hour shift so I was leaving the house at 6 getting the half pass 6 train up to London Bridge, leaving on the to the same bridge leaving on the 8:47 (Alison: laughs) I think from London Bridge, getting home at 10 to 10 (Alison: right)and I couldn't carry on doing that… so family things the commute, oh and I know what the other - I knew there was another, um, reason, the other reason that I chose to look at the time that I chose to look was they're redeveloping London Bridge, and my local train service (Alison: oh yes!) is no longer stopping at London Bridge, it's going straight through to Charing Cross and, or Cannon Street depending on which train, um because they've demolished all the platforms (Alison: they have, yes!) that was (Alison: have you been through it recently) no I haven't been back to London actually since December the 15th was the last day, I am actually going on Monday (Alison: oh right!) but, um yes it's been the longest period I haven't been to London for ages She* had an account with NHS jobs and also read the RCN Bulletin *I do tend to flick through. I wasn't definitely, definitely 'I must change my job', but if something had come up I decided to apply for it*. She took a part time practice nurse post, which gives her quite a lot of autonomy, seeing her own patients with a variety of health needs. This post also has the advantage of using all her eclectic experience *I am doing my own thing; and I have already started to build up a little bit of a, a patient group of my own who want to come back to see me to do various things. A lot of that is women's health related stuff (Alison: yes), but some of that is also people that've had serious illness, have been in intensive care when they've come here I have known what they are talking about (Alison: yes) and so they, yeah, and I quite like that, I like the fact that I have now a broad and quite um, significant lot of experience under my belt; I mean have been a qualified nurse since 1991 however many years. It's a fair amount of time, erm, and I think just the ability to be able to actually help people, help point people in the right direction, if I can't solve their problems, um but help them to manage their health better… intensive care I've met and awful lot of people with COPD (Alison: yeah, yeah) more so than asthma, but although you know, the only time I have met asthmatics in the past and my only experience is when they've been ventilated (laughing), and we are trying to wean them back off (Alison: and you are trying to avoid that here!) yeah, absolutely; the same with COPD, but at least I have some understanding of what COPD is; the difficulty. I am seeing the other end of the spectrum, aren't I, of COPD management now, the last ditch, we'll ventilate, we don't really want to but we will because it will save this person's life, all the way back to first diagnosis and the initial management.*
She likes the autonomy, and is building up a client group, who select to come to her. However, she resents her low pay: *having being qualified as long and have, worked my way up and I was at one-point Band 8A and I now find myself down at the bottom of the scale; I am employed on the same level as one of the colleagues who is been qualified six months! Considering I have been nursing as long I have, and I have the level of experience that I have I think it's appalling really, but that's the way it is, they don't really give you an awful lot of credit for your previous experience…. I mean when I first came here they wanted me to do a - take a certificated course to take blood; I've been taking blood from people for so long, but because I don't have a piece of paper that says, you know, you have been - I have been trained successfully to take blood, so we sort of negotiated and somebody watched me do a few and basically said, yeah, but actually interestingly I was actually mentored by a band 4, but hey ho… Despite the fact that I have taken hundreds of cervical smears in the past – I've got to do training for that, because I haven't done it for long time; I have got to do training for ear syringing; I've got to do training for immunizations and vaccinations, erm, what else I got to do training for? There's another one that's popping up erm* - She also pointed out that she has worked her way up from the bottom a few times before!
(Alison: Mm, great! I think I know the answer to this; have you changed the way you make career decisions?) Danni: ermm, yes because it used to be purely on a professional level (Alison: yes) but having had a family and having got bit older there's other considerations now… I love the job, well nursing generally, I do, I absolutely love it; but if I could go - turn the clock back 20 odd years would I do again? No, I wouldn't; because I find myself now at the age of 46 with no financial security She plans to ask for a pay rise once she has completed all her practice nurse trainings.
Reflecting back on everything that I have done in my career, what could I do now? I thought about may be going back to midwifery doing something in women's health but… this just seemed the best fit (Alison: mm) I suppose (Alison: Mm, great I think I know the answer to this; have you changed the way you make career decisions?) Danni: ermm, yes because it used to be purely on a professional level (Alison: yes) but having had a family and having got bit older there's other considerations now. I like nursing. I like people, you know, so and I could almost work anywhere, to an extent, (Alison: yeah) you know it's - there are certain areas of nursing and health care that interest me more than others; but really the bottom line of wherever you work is you are working with people
After such a varied career, *I haven't, I haven't drifted, but I have been pulled in directions that I wasn't expecting sometimes, so… I hope that actually I will probably stay in practice nursing now. I am, what, 46 years old, I don't really want work too much past 55 if I can help it, and I think probably I'll, I'll be here; whether it's here-here, but in practice nursing I think, I don't know; who know? Nobody's got a crystal ball (Alison: no!) nobody's - but I don't have any plans, I mean I have only been in this post a short time, but I do really like the way practice nursing is helping me to pull together all of the experience that I have got previously; plus I am being offered the chance to develop my role in whichever way I choose to go, um, so yes*

Name	Year of registration	Current post	Gender	Age
Dee N	2005	Research nurse band 6	Female	30s

Dee's parents owned a care home, and she always assumed that she would enter one of the health professions; she wanted to study medicine, but her family and financial background ensured *that dream was quickly popped*.

After her training, she worked for several years in the emergency department, which she loved: A&E was a brilliant experience and at the time it was lots and lots of hard work and being very tired for years but I learnt so much being in A&E *….. and seeing what the emergency nurse practitioner were doing was just - wow, it completely ignited my fire to carry on with nursing….* The nature of the work affected her perspective*: I think my first research post I just became very disillusioned with public and society in general because we see such a squeewed perspective of what people are like, because, yes, in [] A&E you get all sorts coming in and four years of, like, people shouting at you; threatening to stab you; vomiting; spitting; kicking; hitting.*
Unfortunately, this coincided with a difficult time in her personal life: I was getting divorced; the house was on the market... so working shifts in ITU, trying to sleep during the day on someone's floor. I took this research role because, you know, I was getting divorced; the house was on the market; I was sleeping on friends sofas at the time and working with shifts (Alison: what!?) yes so working shifts in ITU trying to sleep during the day on someone's floor, it just, oh yeah, it wasn't happening, so yeah I just made the decision to quit ITU and get a nice predictable, regular research job. nurse. Her reasons for enjoying research nursing were rather prosaic: *the hours are nice, nine to five, your weekends are off... you have lot more times spent at home. There were aspects of this role that she enjoyed, particularly having time to build relationships with patients they send me pictures of their grandsons, and yes, yes, we have got a very good relationship, because as I see them so often. I mean the nice thing about research is that we can spend two or three hours with your patients and not feel guilty.* She then moved to another trust also as a research, but it contrasts with the first: *My first research job was great; I had lots of my own studies and... um... yes it was really good, I didn't realize how lucky I was being so clinical in my previous research job and this research job I have stayed in because I was finishing my MSc dissertation basically and I didn't want to swap jobs, and yes the way they run research jobs in [] was very different from []. Lots of the time I am a glorified secretary or nurse, yes, I am screening clinic lists highlighting people for inclusion / exclusion criteria; not seeing patients so much and whereas at [*her previous post*] it was very, very much clinical even though both posts had the same title and grade. The research nurses here, we treat patients; give them the patient information sheet and go through the, what kind of study it is; do the measurements, but we don't anything to do with writing... whereas at [] the nurses work very closely with doctors and they often get their names on papers… then I just have been taken off studies and put on other studies and – just - kind of carried on. It's not very satisfying when you don't get ownership of anything.* This causes problems*: I think that's why there is quite high turnover with research nurses here, because we are not used to our full capabilities yes. Which is a shame… I will be working on various studies and then I'll go into work the next day and I'll have a week's notice to say that I am being moved off from my cardiovascular studies and into diabetes; diabetes I know very little about, you know I really had to do my reading about chronic kidney disease and different stages…. and yes I find that very difficult because again the sense of ownership of your studies and being able to talk people through the protocols and the patient information sheet is completely gone out of the window really, and it doesn't feel great when you are talking to patient and I ask you a question and you can't answer it, yes I have never worked in diabetes and I have to say to them that 'I will answer that question for you, but I just need to go and ask my colleague' and it just yes it just doesn't make you feel particularly good at your job when you are having to say 'no, sorry, I don't know' of course you can't know the answer to everything*. Dee feels that there was nothing that she could have used to identify that this post was different. Indeed, it was not even the job she applied for: *When I applied I was supposed to be a dermatology research nurse. Before I started my job, role was changed there many times and since then it's changed immeasurably.* She also has concerns about ethical practice: *(the patients) don't even know what the study's about and, you know, you can't continue (Alison: it's not informed consent) no, no and you get the doctors, doctors that just try to do things in a back-handed way and really…. It's very wrong, it goes on still, you know 'oh just take 5mls. from that person that you consented for that study and we can use it for that study' no, no that's not how, but it, still happens, so research nurse are very much and a patient advocate, they have a very strong position to being a patient advocate.*
She has seen others suffer from stress: *So ideally, I would have liked to stay in A&E, toughed it out and, you know, been working as a nurse practitioner years ago but…mm…yeah. One of the nurses I worked with in A&E, one day she just didn't come to work, and um…a few days later we were told that she was in a mental health institution, her hair's gone grey, she spent a month there, literally after two months she was learning how to wash her hair again, yeah, and that, you know you just wouldn't have known, because she would come to work, and be all jokey and lovely, but actually she was having a massive break down, there were other, outside, contributing factors, it was that that made me think, yeah, actually you know it's making my marriage suffer.*
Her previous experience has been useful in research: *because of my A&E experience I can cannulate and take blood; no problem (Alison: I was thinking that, a newly qualified nurse couldn't do that and would they train them up?)*
Dee: Yes, yes (Alison: But they were very happy that you could do it already?
Dee: Yes which has been really handy because…um… lots of nurses, the same as me, came out of intensive care into research, and, of course if you have only worked in ITU, lots of ITU nurses can't cannulate because, of course, you get you patients with () lines, with central lines.
Dee loves nursing: I*t sounds really corny but knowing that I am going to be able to help and make a positive impact, and it sounds really cheesy but – yes - if I am just coming to work ticking boxes and that doesn't give me any job satisfaction at all, because I have done something to help that process - that's what makes me happy in my job.* She dislikes being too busy to do her work well, as happened in ITU: *(they) quite often tripled the patients and you can't…yeah…can't give the care that you want. However, she does like being busy: I think maybe I am a bit stress junkie, I like busy, busy clinical areas like A&E and yes, I do like physically being busy and running around….. So that's the nice thing about nursing research you can actually spend time with your patients in …you know… feel, yes they come away saying you know, "you are really lovely", you know, the team here are great and I kind of have to explain to them that most nurse and doctors are, it's just that we have luxury of being able to spend time and actually give them the care.*
She is positive about the future: *there are so many opportunities within nursing you can work anywhere in the world and if I wanted to move to the countryside in the future. I could you know, there are jobs there, you don't always have to work in a big, busy city, and you do get immense job satisfaction if you find, if you are lucky enough to find the type of nursing that you love you couldn't wish for any more, you know and yes, with a lot of jobs, friends that aren't nurses, thinking about PA and things, they go to work, they really don't enjoy it, and they you know what they do enjoy is coming home, and yes I think nurses are lucky and then yes you do have an opportunity to do something you love and think a lot jobs don't offer that, quite often its money or just pay the bills and yes it's not same, this is a vocation isn't it and yes definitely nursing has a lot more to offer to every day nine to five job.* Although she does not have family responsibilities, working as a research nurse has still been useful: *basically it's like a little respite (both laugh) because you will hanker after being clinical again and its really nice and that's what happens there's so many ICU nurses that taken up a research jobs – they go back, we all go back so I would say that research is quite nice for that, it actually, "this is what I want to do, I want to be caring for patients, I don't want to be*

ticking boxes", it offers a breathing space to think, rather than, "Oh God, o' clock start and back again tomorrow to do my shift". You do need a little bit of a - little bit of a - I am really happy with the way my career has gone. It would have been nice to solely focus on my career, but life gets in the way, doesn't it (Alison: yep) and I think you need to do what's best for you to keep sane and, you know, sometimes…. you do need to learn as you go along and do what's best for you at that time, and (long pause) yes, and yes, I think I am quite happy with the way my career's meandered!
She has seen others take a different pattern: *I have been a bit of a job hopper these last few years, but do you know what I think is it is? My friends: one is an oncology, heamatology oncology nurse; he runs two units across London, he's band 8c – he's made it. My other best friend she is a palliative care nurse you know, she has always worked there. Maybe that's what I am comparing myself with, my friends, my good friends that I studied with, that I am still friends with, they have been very focused and the first jobs that they got they stayed in that specialty and they have just excelled in it (Alison: yes) and maybe that is what I am comparing myself to.* Dee is rather disinterested in her pay: when I said I was leaving my manager said, 'well if we offered you a band 7 what would you say?' ... I just didn't have the heart *to tell her that... an extra £100 or £200 a month for doing the job isn't doing it for me. but it depends upon your definition progression, and, yeah, the money isn't my idea of progressing, it is progressing my knowledge, that's what my definition would be.*
(Alison Where do you go for help and guidance in your work?)
Dee: Umm. she isn't my manager anymore, I have just got a new manager because she moved, [] has been research matron for a years and she's lovely and she is very experienced research nurse she used to be a midwife and yes she's great…um…. she doesn't make you feel like you are troubling her, her door is always open and … yes…. you don't have to try and pretend with her but if you want something you can say "look I don't any instructions with this machine that I have just been given to do some measurement some on the patients what shall I do?" and she's great yes my old matron, I still go get back to her
She had recently completed her MSc in nursing and successfully applied for a post as a nurse practitioner and *I'm over the moon, I can't believe that I am going to be doing the job that I have been dreaming of for the past five years. She was attracted to the role because it's completely clinical and it is autonomous - lots of challenges and huge learning that I am going to be undertaking which also motivates me. I did it the scenic route but finally (Alison: Oh, I don't know I think it is a quite a coherent … quite a coherent story there, really) Dee: laughs Yes and so yes definitely and I finally got my dream, dream nursing job and so I am everso excited about starting!*

Name	Year of registration	Current post	Gender	Age
Faye N	1991	Clinical specialist – gastrointestinal nursing (band 8, 0.6wte)	Female	40s

Faye believes she is not academic and did not want to go to university: *I was going to go to drama school (Alison: laughs) and I got interviewed and then my mum was diagnosed with terminal cancer. She was a nurse, my sister was nursing, I thought "no I will do nursing 'cos I need to be in a job where I am getting paid".*
Alison: So ...what, you are concerned that your financial situation with your mother being so ill? Faye: I think, yeah, I just thought I need to know that I am going to be okay and she will know that I will be okay. Alison: Gosh, how sad Faye: Yeah so I did nursing!
Her last student placement was a colorectal ward, *which that I really loved*, and she got a staff nurse post there. After several months she wrote a patient information leaflet, which was based on her own research into life for patients with a certain condition. She undertook this partly because she felt there was a lack of relevant, practical information, but also because she understood that, in order to gain promotion, she had to show that you were willing to do something else. Faye was promoted to band E and the leaflet is still in use today.
However, she had always thought she would like to be a children's nurse because she liked children and had worked with them in a voluntary capacity before she started nursing. She moved to London in order to take a 'conversion course' for adult nurse to child nurse. However, within two months *I realised I absolutely hated it (Alison laughs)... stuck it out for nine months passed every assessment but thought "this isn't for me" and decided to leave.... because parents look after children in hospital (Alison yes), which is quite right, so you weren't actually able to do much as a nurse really Alison: And that was the problem with it? That you weren't actually doing the nursing? Faye: Yes! Alison: So what were you doing if you weren't nursing? Faye: well you would - giving medication; taking observations. But you weren't doing, you weren't involved in the way you are in adult nursing. I stuck it out for nine months just to double check that I'm not on a whim here. I was very much told off by the tutors there saying "you will never get a senior nurse post, you've wasted this" and I said "I'm so sorry, I've made a mistake, this is my one mistake in my career and I have made it - and then got a job as a team leader* a promotion *on a gastro ward in [] (Alison oh, yeah, yeah) which I went for the interview and I didn't even bother to phone up (laughing) to see if I had got the job because I presumed I hadn't! So they had to phone me*!
She worked outside gastroenterology: *when the kids were little I did community night nursing for 2 years, three nights a week; nearly killed me because I'd work from 10:30 to 6:30 and then come home, get them off to nursery, have, like, 2 to 3 hours sleep get up and get back to work again. I don't know how I did it now – I think I was brain dead half of the time, but you do it, don't you?* It was a busy, demanding post *I knew by that point, it was kind of getting to the point to where I'd done - I was married then and I was doing nights and lates and earlies and it was mega busy. I'd have 19 patients in my team with me and maybe a healthcare assistant - really busy and heavy (Alison: and they were really sick patients) oh yeah, you'd get everything you know and I loved it and it was a great team, but you couldn't do that for ever more.* She saw her present role advertised and respected the consultant who was overseeing the work *And I thought "I'm at the point now where I do want to specialize in something" but I didn't want to be a stoma nurse and I didn't want to be a ward manager because I am not into meetings and things, so she applied for a post as a specialist nurse within gastroenterology and thought "yeah I like this, I can do this, I kinda like this, it's gut stuff which I love".*
Faye has high ideals: *I like to work hard and I like to feel I'm giving something back and doing a good job and I know that it sounds really bleurgh (Alison laughs) but that's what I need to do* but also that her attitude has matured: *like that you can't get them all better (Alison no) and I think probably with maturity I've come to accept that more now as before I always felt I'd failed if they hadn't got better. You sort of think "what have I done wrong?" and be sad and now I think "no I'm definitely not gonna get them all better".* For Faye the best part of her work is her relationships, particularly with her colleagues: *The fact that you're with a - a good team, with a good leader and with the two consultants that I very much respect. So even if you've had a rubbish day with patients or whatever being difficult if you've got a nice team, then that's okay.* She also likes the continuity of contact with her patients and the fact that she works autonomously, planning her own clinics and patient contacts. She is saddened by the way nursing is changing*: I think it's so much more complicated now and I wish it*

wasn't quite so complicated to do a good job and get caught up in auditing and all the stuff I hate because I'm not very good at it and it scares me.
She works part time in order to support her family, and enjoys the variety this brings. *You have to keep going and now because I've got kids and everything, am married and I can't afford to not work. So that kinda - so in some ways that's quite good because you don't have the choices that some people do () you don't have to do things and, in some ways, it limits your choices because you're not so driven then to have to do that, because also I had to get a job - you know - I knew I had to get a job. So I kinda of joke with my husband I'd like to be a lady who lunches (both laugh) but actually I'd be so bored if I did it!*
She has worked in this capacity for 17 years, and feels that the work is changing because her patients are now more ill and complex and also more likely to complain. *I've had a complaint - from a patient this week who didn't like it that I said that "I have never heard of somebody getting paralysis from eating an orange or a banana" I didn't say "no you don't get it".* She is fully supported by her colleagues, but she feels that this tendency is forcing health professionals to respond differently to patients, *and I can never collude with that*. The nature of her work is also changing because she is increasingly training up more junior nurses.
I do what development I like, I'm picky on this (Alison: I know!) um, what I feel will help me further and what I'd like to do and - for example when I'm asked... if I'm asked to speak at study days and things or um, like [] has asked me to chair and talk about advanced peritoneal aid, I jump at that because I learn so much at those as well as the opportunity to present and I love all that. And if I see a course available that I think will be good and relevant then I'll apply to go on and it. She will only attend something if it is likely to be of direct benefit to her patients, and for that reason she does not want to do a degree nor to commit the time required and she also believes that she is not academic enough. Her sister, also a nurse, is currently studying, *she works in a hospice and she knows they could drop her band... she's due to retire in a few years and they could drop her band if she hasn't got a degree so she's working all the hours God sends, paying I don't know how much to do it. Also, part of me- it's just I'm a bit of a rebel... 'bog off I'm not doing it because I didn't do a degree for my nurse training does that mean it was any less good and why penalise us for it now?' Isn't that bloody awful, yeah? Faye says that she would leave nursing if she had to study for a degree: 100% I will not do one - yeah. So partly on principle and partly because I don't want to do it.*
She lives outside London and the journey in takes about an hour, which she is happy with, although she does feel that it is an expensive journey.
When she goes through a difficult time at work, Faye sometimes thinks she would really like to be an undertaker, as she would like to work with bereaved families, but is aware that they pay is not sufficient. *Yeah, you go through patches - don't you find in work you go through patches where you just hate it and you think everything's going wrong and everyone's on your case and you think I need to leave now and then you go through patches when you love it, most of the time actually (Alison: you do love it) I love so yeah…... I suppose the other good thing about nursing is, and I presume this is till the case, there is lot, as a nurse, you've got the potential to do so many different specialities with nursing which you don't get. If you join a bank or something- you're in a bank I mean it's kind of a bit one way. In nursing you can do kind of anything with it.*

Name	Year of registration	Current post	Gender	Age
Felicity N	1982	clinical specialist – long term effects (band 8a)	Female	40s

Felicity grew up in a medical family*; my Father was a doctor and my Mother was a nurse and I just always wanted to be a nurse - I played doctors and nurses when I was a child, and I didn't consider any other career*. However, her academic school felt that she should be a medical doctor: *people said "well why don't you consider medicine?".* They did not advise her about nursing, so she missed a place on a sick children's course and only had a limited choice of adult training places. After that she trained as a sick children's nurse and worked in a children's hospital, both in London. She worked in East Anglia and met her husband: *we stayed together and he came to London and we got married and then I thought I'd have a little bit of a break*. She became pregnant which changed everything: *it wasn't going to interfere with my career and I was gonna go back and I was gonna carry on in my career path um - and I always assumed that I'd be a ward sister- and then I had a child and I loved being a Mum and I had left work because, because I couldn't take maternity leave so I then changed tack a bit really - I just pottered along really for years - just being a Mum. I did all the school bits, I helped out at school and I enjoyed being a Mum - what I did I liked to do well so if I was gonna be a Mum I was gonna be a good Mum. So, having said that it wasn't going to interfere with my career it completely did, but I enjoyed those years, and I could still do a bit of nursing- those years were good years*.
From there, she got a job as a staff nurse on a paediatric ward doing regular, part time work, but when 12-hour shifts were introduced she found they did not fit into family life *you don't see your child before you go to work in the morning and you don't see them when you get home at night and I didn't want to do 12 hour shifts and there was no flexibility about that so that sort of pushed me, I guess, into the next move* and she applied for a school nurse post, also studying for a degree in community care. The hours suited family life, but she did not enjoy the work itself and: *my husband also said "you know you keep moaning about this job but if you're not happy do something about it - or find some satisfaction in it but don't be moaning about it!" Which was pretty good advice really!… This degree is not taking me to the career that I actually eventually want to have and actually when you're getting to my age you can't hang around messing about doing the wrong thing because you haven't got time to switch and do the right thing so I withdrew from the degree course. My Mum sort of gave me an excuse because I don't drop out of things and I think I probably wouldn't have dropped out. She shouldn't have had that long (Alison laughs), but you know - I didn't expect her to have that long. We had - there were good times and she lived with me when she was having treatment so - but I had times when I was - you know - trying to meet a deadline for an assignment and she was living with me and I would - I would be taking annual leave days to do that rather than* (academic work). *When I had trained at [] I had enjoyed working on the paediatric oncology unit - that had been probably my - I enjoyed that work, that was one of my highlights. Before I had the children that would always have been my plan to go back to that. So I started just looking out for - for other jobs. And - um - I saw a paediatric day care oncology job advertised advertised (Alison: right) ok? So that gave me Monday to Friday (Alison laughs) working and I rang the sister on the ward and I said that "I'm working as a school nurse at the moment, my oncology experience is from my training and from my general paediatric experience" which was quite extensive but it was over a number of years but at a low level, so she said 'well, come and have a chat with me - but you know - we might be interested'. So, I came - I didn't have - it wasn't a formal interview I went and have a chat; and I was very cheeky so I said "I have children" they were still, they were still, they were at secondary school by now but they were still, you know, needing - my input; they still want their Mum so I said-* "*I would really like to work on your ward but um, I have a Mum who's, you know, who's dipping in and out of being treated for cancer" so by now I was doing my school nursing job 3 days a week so I could manage*

my Mum's chemotherapy so I said "I can manage- um, I'd like a term time only; Monday to Friday; three days a week job" (Alison: laughs) and they'd never considered that before but they said they "would think about it". My husband thought I was really pushing my luck to ask for a term time contract but actually - you don't ask you don't get. So, they'd apparently never offered a term time contract to anybody before but they considered it.

Following that, she felt that she should get a promotion, and applied for a senior staff nurse post, which she did not get but was offered a staff nurse post in late effects of cancer, a new field. She now feels that this was ideal but that she could not have planned it: *but I found that out along the way and I don't think I had ambitions to be a clinical nurse specialist - it wasn't - I didn't - even when I took the staff nurse post - so that staff nurse post at that time it was a band - it was an F grade so it was a senior - so that was my - that was my escape from the, you know sitting at a band E for the rest of my life (Alison laughs) so I thought I'd do the band F- it wasn't actually a job I particularly wanted to be doing… I figured it wasn't going to do me any harm (Alison: mm) because it would be good experience and then I might be in a better position to apply for the senior staff nurse role when it came up again on the ward but I loved it! It just - it just drew on everything I'd ever done; it drew on my school nursing… and I felt quite comfortable and I had teenage children.*

She studied for a diploma in nursing with the Open University, which she chose *because that fitted around the family - I could do it - it was self-directed learning, it was - it was er monthly tutorials. I don't know if you've ever seen Open University courses but they're very, very good for fitting around family life (Alison: mhm) and they provide you with packages - really good quality packages of learning… I did, um, a Health and Social Welfare diploma (Alison: ah right) through the Open University. Fantastic course - not nursing at all (Alison: no). I was working with - I don't know - vicars and social workers and community workers and met some really interesting people (Alison: yes) and did um- a modular diploma which I enjoyed and that took, that took me time - I did a module a year, took me three years to get my diploma in health and social work. So, I have done a module - it nearly killed me (Alison laughs). Had to be prepared to work every weekend; so you work, you work a - you don't work 8 hour days in these jobs - you work nine or ten hour days and then you try and study on top of that and then you work at weekends to do academic courses and then you have nothing else in life (Alison: no) and I - so I - yeah, that's my little rant! And I did it for the degree, so I figured - I needed to keep up with what was going on (Alison: yes). So, at that time it seemed like a diploma was good enough to be - you know up there with everybody else.*

I was pursuing a career now but very late. You know I was probably by now in my mid 40s so - but I actually really enjoyed it and it - and it - so it brought in aspects of my adult nurse training, my advantage came in because I had my dual - I was adult trained and paediatric. Her degree dissertation examined transition care[1], *the consultant I worked with at that time wasn't particularly encouraging he said "well they don't have cancer they don't fit into an adult cancer service" but I still pursued that idea that we should have some sort of transitional – um - service. So, I took a business case to our senior nursing group and said I want to set up a transitional - nurse led-transition clinic where the focus is on patient education, health education, healthy lifestyle and preparing these young people for life in adult health care. I do think the nursing degree took me to a level that I wouldn't have got to because the work that I did for transition - I think, unless you're forced to do a piece of work.* She was well-supported during her degree (for instance she was given time to work on other wards and in the community), but feels that the improvement in service has justified this investment by her Trust. *I think the way I talk to patients is different (Alison: mm). I think... I think they've been in..um.. medically led clinics for many years and they have very little understanding of what happened because they're not being talked to in a way that they understand... (Alison: mm) so I think I can... I think... I think and I don't know if that's a nursing skill but I think that's my skill... talking to patients in a way that they understand and giving them the freedom to actually ask questions and feel comfortable asking questions.*

She went on to complete her BSc on generous terms: *I'd've been foolish not to do the degree because it was offered to me on a plate (Alison: yes). "Felicity, there is a place on the degree course, we will fund it" you can't turn that down up until the point that I had to do my dissertation; but no, I had, I had, I had time to study; I had placements in other hospitals to gain experience - Yeah. It was a modular degree so - so - so I did, I came over here and worked on the teenage unit just as an experience working on the teenage unit. I don't think that happens now.* She now says: *if I'd known that - see it's really - if you'd've know how things were going I - I wonder If - there was point at which I'd completed my degree and to get an honours degree I had to do a dissertation (Alison: mhm) and I could of just cashed in my points and got an ordinary degree; and I was encouraged to do the dissertation to get a honours degree. But I think at that point, perhaps I should have just - moved straight onto a MSc (Alison: mm), because - but I didn't know it - I don't think - I don't think we knew then that MSc's were gonna become so become so important (Alison: mm) and I don't know if MScs are so important everywhere- I think if you're in a big teaching hospital MScs are incredibly important*. Her clinical interests led her to attend a conference in America, where she met three other British nurses working in the field, and they formed a network for UK nurses, and together wrote a book chapter. There are about 40 in the group now! At this time her medical consultant encouraged her to apply for the position of nurse consultant to a national project on cancer survivorship. She is surprised now she had the confidence to do this but *I was beginning to sort of feel quite comfortable with myself, I was beginning to be recognised as an expert, as a nursing expert within this field*. She was involved in writing guidelines at national level and became concerned that the different hospitals that she was working with were not transferring care efficiently. *I recognise that I do have expertise and I recognise that some of my colleagues who are now appointed into other services - and it doesn't need to mention where they are - but within the London area there are other services with nurses who've been appointed into clinical nurse positions which - and there's no training for this job so there's no - there's no late effects training.* She had the opportunity to undertake a leadership course, and as part of that carried out a mapping exercise. This led to a business case for new nursing and administrative posts with the adult care team, and Felicity applied herself, which is her current post.

Working alone can be a problem: *If I go on holiday I can be here 'til ten o'clock at night clearing my desk and then I come back from my holiday and I have to clear what's built up while I've been away - I don't have young children now; it makes a huge difference so I can do that and I enjoy my work so it becomes - it's not a grind of a job it's a satisfying job and I'm prepared to do that - I don't think it's about financial reward I think it's about job satisfaction and I don't think I've ever come to work and not really felt like I was doing something purposeful and – and - and of value*. She works hard, which has become possible since the children have grown up. *You can't do everything! So, while I was working, you know I was doing my regular job and then I was working as an advisor on the survivorship*

[1] transferring children to adult care services

initiative and then developing services across here and you become - if you're not careful you can become too stretched and you can't do anything - well, so I concentrate now on the adult service here. I think nurses can - they can dip out of their career and dip in again, I think it's a career that does fit round having a family (Alison: mm). I think I've proved that you can dip out for quite a long time (Alison laughs) and still reach a reasonably decent level (Alison: mm). In pay wise and satisfaction wise - I think it's a shame people have to specialise so early. One way of building capacity is developing new staff: *This morning I was meeting with a group of reasonably newly appointed late effects nurses – and - we have a sort of supervision - it's an informal group but they can bring to that group any clinical issues that that they have - that they'd like advice about. I guess it's a bit like clinical supervision but not within our-. it's broader than our hospital.* This is necessary because even specialist courses rarely mention long-term effects.

She is now pondering applying for a nurse consultant post, but feels that to achieve that she would need to undertake an MSc, even PhD, and she worries that an academic focus can even be a distraction. *I don't have an MSc and I know that there's a real push now for nurses working in my type of job - I think I'm probably quite unusual but I think my expertise was recognised - um, but I don't think going forward that people without MScs will be able to do jobs like mine, and I think what I bring to this job is my adult nursing experience, my time in the community. I have something else and maybe it's just life experience. You know I've got adult children now who I enjoy being with and I and I enjoy a social life and if you're not careful your work can become the all-consuming thing and I don't know if that's entirely healthy, actually. So I'm saying to me colleagues "think very carefully" because they're thinking about what qualifications they do next and a lot of them are under pressure to do masters. I think master's qualifications - maybe in psychology - I think psychology or counselling or – or- so - there are other things to do (Alison: other than in nursing) other than advanced practise - I don't want to be a not a very good a doctor (Alison laughs) that- that might be unfair but I want to be a really good nurse… I feel slightly aggrieved that the goal posts keep changing - so you never actually quite get there…. you know, my kids both came to my degree ceremony and I thought "yeah now I feel, I feel good about myself* (Alison: yeah*) for having a degree". I don't think I've got the energy to – if - if I was to do an MSc, yeah - so I don't want to sound like an old fuddy-duddy who's aggrieved about having to study but, I think - I look at my sister who's a head teacher who has a very good maths degree and they're very happy for her to be a head teacher without - without a master's qualification because she's a really good teacher, and she's proved herself on the job and she has, has a degree…. I don't consider myself academic, I consider myself very practical - I think I'm very practical and I think I've got a lot of common sense (Alison laughs) and I think I'm good at my job. I wouldn't even tell you what my O-level and A- level results were because they were pretty poor, actually (Alison: yeah, yeah) and I think it would have been a shame if I'd - I think now if I was applying for nursing I might not even - well I wouldn't be accepted on a degree course probably… which I think would have been a shame because I believe I have been a really good nurse.*

(Alison. So if somebody coming along ten years behind you wanted your job, are they gonna have it easier or more difficult than you had?) Yeah they're gonna have it more difficult; they're gonna have to have an MSc. They're probably gonna have to a PhD actually - I absolutely respect you for doing a PhD - I don't know if you know [], but I work with her very closely, so she has a doctorate and works at [] and through [] University and I absolutely admire her but I think there's a place for people like me who have a clinical expertise. I don't think I am academic, but I think I've got something to contribute.

Felicity feels that she could have approached her career differently, because she now knows about all the possibilities: *when I was - when I started the career route was: staff nurse, senior staff nurse, ward sister, nursing officers (Alison: that's right) - we had nursing officers, do you remember nursing officers - so nursing officers were like - that was - you know that was (Alison: that was it really) that was it, wasn't it? That was as high as you were gonna go! Um and I - and I suppose I always thought that's the route I would take I always thought I was gonna be a nursing officer I was quite cocky, I thought I was pretty good. I thought I was gonna be a nursing officer and then, you know, I had children and all that changed a bit (Alison laughs) but, um, and I suppose I thought I was gonna be a ward sister one day and I never - I never was (Alison: no). Most clinical nurse specialists do probably take that route (Alison: I think) though probably. There wasn't such a thing as a nurse consultant. So I think they should know what - they should know - what's available and I think they should know the difference - so if you go into a research career you're probably moving away from clinical nursing, if you're go down a consultant nurse path - so if I was in nursing for another ten years I think I'd probably be looking towards aiming for a nurse consultant post, because that - that would give me some research and - but keep my clinical involvement going. I think that's fair to say - I'm just thinking of the nurse consultants I know... they're still doing clinical work but what I'm doing is not very different (Alison: no) actually - it's not very different (Alison: it isn't) and probably my sticking point is the MSc., actually but I think I've made a decision that it's too big*. However, she also feels that *I missed a trick with the transition work 'cos that's now been taken forward by the medical teams - and they've taken a lot credit for that work- that was a nurse led initiative.* Yet her young clients *want their story to be told (Alison: oh right) they want people to know (Alison: what's they've been through) what they've been through and that, you know, that just treatment and cure is not the end of the story - and they want people to know that.*

(Alison: and the young people are urging you to do this?) These are people in their twenties and thirties, who want - they want - they want to be on the map- they feel they're a bit of a lost group, so they're quite keen to-.

Some of the career decision were around the fact that we would never had been able to pay our mortgage on my salary because we live in London, my husband's always earned probably at least twice much as me if not more so he was always the main earner and I - I feel a bit embarrassed to say it - but I was always saw my salary as, sort of, a bit of an add on really (Alison: mm). And his salary was what we all lived off (Alison laughs) you know he paid the mortgage and I dipped out of my career because we could afford to live on his salary to be perfectly honest. So my career decisions were made I suppose being able to afford - I could afford to be at home (Alison: mm) just about. We - we weren't wealthy, we were tight for money but he could afford to keep us all going (Alison: mm) so that contributed. And sometimes I regret it- I think said at one point- I sometimes wonder if my career had taken a different path if I'd been forced (Alison: if you needed the money) if I'd needed the money and had to work. Cos I always say my career didn't really take off until I was in my 40s; I think all my other jobs were sort of - fiddling around really (Alison: mm) but I would - I suppose I'd maybe I would consider this a career job but um- the earlier job was - I always wanted to keep my registration and I wanted to - I enjoyed nursing (Alison: mm) so I wanted to work so money was a consideration.

Felicity thinks her next move will be retirement: *that's another thing that none of us- nobody talks to us about retirement.* However: *I don't feel anything like old enough to retire yet. You don't do you? You sort of - it comes up on you - I'm 54 now (Alison: blimey) - I don't want to retire! I'm not ready to retire at 55. (Alison: no) But I'd quite like to know I could if I wanted to (laughs)* but she feels that she has been misled because her gap in service could have a serious effect on her pension entitlement: *then I thought I'd have a little bit of a break. Now I had no thoughts about pension or - future 'cos you don't at that age (Alison: no) so I suppose if you're looking at how people might be advised that's something that I regret that I took a break in career at that time, and I remember somebody saying to me when I*

was in my 30s "I hope you're one of these women who thinks they can rely on their husband's pension" because at that time there was an option to top-up and pay-back if you were working part time and I didn't - I just - you don't think about the future- I just figured "well that's a long way off and I'd rather have the money (Alison: now) in my hand now" (Alison: yeah) and I - you know I was in a stable relationship; my husband was working; he had a good salary… I didn't know that - I thought 55 was early retirement but she said 'no that's not the case your normal retirement age would have been 55 except you've got this big chunk of gap in service' which I'm disputing actually, I've got, I've kept records.

Name	Year of registration	Current post	Gender	Age
Florence N	1988	Preceptorship coordinator	Female	50s

Florence received poor quality careers advice at school: *our careers advice, if you like, was secretary - or maybe go and work in a factory or something like that - Or a mill or, or whatever, and umm, I thought, you know. We went on visits and I thought 'this is not for me'! My sister um was a nursery nurse, and that wasn't something I was particularly interested in, but my mother had some, quite a lot of health problems, so I guess kind of nursing seemed the most appropriate progression. And I umm and that's really I suppose what made my decision (Alison: Mm?) was I suppose - dismissing all the other - well the other two options (laughs).* Uniquely for this group, she initially undertook her pupil nurse training, because qualifying after just two years appealed to her; although she does not regret it, she nevertheless feels that this was another result of having poor advice.

As an enrolled nurse she worked overseas, returning to the UK to gain her registration. After that her first post was in women's health, which she loved, but she felt that the promotion opportunities beyond ward sister were limited. *So then I went to umm another London trust, and unfortunately, although it was a really good job, I was managed by the general manager - a complete bully. And she made my life absolute hell. I hated it - I though I've gotta get out of this place, you know. Because, it really eroded my confidence in a dreadful, dreadful way. It was absolutely awful I can't tell you. And umm, so this was kind of a, an opportunity that came up that kind of got me out of the situation*. At this time, Florence benefitted from coaching to: *help me to understand, where I was and how, these situations had arisen, and to kind of stop, stop the self-destruction really - it's like fighting your way out of a paper bag - that I was, felt I was going through. You know, and sort of blaming yourself for everything that went wrong in the department.* She later undertook a management course, which: *helped me in thinking that I needed to something different, and that really encourages you to take risks with your career, and your life really. So, it really kind of, you know, encourages you to kind of think outside the box and step into some, step out of your comfort zone.* Thus encouraged she applied and was seconded to a deputy general manager post. She left this for reasons she could not explain, in a knee-jerk reaction, she resigned and joined her husband working overseas. However, her husband's job did not last as long as expected and they returned to the UK, and she commenced job-hunting.

She has pondered taking a very senior post: *I mean I was potentially, when I was doing the deputy general managers job, I was potentially thinking that I could do the general management job; but actually now I am glad I never did, because um, that is a, you know, I mean I don't even look at those jobs anymore (Alison: no) because it just doesn't – the stress levels are just huge, and, you know, life's too short (laughs), um, and to me it's all about, now it's, it's all about quality as opposed to quantity, I think, um, so, I, have I, yes, I suppose I have, I suppose I have, I mean, I would have probably, I would probably never have left um, the hospital, this, this trust if there'd have been a career opportunity like I have found at the other trust (Alison: mm) I probably would've stayed, but there didn't seem to be anything to kinda, for me to sort of, you know I was, I was chomping at the bit really, to kind of go up, and there wasn't, there didn't seem to be anywhere to go.*

Instead, Florence has trained, in the last few years, as a foot health practitioner, she says she wanted to *do something for myself* and she also wanted to run her own business, as her husband had always done, and is successfully building up a private practice. She was inspired because her husband is diabetic*: my husband's diabetic, and he was having somebody to come and do his feet, and, and then he was having difficulty finding somebody, so I thought "oh well, yeah, maybe it's something that I could do". And you know, I'd never worked for myself before, I'd never run my own business, or anything like that, and it was a completely kind of, left hand curve if you like. And err, so I did the training. Yeah I did all that, and then umm, you know obviously I'm all sort of fully, fully public liability insurance, and all set up properly as a small trader. but I love it... I've got my regulars, who I sort of see and catch up on about, you know their holidays, what they're doing with their families and all this kind of stuff, and then you meet new people and you find out all about, I mean I love meeting new people.* The business is going well: *I've just had my accounts back for this year, and I've made quite a decent profit, so I'm really pleased.* Florence has kept her registration, and this gives her work as a foot health practitioner some credibility. She currently does this work for three days a week, but this could expand, particularly if she were to advertise. This also met Florence's desire to return to clinical work.

She looked for work agency work to tide her over whilst the foot-health business became established, but saw her current post as a professional education practitioner. She knew the health Trust and had always enjoyed teaching and seeing nurses develop and so applied, despite the fact that this was on a lower band than she had previously been on. It did, however, allow her to develop her business two days a week whilst providing a safe income for three days a week. It was a six-month contract, but it was repeatedly renewed and she is now nearing the end of three years. She was also promoted from band 6 to band 7, whilst continuing to do similar work. She has enjoyed this work, but now feels that it is not challenging enough*: So I've been doing it as band 7 since, I suppose, January. Umm, Am I still enjoying it? I'm enjoying it (short pause) to a point, I think I'm getting to stage where I've kind of been there, done that! (Alison: Mm) seen it. And I'm probably looking for a, if I'm completely honest looking for more of a, a challenge, now. I can do it fairly easily, the programme runs, the programme's set. I think, I mean I don't know this might be one of the questions, but one of the things that is frustrating me about, the job at the moment is that, there's sort of changes happening sort of in the macro environment if you like, but it's not kind of filtering down, in a very timely way, or in a very, communicated very well in the micro way. I suppose, over the years I've become a bit sort of project orientated, where I like to come in, do something, and then move on. So if somebody said to me, even within the same team or organisation that they would like me to do A, B or C, over this period of time, you So that sort of concerns me about how it's gonna, go… It's not, it's probably the least stressful Job I've ever had, so that part's good, so I know I can go to sleep at night!* Her role includes giving career advice. *I think a lot of it's about knowing where to go for the information... Because the other thing that I spent, I spent a lot of time with her... going through the NHS jobs website, and putting the appropriate filters in for her. I said to her, I said 'you need to phone these people up, and say –', you know there were some jobs advertised, and I said you know, I said 'you need to phone them up and say you know, 'I'm interested in doing this, I don't have community skills but can I come and talk to you?'' You know and I said "and you really need*

to focus on just transferable skills that you've got, not what you haven't go" (both laugh). So, uh, so yeah! So anyway, so I'm pleased about that, so she's – (Alison: Yes!) I think she's going in September. She has always been quite good at maintaining professional contacts*. I had some contacts in [] that's where I got this job and advises others to: I am saying, if there is nothing else you get out of this programme, you know make sure that you kind of meet as many people here as you can (Alison: mm) they are all from different hospitals, they are all from different backgrounds, you know, it's an opportunity to start sort of building those professional networks because it's not like, you know, you never know when you might need them, but it's also about kind of sharing knowledge as well, and if you want some advice or – or whatever – you know just somebody to pick up the phone to, and say "you know, I'm struggling with this", or "I'm thinking of doing this, what do you think?". (Alison: mm!) and you know, bat ideas about.* She worries that modern nursing misses some important aspects of care, such as spirituality, and ponders that it would be nice to return to return to clinical work for a while but feels she is too de-skilled *But I mean, I just, you know, the wards now are just so - I think it would terrify me.*
(Alison: Mm) You know, I'd be terrified of making errors and things like that. I really wish I'd have kind of – although I've enjoyed what I have done, and I have really enjoyed the management side of things... I feel very de-skilled, and I wish I'd have kept more of a clinical focus. This is one of the few aspects of her work she regrets, feeling that taking a management post had moved her away from clinical care. This is a short-term contract, and is due to finish about three months after the interview. Florence has the sensation that her career is coming to an end; she no longer looks at potential nursing posts: *I've not made any plans for my NHS career or my nursing career if you like, beyond January (this recorded July) (Alison: mm mm) which is a bit scary, but is also a bit, kind of, well just wait and see what happens, you know, I have survived this far (laughs) and you know if I, if I could do some project work, or some consultancy work or, or something, you know, but I've still got my business, so, I don't feel too vulnerable (Alison: yes) at the moment. My husband and I, have planned ahead sort of quite successfully; we own a house in France and we spend a lot of time over there, and we are planning to retire there, um, whether that will be in the next 2-3 years (soon) I would be in France, in my little house, hopefully with my husband, if he is still alive (laughs) um – surrounded by animals and (Alison: lovely!) people and - yeah*

Name	Year of registration	Current post	Gender	Age
Gem N	2000	Senior sister – intervention radiology	Female	40s

Gem grew up in the Philippines and saw nursing *as a way out, from the Philippines, to earn more money, you have to take up nursing. So, there's a lot of us who did nursing, and my grandmother who lives in America wanted me to become a nurse, said it was easier for me to go to America, it's either you go into computers, which is big back then, or nursing. And I took up nursing.* Obtaining a nursing post after qualifying was difficult, and she undertook further training in intensive care nursing, before working for four years. However, she found nursing in the Philippines dissatisfying because nurses have a low status, and Gem describes herself as competitive. America was not recruiting overseas nurses but the UK was, so she applied via an agency. She came to a northern city to undertake her adaptation course, and then started working, first in a private hospital and then an NHS hospital, all in the same city. However, she became resentful of the amount of responsibility she had as a band 5, particularly when more senior staff were away; *I was very demoralised because they wouldn't give me the band 6 job. And I thought that's really unfair because I feel it's cheap labour. You're just taking advantage of me! Although we have a registrar, but then we come down at night to see ECG's. And decide, "Oh this patient is suitable for Thrombolysis". And I, but it, it's not all that, only that, we have a chest pain assessment unit, and as a senior E grade, you're, you're there. And you look after people who have chest pains, well no, not really, but you sort of work as a clinical nurse specialist, because you look at ECG's (Alison: Yes, that is) And then you, "this patient's having a heart attack or ischaemia" it doesn't really matter, then you and discuss it with a consultant. (Alison: Mm) And I thought "This is too stressful". And not, it's not, it's not, how do you say it is, it's not in your pay grade (Alison: laughs) Because if you're on an, on a day, the lead person in a chest pain unit is a band 7? A G grade I think it's a band, I don't know. (Alison: something like that, it doesn't matter, yeah) They're a G grade, yeah so, and then they would expect you to do it, at night, well you do it every day anyway, but, but I just though I do not like this kind of environment, it's too, you're putting a lot of pressure for somebody who's, more or less junior.* At this time, she saw others in her age group getting married and having children, and she wanted to move on with her own life. She wanted to move to London and saw it as a chance to live alone, rather than share, as she had been doing. She approached the agency that originally recruited her but a friend, who had recently moved to London, advised her that there was a band 6 post available in the cardiac catheter laboratory, and Gem moved there. When the band 7 became vacant the senior nurse, who first recruited Gem to London, suggested that Gem apply; she had not thought of so doing, but always liked a challenge, so she successfully applied for the job, her current post. Shortly after the appointment she was offered the opportunity to have mentoring, she believes that her medical colleagues wanted to protect her as the post had been difficult to fill. This gave her the opportunity to explore her new role, and she found it very helpful.
*The basic pay is actually - I don't know. It's probably Ok with me. But the, but I'm not happy with, there's no increase every year. (*Alison: Mm hmm) *And you're, stagnant. Unless you do increment.* Alison: Are your increments ended?) *No, no, no, you get increments isn't it, but then you do not get, the, so if you hear the news about this MP's going to get (Alison: I know) 5% pay increase, or even the doctors. The doctors get a pay increase, I think? (Alison: I'm not sure.) Okay because I was reading through the RCN and, and the nurse, and the government is saying no to a 1% pay increase for the nurses. (Alison: I know, I know.) And that's frustrating. (Alison: Mm mm.) Because what would happen if you, you're in the front line! (Alison: Mm) Surely you should be appreciated. (Alison: Mm)*
What would happen if there's no nurses? (Alison: laughs) It's not very, our radiographers for example, but they earn a lot. So... yeah. (Alison: Mm mm. So it's enough? What you're saying I think is it's enough but you see other people doing better? Which isn't fair.) Yeah. Yes. So I think it's OK,
(Alison: huh) But where's the fear fairness in... why would they give a lot of money for, for, I'm sure doctors will have a lot of money, but why do they get an increase but not us? (Alison: Mm) And we cannot even go on a strike! (Alison: Not easily, no.) Nurses never. (Alison: We don't, no.) You, you just still have to stay here, and look after patients. (Alison: Yes. Mm, that's fair enough. Umm) Although I must say some of my band 5's, earn more than me. Because we do on call and we - and they do. (Alison: Oh right) And then we, umm, that is they, they get called up quite a lot? I don't do as much. (Alison: That's interesting. So the actual amount they take home is, is, is greater than yours?) Yes (Alison: because of these extra payments?0
She also is overly busy *technically, I'm supposed to be 60% management, and 40% clinical - never happens, so today, I'm supposed to be non-clinical. But because we're short staffed I have to take myself out and do clinical work.* Gem looks at job adverts, and receives email alerts from jobs websites, but: *I think this is more about for everybody working in the NHS at the moment, they're all looking for jobs and,*

and they look and then they decide "Oh that looks nice", but then you end up staying in the same place because it's not always great somewhere else! Furthermore, Gem feels that she is still learning in her current role, and there is much to keep her interested, particularly as *My Matron thinks that she's grooming me, become the next matron. And I said "I don't really want to become a matron, but –" we shall see, because I'd rather stay clinical, than go in the more of the management*. She feels that there is no progression for her in clinical roles, particularly as her specialism is *small, and does not use clinical nurse specialists, there's nothing in interventional radiology unless you become a matron. There's just no CNS, there's nothing else.* Gem wonders whether she was wise to leave cardiology, which is a bigger specialism. *It's like, occasionally there is a cardiac setting, and I always thought, err, you have more option of transferring somewhere else if you have, if you're cardiac trained. (Alison: Yes, yes.) Because with, I do not (), there's nothing in interventional radiology unless you become a matron. There's just no CNS, there's nothing else (Alison: Right). So unless you transfer to another hospital as another senior sister, then, the only way up, is a matrons' post.* The specialist nature of the work also makes it hard to recruit more staff, as applicants tend not to understand the role. This in turn causes Gem stress, because she is unable to provide staff to fulfil all the requests she receives, such as following up their patients on wards.

Gem has pondered her retirement, *Err, so, I pay the pension, and in it, I () (Alison: Which in fact is compulsory, you couldn't not do?) Yeah, I can, err no, no, no you can opt out of the pension. (Alison: Yes you can now can't you?) Yeah. And I'm just continuing it. But I don't think that's going to be enough if I stay here. That's one of the reasons I think, if... (Alison: Oh!) I don't think () Is not enough when you grow old I think. (Alison: How interesting, so do you think that your pension wouldn't be enough to live in London, but might be enough, the same pot of money, might be enough to live in the Philippines?) Yes it will be more than enough!* She assumes that she will remain in nursing until then, but vaguely hopes not in the same role!

Name	Year of registration	Current post	Gender	Age
Jack N	1994	Senior sister – oncology (band 7)	Male	40s

Jack entered nursing for traditional reasons: *Wanted to care, wanted to do something that was worthwhile, rewarding… also like when you were visiting people when they were having treatment in hospital and you saw, it was at [] and saw the student nurses running around, and I thought "this looks quite interesting, I wouldn't mind having a go at doing that".* He commenced his training as Project 2000 was coming in, but he opted to do the traditional training, believing it to be more practical, which he enjoyed.

And I suppose it was when you were working on a general medical ward, and some of the patients were then having chemo on this ward, and you sent them to [] for their, transplants and things. And you sort of thought "This looks a bit more interesting" (Alison: Mm) "what is it that they're doing up there, that we're not doing here?" and that's what got me to apply

He commenced on a general medical ward; *the ward I was on actually closed to be decorated. When and, got moved to the haematology, oncology and general medical ward, we were doing some chemotherapies to patients there, and then thought "I want to look more into this"? So then ended up - eventually getting a job on the bone-marrow transplant unit here.* He found this rather limiting because the patients were quite well: *But because - to go for your bone marrow transplant then you had to be quite fit and well - there wasn't much hands on.* After that he worked an oncology rotation before returning to medicine. He applied for one job, but did not get it *So I then saw that there was a local hospital that was do - had oncology bed. But, it was the worst, (Alison: laughs) decision! I suppose I didn't really give it long enough. I stayed there 3 months, but when - Well, you know when you feared for your registration? And you just did not know, no orientation, no nothing. And they said "Oh this was your orientation, but they've just slashed our staffing, so it got ripped up". I was like "Oh!"! And they said You're in charge, this was on my second day, and I went "could somebody tell me how you bleep a doctor?" And I'd lasted 3, and then after the 3, you know, you're all doing extra shifts to cover each other. (Alison: Gosh.) And I just though, I thought "My haematology wards at [], they had the staff", but it was just busy and chaotic. But I just thought "No. I won't end up nursing, the way this was". Beds that still didn't go up and down, they were flat level beds, had to fight to get pressure mattresses.*

He returned to his original employer: *I phoned my old line - umm senior nurse at [], said "Can I have my old job back?" and she said "no. It won't look good on your CV. But you can have a job, on the haematology oncology", which had the worst reputation, at [] - because it was so busy, it was in a portacabin. And I just thought "Well at least it's 5 or 6 qualified"!* He says of that advice: *And again I think some of that was the fact, that the other ward was desperate for staff! But because - to go for your bone marrow transplant then you had to be quite fit and well (Alison: Yes) there wasn't much hands, there was hands on care when they got sick, but it was different. (Alison: Mm). So when I went and did the oncology course and did the placement on [], it was like general medicine with a speciality. (Alison: Mm) And it was getting right back to, cos the population was generally older, getting back to what I love doing which was the hands on physical care. What I call proper nursing!* He planned to*: do that for a bit, until I find something, so did it for about a year, I think. He then saw the previous post re-advertised and applied, this time successfully. But because there was no staff whatsoever, and everybody thought it was the time when [] had the threat of closure. (Alison: Yes.) And everyone's at []'s like "what are you going there for, it's closing down?". (Alison: Yes. Yes, it was) I said "I want to go and see, what, they do in a specialist centre". Ideally I'd like to have gone to [], 'cos that's where our patients went to (Alison: Mm hmm, mm hmm.) but there was never any jobs advertised, it was always seemed to be recruited in-house. And then that job was there, and then, I come, and thought I only ever thought I'd come for 6 months. (Alison: So that was the risk you were prepared to take, that they would close []?) Mm, yeah. And just think. And 6 months, then go back to [], (Alison: Right.) So that I could then put into practise back there (Alison: Yeah) stuff, so that, but, I've come and I've stayed.*

Asked why this application was successful, he was unsure, but thought that it may have been technical knowledge, or *maybe they were desperate*! Shortly after: *I ended up (*applying for the ward managers post*), well actually I was told I needed to apply for the post. (Alison: laughs) Because there's been a number of sister's who'd had it, who were either short term, covering, maternity leave, (Alison: Right.) people on long term sick. And they actually said 'Oh we could do with a bloke in that role, who's good for -'* Despite this, he still does a lot of bed-side care: *I'm very much a ha - some of the charge nurses will put themselves in the office, and go on the ward, not very often. But I do it the other way around! I've always been the hands-on person, and recently with the changes in terms of, the matrons have gone, and you're, they're divulging that role down to us. It's just pulling you a bit more away from the bedside. And I don't like it (laughs). But I still probably do far more out there, and then tend to do the extra bits in your own time. Rather than, come away from doing what you enjoy, and missing the patients sort of thing. This surprises some people: I said "That's what nursing, I didn't come into nursing to hug a clipboard" (Alison: laughs) "I came in to care. And if this is what the patient needs this is what caring, this is how care should be done"*. This means that he works long hours: *You're often doing 70, 80 hours a week. And then you do, you know, you'll be here till an early shift's supposed to finish at 3:30, earliest I leave is 5, sometimes you're here, this afternoon I've gotta stay do an extra shift cos it's not been filled.*

And then I feel that I can't leave my 3 nurses and an agency A grade to look after 20, 22 patients (Alison: Yeah) It's not safe. So, because of the team spirit on the ward. It would be possible to work fewer hours, but Jack thinks that this shows: *But, you sort of look at them and they've done it, and there was always a high standard of care on those wards. Those that 3:30 run out the door, the wards were awful! … Cos last week, cos we've got at the moment all these appraisals to get done by a certain deadline, and was on days off coming to try and get it done, locked in here, it was awful…. And then you get frustrated cos systems don't work (Alison: sighs) and they crash, and you just think: "there's a patient to wash that's the easy".*

Recently, he was obliged to apply for his own job, during the consultation*. This was flowered up as development. But, it wasn't, it was a way of "Who had the skills?" you had to prepare this big document to give evidence to justify why you did what you did. And then - And what you'd, achievements you had made to support you in there. Then you was in like an exam condition room, and we sat there for 3 hours, and then you were given, one of them was you just got, and it was all, it was all - you're not meant to have said what happened but it was all ages ago now - but - You were say given a budget statement, and you had to work out the staffing for this unit, where would, and we'd never ever done, but it was the processes you did to work out how you would sort these things out. And then part way through, and there was all different scenario type, but slightly longer questions, and then when you'd done that, half way, part way through the exam you were called out for an interview, and it was a scenario, what, how you would deal with certain things. And I got something - one of your, umm nurses has given an IV antibiotic and the patient had anaphylactic shock, had a cardiac arrest, what would you do? They wanted your answer. And then, if they were, and then they just drilled you down, drilled you down until you'd say what you'd have done and why do that, and when would you have esc-, and who would you have got involved etc etc. You know "How do you think you would sup-, support the staff member?". And you thought "Well they wouldn't be able to work because of what's happened, you'd need to probably provide counselling, the doctor, the whole team. Because everybody, you know, if somebody hears that in the hospital, then the ward gets labelled as - and all of that. And there's all those issues and the stigma", and stuff. (Alison: And you weren't given any help with preparing for this?) No… And then once it'd all done, and they submitted it in the computer and it was all analysed (Alison: Huh.) You then got feedback, and you could have either been red, amber, green or very green. (Alison: laughs). And I think, mine, within cancer in general, we all scored quite highly. But they said, I think I got one of, they said one of the highest ones in the, in the thing. (Alison: oooh!) Jack: But the only thing that pulled mine down was the fact I hadn't got my degree. And it had highlighted that, my corporate leadership skills needed development. (Alison: Right, so you got that out of it.) So in leading, yeah, so from leading I then shadowed the regional nurse – (Alison: So they did do something to address that?) Yeah. We did it once, and then, that was it. (Alison: laughs) But that was an awful time for (Alison: It is!) all the band 7's. (Alison: Yeah, yeah.) And those who didn't meet it were then either, slotted into different positions, and it was when we was all work - I suppose it was at the time when they were looking at [], there would be different number of wards, a way of justifying who'd got what Job - (Alison: And you were called in from leave to do this?) I'd been off, and, I was off, I think, was I off? I think I was off 'cos my brother had died, was only about a week or so after he had died. And they said "Well you'd have to do it", and then they said "No you've got to do it". And probably, because of all what was going on, I was probably quite angry, anyway. And the fact I'd, it come, and it's like, that, that question about the anaphylaxis, and an emergency situation, it was all, he died of a PE on the ward. (Alison: Oh.) He'd broken his leg. (Alison: Oh!) So he'd been at home, and he developed a DV-, he was 35, developed a DVT. So, to me, the question I got, was quite similar. (Alison: close) And it was all a bit close, so... And they said "you answered it excellently", I said "Well it's a shame I wasn't there at the time, when this had happened with him".*

Apart from clinical care, Jack's favourite part of the job is: *seeing the students come through. They all think "Oh it's Oncology, oh my God it's gonna be..." (Alison: They'll be frightened.) And by the end of it's like, they're general med- it's general, you'll get a lot of general medical, and a lot, what we do here: yes we are a speciality, but management of pain, management of nausea it's all transferable to any other area. You go in the community, it's transferable….. seeing them develop. Quite often, on here, we, well I prefer that we appoint the newly qualified? And then. (Alison: Bring them up.) you can then bring them up, and you nurture them to how you want them. And then eventually they will go off and do stuff (Alison: Mm) and they're actually surprised as to how much they do learn, while they're here with us. (Alison: Mm) Or when they go to other areas and they say, cos we look after, we're the designated ward for tracheostomy, we're the designated ward for inotrope care. And they don't actually appreciate how much they've learnt (Alison: laughs) or the skills they've developed, until say, they've moved on somewhere else. Or they go to other areas and think "what we did on that ward, was all one in an HTU or an ITU, (Alison: Yes) but we do it here"… And trying to get some of them to lead on some of the projects that the wards have been doing. And that's worked, one of the staff nurses is quite recognised now, quite high up, with all the work he's done with his pressure-sore patients…. So he now represents the cancer cag (commissioning group) at meetings at trust level, because of the work that he's done. It was part of umm, a quality improvement programme, we got some of the staff nurses involved in it, and with the tissue viability stuff, and then trialling things, changing it. And that's how it's moved forward, (Alison: mm) and that's how, he's carried on taking it forward. And err, has now got this recognition.*

His enjoyment of teaching has given him career ideas: *I've always wanted to be, like a lecture-practitioner. But having (laughs), but because of working here, they usually, when we've had them, they're the first posts to be.. gone…. And also, I think - and to me that still keeps you clinical, but developing the teaching role which I quite like teaching, well I do enjoy teaching the students.* His interest in the work is what keeps him here*: I think it would come to the point where if you weren't feeling motivated, in the role that you do, would be the time when you definitely got to think about doing something different, or, if this go, if they try and make this even more of an admin manager (Alison: sighs) rather than a nursing type of role. And then I would say, "I'll have the band 5 that's being advertised". Or do something diff- yeah. Not leave nursing, but perhaps, even though it's something I've not thought, cos to me a CNS had, a CNS type role, you've got to be all singing all dancing about everything. The other thing that keeps him here is friendship: I think I'd feel I was leaving, letting down my team; who would take them on? Because a lot only stay here because of the support and the camaraderie of the team. Because they could all go in to get the same money, on a much easier ward than what we've got here. And then once a year, what we sometimes do as a team, umm we all used to go away, so the band 6's, myself, the families, and then we'd all hire 3 or 4 caravans, they bring their husbands, their children. (Alison: Yeah) And we've had, sometimes, last year we had 3 caravan fulls. (Alison: Yeah) Have a barbeque. And they used to do it around about my birthday.*

In contrast, *pay is no longer an incentive I think, when you're going up the pay band - is fine. But I think when you get to the top of it, and I reached to top back in 2010, so the last 4 years I haven't had a pay rise, there's no actual incentive to stay in a ward manager role in terms of financial. You don't do nursing for the money!* He is considering his options for promotion, but none really appeal: *And I think a lot of CNS' get their roles now far too early in comparison to what, (Alison: yes.) you know. They're, and now they're quite junior who get in them. (Alison: That's interesting!) And I just think 'What have, you've got a band 7 as a, as a CNS, you've never even looked after that*

group of patients, but -' Somebody who's got umm, an I post recently has got no I experience, has got a band 7 CNS. Someone's who's never looked after lymphoma patients, has got a lymphoma CNS post. I think there's too many people getting them they're giving them out, and then that sort of then devalues (Alison: It does doesn't it?) Those CNS', who like our uro-oncology CNS who's been doing it for donkeys years (Alison: Yeah.) who, what she doesn't know you write on a post-it note! But these people think they can do that role (Alison: Yeah.) And they, they haven't got a patch on them. and they've done - one, this girl, she's a friend but, (Alison: yes.) you know she's been a band 5 on the ward, went to the community, didn't like that, come back got a band 6 research nurse post. Has done that for about 18 months, she got a band 7. I just think it's ridiculous that they're putting people into these things. But then you think "Oh she was the only applicant, so –". (Alison: No!?) And so you sort of think, "ooh a bit", and then to me, the next step up would either be, a CNS role or a matron, which brings in the clipboard, but the clip, they've all (Alison: yup) - Or sort of practise development, that sort of stuff which I would like to do, but those are the first posts that seem to get chopped whenever the trust has a budget reduction. So I feel you might as well stay in the role that you've got - that you love and enjoy, and just put up with the fact that you don't get financially rewarded for it. Jack starts out being quite systematic in his career decisions, but does not see this through: *I would write down, and at that time I had 2 posts that were being offered. (Alison: Mm hmm) So I looked at the positives and the negatives of each role, went for the interview and then, weighed it up that way - weighed it up - but in the end I think my heart was, I was a medical nurse rather than a surgical nurse. I mean my head was telling, cos one of the jobs was a 6 month temporary job, which was on a ward I was working on, and the other post was a permanent post at [] in the end I went with heart, rather than what my brain was telling me, my heart was saying I want to stay with the team that I've worked. I did do the right thing*! Jack is also aware of his other responsibilities: *I suppose with your parents getting older, it might sway you as to where, and my brother died about 3 years ago and was younger than me, so, (Alison: Oh dear, I am sorry) because they're.. they're around, if I wanted to, say, go and, but then that could be moving, it could be work, like go further afield, that might prevent me from doing that.* He feels that this does not restrict him*: But then I think you work in London, you should, you've got most of the opportunities here*. He is not actively looking for work but may view NHS jobs when he is advertising a post out and then notice others, but has not even created his own account.

He has had careers advice, but mostly has ignored it. For instance, he was advised against one hospital which was supposed to be closing but went anyway. He planned just to do six months, but is still in the same trust. Although happy in his present role, he is aware that it should not last forever: *I think though now you're at this post, you're, you get a bit stuck. As to how, and whether now because you've been, I've been in this role for - this is my 14th year. You're a bit (laughs). Somebody did say to me, "do not get stuck in that role for a long-" and I've done exactly what they said not to do. And I think now, because you're comfortable in it, I'm quite nervous about, (laughing) going somewhere else*. He worries that the role may change: *if they try and make this even more of an admin manager rather than a nursing type of role, and then I would say, "I'll have the band 5 that's being advertised". And more audits, and you've got to justify things, and what the government, there's lots of tick box exercises (Alison: Mm mm) you know, you can be judged, not on the care you provide (Alison: I know) but, have you produced the right piece of paper. And I think really (?) And it's quite frustrating sometimes, and if, you know, that's not picked up on, but there might be a compliment on excellent care that's been provided, that sort of, doesn't matter, cos that's not a tick!* He would like to complete a master's degree, particularly as he is aware that now all students are undergraduates or graduates, and has even experienced hostility from some of these students*: And you sometimes get the comment of, 'Oh, what do they know? If they've not got a degree, how can they teach us? (Alison: You don't get that do you?) Did years ago, long while ago. (Alison: Gosh) But sometimes they say 'Oh, if you've not a degree, and I'm on the degree pathway, how can you mentor me?' You do sometimes get comments like that.* He is about to complete his degree, but it has not been easy: *And the level of study, I think I'm not an academic enough to go into that sort of - (Alison: Right) part, I've done it at [], so everyone says they've got a different standard to everywhere else. But it just - Whether it would be t- It's just put me right off of it.*

(Alison: That's a shame!) I've got one more exam to do, (Alison: Right.) and then it's done. Cos I started my degree with [], and then there was issues on the ward, in terms of allegations made against you about patient care blah blah blah. (Alison: Right.) That investigation went on for about 18 months. (Alison: I can imagine.) So then, courses I'd done were then becoming out of date, and then all I had left was the dissertation. By the time I got back to do the dissertation, it had all - they said, just because the [] don't accept anything. Here therefore started again, at a different institution: *(Alison: is the standard [] higher? Academic standard?) It seems, it's different. I'm much stronger on the practical type ones, in comparison to the, theories, So like, I struggle, when I did [], umm, the [] courses with the umm, the one that's got the 'professional' the ones more about your professional and accountability. And then the exam was an essay. And it's one of the compulsory parts of that. And then like, your re- the preparation for research. That's what I struggled with. And at [] it's been the similar, the practical ones have been alright. But the more - I suppose with me, because my pra- working seems, I take that as the pri- and I always put my personal stuff on the back burner. So if I actually spent more time on it, I probably would have found, (Alison: Right. That's fair enough.) But I think it's the ones that, the practical ones, like I've just done acute cancer care, and then you're in like the simulation lab and things like that, which was the first ever time I've done something like that. (Alison: laughs) That's been quite good. And the ones that are all practical related but, (Alison: Yeah) some of the more theoretical ones* - He has found some of the modules helpful: *And it was looking at things differently, and we had to write these patches, and when you sometimes listen to them at handover, and they were going "Oh, that relative's been in and they do nothing but worry, or they're very anxious" blah blah blah. And then I've actually made me sort of stop them and say "You, your, it's your son, or it's your daughter in that bed".* He also wonders how long he can work in his current way *I think we've sort of made a pact on here. "I will probably still be here, when we retire!" But then other times we think "How can we still be running around like this? We'll be on our Zimmer frames!" They said "Can you let us know if you are, cos if you go, we're going*'. He also feels loyal to his team: *And like when our trust has gone through all the changes they'll go "Oh you could go and get a job any- you know, anywhere". And I went "Well I don't think so" and a bit of you thinks "Yes, we've had this turbulent time, I'd like to try and see it through, and if we come out the other end". And if it doesn't, then, you can look then. And you just think, some places, you know, how could it be so different somewhere else? To me, it must just be, exactly the same, just with a different logo and a different name.*

Name	Year of registration	Current post	Gender	Age
Josh N	2010	clinical specialist – gastrointestinal nursing (band 6)	Male	30s

Josh grew up in the Philippines, wanting to be a lawyer. He started university, but found that all his friends were reading nursing. His first year, a foundation year, included science, and he found an aptitude for biology. Furthermore, studying law would have taken about eight years, with consequent costs, so he transferred to nurse training. He is happy he did because he finds nursing interesting and satisfying,

but also it was easier to travel with a nursing qualification. Indeed not starting nursing sooner is one of his few career regrets. He was doing well in his career, working in the prison service: *it's very interesting because its little bit dangerous (both laugh) you will be dealing, er, you know, with prisoners as well (Alison: yes) and you don't know them, you know some of them would have paranoia and everything (Alison: yes) the criminal minds, but it was interesting*. He was aware that this was a rather small specialism*: it's like you only know about prison nursing, but the outside world has - especially with hospital, er, setting - you don't know much about it. So that's what I thought about it, and gives me the courage to really – you know - to decide that have to leave Philippines, I have to apply for that professionally and personally would develop you as a nurse.* He wanted enhanced professional opportunities but felt that promotion was slow unless you were in a favoured family: *You could stay in a very modest pay for 10 years without being promoted and that's it. And we have that favouritism, if you are a bit close to the manager you will be given some education at the same time, but in there as well you have to pay for it, if you want to further your education, but if you want to have a master's degree there you have to really work heard but we don't know how to - even though you work hard still you will not be able to cope with the fees (Alison: no, no) but at the same time, here I think - if you work hard, if you get to do some bank shifts - you will be able to pay for your university fees* and he decided to move to the UK*. To be honest, professionally, um professional development, um, I believe that UK has big things to offer when it comes to education; even though we had universities that is also offering this kind of job but I think, um, globally, um globally UK is offering the things that heads; you have the competitive heads when it comes to nursing (Alison: yes) to the facilities as well, at the same time. And second, well, of course, you need to also have - um - you need to look - to think about your future (Alison: mmm), because in the Philippines nurses are only paid very um - the salaries are a little bit low*.

He knew that this would involve a loss of prestige: *but I was really happy to do that, Alison, because I know that when I came here - I know in my mind this is just a steppingstone, and I need to have a little bit of experience.* Indeed this was even an advantage: *it's good to start the, you know, from the lowest level, and then you come up yeah? So I just thought it's a good thing, yeah? And then at least you know the lowest level how they feel!* When he first arrived he lived with his aunt, who had helped him get to the UK, and she remains the only person who has given him career advice. She did not want him to be a nurse and he studied business studies (she ran her own hospitality business) and also improved his English. He found the course interesting, but really wanted to get back to nursing, so took a job in a care home, as an unqualified nurse. The care home supported his undertaking a course leading to registration in the UK by allowing him to work flexible shifts and providing suitable clinical experience. However, it was still hard work, as he had to travel a significant distance to college, requiring him to leave home at 4am. Once registered, the care home would have employed him as a staff nurse, but were generous in not insisting that he stay with them, and he moved to a local hospital. He is grateful for all the training and development opportunities he has had: *even though they want me to stay there but have the choice, you know, that's the good thing here (Alison: it is, isn't it, yes) so no string attached - even though my manager helped - me no string attached you can go any time you want so it's for your own good.*

His first post was in a renal ward. He loved this work and found it very interesting. *However: So I was 18 months there, more or less 18 months, I loved the job - it was very interesting, very er - what you call that - er interesting and challenging, yeah, and then, it just happened - even though I loved the job - it just happened my wife, now, was working as well [] London so we met, so took up the short straw (Alison: laughs) because, you know, I have to be with my -um - girlfriend at that time, so I decided to look for something that is would also would interest me; for some reason the neurology, when I applied for it, first caught my attention, so because it is a different field, (Alison: yes, indeed) so I want to try, I want to try a, er, very different field; I don't want to be going to the same, er, you know, otherwise you will not know, you know, you have to be - as a nurse - I think, you should be, um, you should be with your own knowledge should not be confined with only one thing, with only one field of nursing you should have knowledge of almost everything under nursing.* Although interesting he felt that that post was physically very demanding and left no energy for him to pursue his career: *so I am just saying "how I am going to – you know - do my further studies if the workload is too much?" – you know - if its physically exhausting at the same time mentally exhausting so when I saw this job on the NHS jobs, so it's like "Oh its giving me something to" – you know – er, it's like something I hope that professionally and personally will develop me as a nurse*. Furthermore, his employer offered limited career prospects; after about a year, he wanted promotion but even more he wanted to develop his expertise. Towards the end of the interview, Josh shared that before he moved, he had witnessed a significant lapse in the quality of care: *actually I have seen that happen in my previous trust when I have done an incident report; because I don't want that to happen its pure dealing with er, you are dealing with lives, Alison, just imagine, Alison, it was my night shift when I received the handover there are some patient who haven't had any observation done since morning, (Alison: mmm) (*they were receiving infusions of infliximab, a powerful anti-inflammatory drug*) so looked like, okay, what I have done I make sure - I am not the person, Alison, that would really, you know, really fault finder, but I have decided because – on that day – I have decided because I have been seeing it for how many days already, so it's not good, so I need to make a statement "you should not be doing this, this is not acceptable" so I have done incident report. So the whole morning shift staffs had been investigating (Alison: had been talked to) yes, because this should not happen.* Josh himself did not link this with his wish to move posts, but it is possible that it contributed to his dissatisfaction. After three or four months of looking a new jobs he saw his current post advertised on NHS jobs. This was the first post he had seriously considered; *it caught my attention because these patients often experienced gastro-intestinal disturbance.* He was also attracted by the possibility of undertaking research. *Before I decided to apply for a job I had a previous, previous - thing what you call that.. pre employment visit, sorry, (Alison: oh right, yes) I had a pre employment visit so I was able to see what's [] is really doing during the - you know - because I - I need to know if I would going to love the job (Alison: yes, indeed) if I am going to like the job. So somehow when that pre employment visit I was able to decide Oh I think the job is little bit...it's interesting - because from my previous job that is band 5, band 5, so it's a bit, it's a lift to band 6 so it's a bit of a big responsibility and at the same time I think I just thought this would be challenging as well, so I need to be ready, that's why I, I, I made sure that I would have the pre employment visit, otherwise - you know - if you could not do good with the job why apply for it?* His expertise in neurology stood him in good stead at interview, but he made clear that he did not have gastro-intestinal experience*: I was also, by one of our - my colleagues that, er "don't worry if - um - you don't know everything about gastroenterology because I know you are coming from neurology; if there will be studies to be done there will be trainings to be done (Alison: yes) so - the only thing that we want to see if are - if you have the character, and if you have the responsibility that you can take on the job"* and he decided that he would love the work.

His wish for professional challenges in the UK has been satisfied: he has worked in a variety of settings and loves his present post; he finds meeting and assessing the patients deeply satisfying: *What motivates me? Well, Alison, it's the challenge - for every case, a different case - you have to face, you have to face every day, because some of them it will be just be easy to talk, but some of them will be a little bit tricky, you know, they will not answer you directly (laughs), they will not answer you directly so - so you have to work around it. And sometimes*

they would not, they would not right away believe your explanation (Alison: I can imagine) so you have to be really, if not at least a bit evidence based, know what you are talking about. 'before you see the patient - you have to look at their profile, everything: medical condition and everything; any test that have been done. You have to be able to explain to them the importance of that thing, of that test or of that management of their symptoms. So I find that one a little bit challenging! Furthermore he has participated in research and even got his name on a paper. Asked about mentoring he had received, he discussed training in procedures which had occurred in his different posts.

He is happy that his current employers are generous in their support for professional education, and he feels that he is learning every day; in the near future he would like to do an MSc, but he is not sure which and is vague as to the exact benefits of a degree: *it would improve my, er, er.. nursing skills; my nursing knowledge and at the same time my, yeah, mostly with my skills and knowledge in order to - you know - to further improve my nursing.* He thinks that he is fulfilling his potential, and has few long-term plans.

Name	Year of registration	Current post	Gender	Age
Margaret N	1991	Senior lecturer, community nursing	Female	40s

Margaret felt that her career options were limited when she left school: I'd have been doing my A levels at school and wasn't predicted to do very well, and my mum said "why don't you become a nurse?". She knew that I would want to leave home (long pause) and it was a way that you could leave home and have a career. So it was either that or going to secretarial college. So I became a nurse! She opted to train in London, again influenced by her mother: my mum spent her youth in London - I think they were possibly the happiest days of her life. I think she thought London was the place for an eighteen-year to be.

After registering, she wanted a post on her final student placement, a renal ward: I don't know why - I wanted a job in urology and um, I kind of - I don't know – it would have been 1991 or something, and you know, you do your management placement, and they kind of promise you job back, don't they, back in the 1990's, and the sister kind of promised a me a job when a vacancy came up, so I was waiting and I was waiting and I was waiting, and I went to do some agency erm, on a care of the elderly ward, and I kind of enjoyed my care of the elderly placement, but it wasn't really what I wanted to do, erm, and I got sharps injury… so I had to go and see the site manager and the site manager essentially offered me a job and I thought "this is been silly, I have been waiting for my urology job so long that I might as well, erm, take this job" and it was, was the wrong decision (Alison: taking the job the site manager offered you was the wrong decision?) well yes and no, I guess I should have just bided my time, because I think I took the job and then literally a month later I got a letter inviting me to interview for urology, (Alison: mm) but I thought I had taken the job be wrong of me kind of jump ship, and it was OK, it wasn't really the right job for me, it was just a little bit - it was the culture on the ward wasn't very, didn't, wasn't very forward thinking, it was a bit of a *kinda* dead-end kind of place, erm didn't have much pace there, it was all bit kind of sedate for newly qualified nurses but I guess had I gone and done a urology post then I wouldn't have left to do my degree (Alison: mm) and, you know, it was because I wasn't feeling very challenged on care of the elderly ward, they were nice, I met some nice people, nice patients, nice staff, it were nice, but it wasn't challenging, in any way, it wasn't vibrant enough, um, that made me leave to do something different.

She returned to university to do a first degree (using a student grant) then did a masters then kind of entered community nursing really just by, by accident so whilst I'd been at university I'd always been working agency (Alison: ah ha) and then, after the four years, it'd been mixed of nights and working in a day hospital and then nights again and then when I finished my master's I just said to my agency "ah, have you got anything different?" and they said "we've got a line of work in the community" and I said "fine, I'll take it!" Soon after that she successfully applied for a research post: they were looking for a community nurse, who they could support doing either a masters or a PhD, I think at the time there probably wasn't a great deal of competition to be fair. Whilst doing this she also completed her district nursing training. Once she finished her PhD I suppose I could at that point have gone straight to education but I felt like I had taken quite a lot - I think I had quite lot of support from the NHS, and - it wasn't appropriate to jump ship straight away... Didn't apply for it, but I would have had to put an application in (Alison: you must have done, yes) yeah, yeah, but you know, they asked me to do it - mm, so, um, obviously once I'd finished my district nurse training, because I had been sponsored by [], automatically they were going to offer me a band 7, and so that's what they did…. and then when I left that post I did leave intentionally because another post had been advertised, but again I think I was asked to apply for it, it was um, a post working with, um, metropolitan police, and kind of assessing older patients who'd been victims of crime - I was finishing off my PhD for part of it, so it was either five days then some of it was four days, and that kind of was of interest to me because my degree and my masters were, well my was primarily criminology and then my masters was criminology justice policy so, and a few people kind of knew that so that's way I was approached about that position, um, but it made sense for me to apply to that, and then after that - that was just a project - and when it came to an end I kind of automatically slotted into another post, another professional development post, and then like I said [] so a lot of it, it's just been kind of chance really, people telling me about jobs, asking me to apply for jobs, so I applied, you know. After a few years she was invited to apply for promotion if you think what an employer wants from an 8A then, I had it so they asked me to do it - didn't apply for it -.

She made an unsuccessful application with her current employers, a university, but they contacted her when another became available and she successfully applied for that. She was glad to move: I had been working clinically more or less from the age of eighteen to forty-four and I couldn't deal with the aggravation anymore - I felt it was taking years off my life that is, you know, I wasn't having – well, you know kind of just having palpitations every day, yeah, thinking it was normal to be super anxious - it wasn't fun anymore!

She feels that working for the NHS for a while was important: I've since seen people who've been supported to do degrees; master's degrees and so on, who as soon as they've got that master's degree they are out of the NHS, teaching, and I do always say to myself "well I am glad that wasn't me" and I do always say to myself (Alison: yeah, yeah), I am glad that I've, you know, done my God knows how many years in the NHS. However, there was no requirement for a period of service after her education.

She is concerned about the security of her employment: obviously security so, um, take into account whether it is permanent post or not (Alison: mm) so when I came into this post at [] it would say, initially it was a one year fixed term contract, so I arranged for it to be a secondment from my permanent employer, but still obviously didn't want a fixed term contract, it's no use to man nor beast, is it (both laugh) so, *er* I arranged to go on secondment, so certainly to a certain extent security. She continues to receive daily job alerts: (laughing) I don't know why! Just in case, you never know… Oh yes! I get daily alerts from jobs.ac.uk, I'm always flicking down it, flicking through it! (Alison: laughing why?) (laughing) I don't know why! Just in case, you never know, so yeah everyday get daily alert (Alison: and that comes from NHS jobs) No from jobs.ac.uk (Alison: ah, right, and you get one every day?*) E*veryday! (Alison: you are quite unusual!) *I*t used to be just in London, and then I thought 'no I'll widen it out just in case I ever want to move out of London' so, I've looked at jobs in

Northumberland (Alison: so that daily alert comes in, do you look at it?) Oh, yeah, on the bus, on the way in! Yeah (Alison: that's hilarious!*)* mm, because sometimes it's just, you know, it's just you see a job and then - sometimes it's just you do on a bus on the way home; I'd never go and work for university of [], because it used to be a college, the tech. *(*Alison: and that'd be obvious for you because it would be going back to your roots?) I was just thinking of it as an example so university of [] had a post for a health care lecture or something relatively recently, like I say I wouldn't go back to university of [] for many reasons, and I wouldn't go to [] college because for me its main college is the cookery college, but its still, you know, interesting just to open it up, look at the JD, look at person spec, look at the pay - it always makes me think I have got options - but you know, you do actually think, you know, it's nice to know that you, one has options (Alison: yes) and if nothing else maybe that's why I look at it so I know that, you know, if it came a time when I couldn't bear it, couldn't face it, I don't want to be sitting in the corner whingeing all day long (Alison: no) you know, that you just move on…
(Alison: you haven't got a LinkedIn or Facebook or -?) No, no, I think I started to do one of those LinkedIn profiles but I don't think I got further than my name. I have got Facebook for friends *(*Alison: right, so you do have Facebook, but you don't use it?) professionally, no
She retains ambitions within her current post, for instance she would like to undertake a new research project. She is rather ambivalent about her pay it's alright, it's not enough to meet my financial needs but um it's alright – yeah... how many hours (agency) do I probably do? About, only do about five hours a month or something - maybe I am not just good with money maybe (both laugh) it's just living in London isn't it, it's expensive, it's expensive. However, she has no plans to move this is me now, until retirement. She is vague about retirement: Do I prepare? Um, no, no. I kind of think about it in of my pension, I think about it (Alison: right) so when I came to [], um well obviously I was on secondment so I didn't have to worry about my pension, but then I became permanent at [] I had to start thinking about whether or not to transfer (Alison: ah ha, yes) my NHS pension over into, erm, whatever it is called, and those kind of things (Alison: are you paying any extra AVCs or anything?) No! (Alison: and you've not *go* to private – pension or anything) *N*o, I mean I have times thought about when I was working in the NHS because I had these kind of four years out, whether to buy back the years (Alison: ah ha) um, and I remember inquiring about it, and I can't remember, but I never did buy them back, (Alison: no) I kind of wish I had but - I don't even know how old I am going to be when I retire, so I don't know, I don't know.
Margaret says that she has never had any career counselling and she makes her own career decisions, she has no children but she is married: No, he's a teacher so he just moves from one north London school to another north London school to another north London school (Alison: There's plenty of teaching to be done, isn't there?) Yeah, particularly in [], so no, it doesn't impact, but I can imagine, I can see how it might do if you are outside London. I can remember when my dad moved we all had to up sticks (Alison: yeah) and move, yeah.
She says she tends to act quickly in her career decisions, and has never sought nor received career advice: I don't think I have ever made a career decision! I don't think I have ever, ever made a career decision; everything has just been chance, knocked onto chance, knocked on to chance, knocked onto chance. I have never made any major career decision because I have never changed career, I have been a nurse since I was eighteen.

Name	Year of registration	Current post	Gender	Age
Mark X	2008	Emergency planner; ambulance service	Male	30s

Mark knew he wanted to do a vocational degree when he left school: *I applied to two completely different things at University, so I really didn't know what I wanted to do; I applied to do nursing and I applied to do merchant shipping operations course*. He decided that the merchant navy, which involved long periods of time away from home, would not suit him, so he commenced a nursing degree. He enjoyed his course but: *towards the end of my nursing degree, I was really enjoying the clinical placement fine, but finding it really frustrating; um - I think - I don't know, I guess I have always had an eye on – kinda - the wider politics, and the finance and the - so seeing some of the things that were going on round the care that you were giving - you know - on the ward and elsewhere was just really frustrating sometimes*. By that time he had developed an interest in emergency care *So I got involved in that in a voluntary capacity, um, whilst I was studying, um and then towards the end of the nursing course we did a study day on major incident with [] and – er - got talking to, to him and to people I knew who worked in the field and decided that at some point after I qualified I would, sort of, do a masters in that, which I did.*
He commenced his MSc immediately upon graduation: *I funded it myself initially, it looked really interesting, um and I kinda wanted to do the role of [] was focussed on the kind of preparedness, resilience kind of thing (Alison: mmm) um, what was really nice in that it still gave me some clinical insight, um, and I think I have found that all the way through. It is that clinical insight and being able to kinda understand, then influence from a clinical perspective as well from a management perspective (Alison: mmm) has been really useful.* He was appointed to the ambulance service part time whilst he completed his studies: *initially it was a kinda temporary, well, not temporary but a part time administrative role because I really wasn't sure exactly what I wanted to be doing, and, I had signed up to do the masters and I knew that was going to be taking a lot of my time (Alison: mmm) um, so yeah, it really started very much as a part time administrative role with the [] and kinda broadened out and eventually it was a, a full time role working on various different projects, um, all from a - an emergency planning point of view, um but working quite closely with a lot of the clinical team and scientists, because a lot of my colleagues from the emergency planning world were - retired military and retired police (Alison: laughs) and that was - that was the cohort of people that historically have done emergency planning roles (Alison: Ohh!) um there are a lot more sort of masters courses, and you have some degree courses now, so people are coming into it, as a profession. It is that clinical insight and being able to kinda understand, then influence from a clinical perspective as well from a management perspective (Alison: mmm) has been really useful.* His work involves running a series of short term projects: *really varied, really rewarding, um, and I think because I have got a fairly project-based role, and because I have done lots of different things over the last five years, I am quite lucky in that they are all - you know they are quite happy to set me up with a new challenge, and say 'we want you to look at this for the next year, and then we are going to pull you out and get you to look at something else'*. He enjoys the degree of autonomy he gets, and the satisfaction of delivering a good project on time. He also enjoys the amount of inter professional and interagency working his work *involves.*
This is not a nursing post, and he now wishes he had spent a few months consolidating his nursing degree, but he feels that his background gives him valuable insights, and he has retained his nursing registration as his employer has allowed him time to undertake clinical work. I am quite lucky in that the trust are really proactive in terms of getting people engaged clinically (Alison: mmm) I think probably 5 of our 7 board are clinicians, so there is a real kind of - top down approach to making sure that people do get clinical time I am quite lucky in that I probably get a day a month as clinical, to kinda maintain my skills, which is really good, I think, in hindsight, if I did it again - I would be tempted to spend some more time clinically, um, before I sort of dived in, I think it would have been finding a, again for me, it would have

been finding a challenge, which as a newly qualified nurse is quite hard to do (Alison: mmm), and I think that's probably why I took a sideways step at that point, where I could, kinda, grab hold of something and start to shape it.
He has a lot of contact with young people through his voluntary work: *you have got be a certain kind of person and I wouldn't necessarily say its er - standard, you know it's not a standard career trajectory (Alison: no) for a nurse, erm, so I think that the kinda people coming out, you know, newly qualified - I come into contact with an awful lot of students, particularly through the involvement in [*charity*] and an awful lot of student nurses are at (Alison: really?) yeah, masses, and student paramedics.* Although he followed an unusual path, he finds he can easily recommend nursing because of the excellent opportunities to be had: *I tend to have a lot of conversations with the students and they speak I think quite broadly the range of opportunities that are out there, you know, it's not just being a ward nurse, being a A&E nurse, being a district nurse (Alison: mmm) there are so many opportunities out there, um, you know whether it is education or research or management, I look at what, you know, my friends I have stayed in touch with from my cohort have gone off and done – a really broad range of things, so I think it just kinda widening people's horizons as to the kind of things that are out there.*
For his own part he is pondering his future: *if you had asked me a year ago I would have said there (Alison: up the hierarchy?) yeah, but I look at what they do, and - they don't have any more influence to change things, they just have an influence on different things*. He is also considering undertaking another degree, possibly a PhD or MBA or work in the private sector for a short time in order to gain experience: *I really struggled to find something that, not knowing what I want to do, finding something that's engaging now, that will still be engaging and relevant to me in 4,5,6 years' time is a real challenge and I think the way my career is going - unless you've got some kind of finance or - some kind of private-sector health-care or business experience it's becoming increasingly hard to kinda make that move into a senior management post…. I think I've got to the point where there are two or three different options, but they are quite long-term - pathways. You know I've got to make a decision now about the next 5 or 6 years (Alison: right) um, and decide one way or the other, which is probably why I have been kinda mulling it over and not made a decision yet, um, but I think in terms of opportunity in the NHS the opportunities are there in abundance, you have got to go and find them, you've got to – you know – proactively hunt them down and ask for them.* His next career decision is likely to have quite long-term implications, so needs to be pondered carefully: *whether that will be the same in 5 years' time, probably not, when we will have had our next re-organisation and we will be going in a different direction, but at the moment that's where a lot of people are*. He feels emergency planning now has a clear career trajectory, which was missing when he entered: *with that comes the career progression, erm, huge amount or research is starting to happen, which is brilliant because it is an area that has had very little in terms of research and development and so there's a huge number of opportunities. And I think the other thing I would say about it is that it exposes you to - the whole of an organisation: you've really got to understand a little bit about the whole organisation, to be good at the job, erm, so even if that's not their end aspiration it's a really good way of understanding an organisation (Alison: mmm) and meeting lots of people in the organisation and across other organisations. I have been kinda proactively looking at options over the last 3 months and there are secondment opportunities all over the place (Alison: oh!) erm, there's – you know – external funding for a - a master's course, and I have just finished a, um, some work with (name of organisation withheld) um, for 6 months on leading change management. So, there are lots of things out there, um, but yeah, they are not presented in a brochure (Alison: no, laughs) you've got to go and hunt for them.*
However, health care is not as structured as other careers, where progression is more clearly defined: *to become a sergeant you go on a course and sit exams (Alison: yes) and is really structured, the NHS is really haphazard, in comparison, in the way that it - um - it recruits and develops managers, um, so you get a really broad range of people in those roles, which is good, um, but sometimes it lacks structure and – like I said earlier – there are the opportunities out there to formalise that; there are, kinda, courses and development (Alison: mmm) but it's not offered in a structured way, I don't think, um, it's something you generally have to go and find. Um, I think that some trusts are starting to organise that and provide it in a - a structured way um, but I don't think that is a consistent approach*.

Name	Year of registration	Current post	Gender	Age
Mary N	2005	Ward Manager (acting), coronary care unit	Female	50s

Mary left school interested in nursing but: *I went to college with my friend, and did hair dressing and beauty culture; And I wasn't really that keen on it, but it was that time when it was really hard to get a jobs... And we used to have a factory in the town where we lived. And when I was at school I said 'I would never ever, work in that factory' and then I did actually end up in this factory which was a good experience 'cos I made lots of good friends and there's a lot of ladies in there that have you know big characters... but there's some nice people there*. She left to have a baby and then moved to Germany and then to London, both with her husband's job, and, influenced by another friend who was a nurse, decided to undertake an access course to study nursing. Her later entrance into nursing is one of her few career regrets.
Her nurse education was complicated by her young children: '*obviously it affected my daughters when they were younger, you know they had to go to after school club and breakfast club, even though they didn't want to. But where we live we've got some good friends and, you know, we used to take it in turns to take the kids to school, so it - I've always had good support. And my husband's really, he's really good, you know, he'll put himself out, for things that I want to do, vice versa. But, you know, sometimes you just have to go and do it, and sort it out as you go along*. *But where we live, umm, we've got some good friends, and you know we used to take it in turns to take the kids to school, so it. No, I think umm, I don't think I've got any constraints. I mean the children are sort of more grown up now, and, I know my husband would support me in, you know, anything that I wanted to do.* However, she is proud of the manner in which they coped and that she never had to ask for special arrangements.
She initially thought that she would like to do community nursing, but was allocated to a cardiology ward during her final student year *I wasn't too sure about it at first, but gradually got to know what the ward was about - And then the manager then, because I was really interested, she said "Well if you'd like to come back for your last placement, we'd be pleased to have you". So I came back in my last placement and they offered - they'd consider me for a, a job on (the same ward). So, I got the job and started as a newly qualified nurse.*
Mary continues to work on the same ward, although *I did leave once - And at that moment I was a bit sort of, 'Why did I - sort of - come into nursing and -' we were short of staff and it was so busy, and I was a bit sort disillusioned with the whole thing - So I applied for a job.*
She liked the new work itself, which involved caring for elderly men: *You know there's a lot of lovely men there. And they had lots of good stories to tell…. But, when I got there it wasn't - what I thought it was going to be! It was more like a nursing home type of environment… because I thought it was gonna be a medicals admission, so if they were ill, they would come to this ward, they had a lot of umm, sort of dementia care and things like that. But this was supposed to be, umm an admissions ward. So, if they had a, if they needed antibiotics, but*

what i didn't know that, they couldn't do the IV antibiotics there, they would have to go to []. So even, (Alison: Oh) sort of to give in IV's and, things like that - So, I applied for my job back on here, and took me 6 months to get back here!... *I knew, the first week that I got there, I thought 'Mm, this isn't for me*.' The slower pace of the work caused her to worry about becoming de-skilled: *And I thought 'this is no good cos I'm gonna lose all those skills that I learnt when I was here*. Another problem was that her previous colleagues had now become friends, *and because our ward manager then she said, you know, cos I was upset about leaving, she said 'Don't worry' she said 'you can always come back if you want to' (both laugh) So yeah, so I've been here! (Alison: laughs. So you must have initiated that process within weeks of arriving at -) I did. (both laugh) I knew, the first week that I got there, I thought "Mm, this isn't for me." I mean, because the staff on [], they were, they were like friends and I'd know them when I was a student, even my mentors that were here. They, they were like friends? because the patients become, can become ill, that fast, it was so fast paced - You know, everybody was.. they're there for you really. And it's, the ward's always been like that.*

After her return, a band 6 post became available, but she was unsure about applying: "*I thought 'Ohh, I don't think I've got that in me, could I be a band 6?'. And my husband sort of pushes 'Yeah yeah, you can do it*.' Her husband also helped her prepare her presentation for the interview. After that she had the opportunity to act as ward manager, whilst the manager was on maternity leave. Initially it was to be shared with another nurse, but that nurse was "debanded" to band 5, so not eligible. She was unsure about taking it *but I said it would be good experience anyway - I didn't do it for the money*. *It's a good job as well (laughs).* She has enjoyed it, and would like to continue even though *it is hard work because you're sort of involved in clinical and management. But I enjoy people coming to me, even though I complain sometimes you know you just get - they've got this problem, that problem. And I do complain; but I enjoy trying to solve their problems… Yeah I'm actually not a, an assertive person anyway, so it's good for me in a way. Yeah.* However, she notices that her role is less clinical than it was *I do miss sort of getting involved the patients.* Nevertheless, when they are short staffed she does get to do clinical care. She also likes the hours in the manager post, which are traditional 7½ shifts (rather than 12-hour shifts), Monday to Friday. She is very satisfied in her post although it can be stressful but: *everybody's so supportive… everything on the ward, especially cardiology, because the patients become, can become ill, that fast, it was so fast paced? And it was pretty scary, but everybody was supportive, and said 'If you don't know anything, or you're worried about anything, you just let us know, don't feel silly or… whether it's just cos it's new to me, this management. Umm, you know. And it's a big learning curve, and it's a big learning curve when you become a qualified nurse. But this is, even from being a sister, because we didn't get that involved in the management side of it when, as band sixes on the ward, going to a band 7 and sort of doing recruitment and things like that, it is - I just, I enjoy the responsibility, yeah. I like the managerial side of it, even though, as I said before, we do complain about it. And your emails, and all that sort of - But it's a good sort of, there's a lot of new thing, like there's variety, when you're doing the management, stuff, and then you're looking after your patient, and I enjoy it, when I get a day when I do have to look after the patients and I, I don't think about that management stuff. So I can have the best of both worlds really*. Mary and the Alison also discussed the consultation and debanding: *We had to do an assessment, and she (*the nurse who would have shared the band 7 post with her) *actually lost her band 6. But she's, at the moment she's acting up into my band 6. (Alison: Right.) So, she's kept her band 6 for, we don't know how long. (Alison: Blimey!) And that's why we've lost quite a few staff, because of the debanding... Some people didn't really show that they were bothered about it but yeah. I think I would have actually left and found something else as a band 6 if I'd have lost my umm band 6.*

Mary never intended to have a career: *when I was a band 5, I didn't think I was really, what's the word? Umm, I was quite happy, I wasn't really looking to go, you know, like forward, like into band 6, and and never ever thought about a 7, -… Cos when I was a band 5 I thought 'Ooh no'. I, you know, I couldn't be a band 6 with, you know, people looking at me to sort of solve things, and being responsible, and, you know. Umm, but yeah, I do look at it different now. You, you can do things, (Alison: Mm) you know, if you say... you can surprise yourself…. You, you can do things, you know, if you say... you can surprise yourself*!... *I think it was a gradual process really. Umm, when I first took over the band 7, it was a bit, umm like - overwhelming? You know the things that I had to do. But you just have to, sort of, take each day as it comes and just, you know there's always help there, you know people with more experience, and we've got a good matron. And she's always there to help. Because sometimes you think 'Mm, I, I don't really want to ask for help'. Because they might think, you know, 'God, does she know what she's doing?' (Alison: Yeah.) But you have to, and they're there for you, you know if you're, if you're not sure? So, you just have to, you get through it. (Alison: Mm) Sometimes I think "Oh God, I've just got too much to do". But, you get through it. (Alison: You manage?) Yeah, yeah. Yeah.(Alison: Mm) I try not to think about it when I go home though (laughs). I think sometimes you have to shut off when you go home.*

She has never had career guidance nor any career plans, however if the ward manager returns she would look for a different job, partly because: *I don't really want to go back to long days and night shifts*. *Sometimes I say "I need to start looking", umm but unless somebody says, "Oh I've seen such and such a job", my friend does, and says "you know there is some heart failure specialist nurse posts out there". I looked the other week, but - no I don't.* The ward is due to move into the newly refurbished hospital, but not everyone is looking forward to it: *Because a, there's few people on here that would like to stay here, because we're in our comfort zone*. She is interested in the community, as she originally intended and, although she does not look at different posts, *there was some posts out a couple of weeks ago, but I thought "Oh no, I'll leave it for a bit and just wait and see what happens", but yeah. I would like to stay in this role, but if it doesn't work out that way, then yes, I will look for umm, something else.* She does not seem to really want to move: *I like this, I like the ward, I like the people that I work with (Alison: Mm); I like the speciality and it's something that I've been doing for quite a few years. Umm, I like the managerial side of it, even though, as I said before, we do complain about it. And your emails, and all that sort of - But it's a good sort of, there's a lot of new thing, like there's variety, when you're doing the management, stuff, and then you're looking after your patient, and I enjoy it, when I get a day when I do have to look after the patients and I, I don't think about that management stuff. So, I can have the best of both worlds really*. *Unless they want to offer me something else in the trust (laughs) (Alison: Oh, that's possible?) Yeah. Cos we are actually moving over to the new hospital in probably 2016, over there.*

She rarely thinks about retirement: *Mm, God, I haven't thought. Cos I've only been doing, you know I've only been a nurse since 2005* (10 years ago)*, even though -Alison: Yeah. That's not long - Mary: You know I'm 52 now and it's like - you know. Alison: It's like what? Mary: Well, I've just, well I feel as though I've just started really. Alison: Yeah, yeah. Mary: You know, we have got a nurse on here, that, he's been, well he's been in the trust 25, year, then he's a few, years older than me, and he's thinking about retirement. And I'm thinking, 'Oh gosh'. Alison: Oh. Mary: Yeah but. Just have to keep fit, and keep going… I don't want to think about that, cos it's thinking about getting older -*. One of her colleagues is much older: *He's been doing nursing for a long time. (Alison: Yeah) And I think his body's, just about had enough.*

Name	Year of registration	Current post	Gender	Age
Melody N	2007	Clinical nurse specialist (gastro-intestinal nursing) band 7	Female	40s

Melody can remember exactly why she came into nursing: *my dad; he worked as a nurse in army and he used to talk about nursing all the time... he retired at an early age, from the army... Then he always come home telling us how it is in Africa once people know you are a nurse they come to you with all their problems. And he was ever ready, no matter who you are. So, to be honest that really started me thinking, he always used to tell me 'oh gosh! You will be a good nurse'. I am a daddy's girl and I will follow him everywhere*. However, in her native Africa there was a shortage of nurse training, and Melody was unsuccessful in her application, so she studied first agriculture and then dispensing, and also had a family, all the while wishing she was nursing. Again, her father influenced her: *he used to say, 'when are you going to do that nursing yet'?... he told me that in London, United Kingdom, even after having kids, you can still go to school so…. I went to college one year, to do access to nursing and then the tutor really promoted [] 'one of the country's top universities and they will support you, I mean they will be with you throughout. So, she advised us and, well I took it and I went and I didn't regret*.

Melody's first job was on a gastro-intestinal ward in the hospital where she had done much of her training, and she saw the clinical nurse specialists at work: *Because we will get the specialty nurses do come on their ward and watching them and a friend of mine, she is done as practice nurse, we used to stand back and just admire it, and we will stand and admire them. So we always say gosh we will go into specialty,*. She applied in urology, *I was to do urology, because I was the link nurse that was () and I didn't get in. so this came and I said off course elimination is the elimination yes, so adopted and I did, did because it was more of doing anyway on that ward, so applied and I got the post and () so I started there before coming here.*

Before applying for that post: *I think the best thing that I did was I spent a day with - prior to the interview I went an informal visit, and when I got that post - before starting - I spent a day with the clinical nurse specialist, I said I really want to spend some time, she said don't worry, you don't have to come, you will be with me, you know, you will shadow me for about two month before we let you - two, three months depend on how you do before we let you go, so don't worry. I spent a day with her, it was okay actually it wasn't that bad, I thought I was really expecting something really bad, it was fine I think it was her, as well. She made me feel at ease so it wasn't that bad*. She worked there for two years and then *I had a meeting with line manager, because... what I was doing I know it wasn't a band six post, it was a band 7 post. But I was told you know, when because of the cuts and everything, we didn't have enough funding so I was told I won't get a band 7, I will be working for a band 6... 'till thy kingdom comes, so I said well if something comes up, I will go*. She actively looked for other posts and shortly after a band 7 post became available at another London hospital, and she applied successfully, which is her current post.

She enjoys the autonomy of the role, although she is aware of the degree of responsibility she carries, and she worries that she is sometimes expected to work outside of her specialism: *but when I first joined this trust, I commented to my colleague, that 'gosh you do a lot of things' and she said 'yes, we are jack of all trades' and I thought 'well, I think that is not right' and although, yes we are all doing the pelvic floor, we should - we all have our interests, so I think we should be put at where are strengths are… What I just hinted it to the management and what she said was I want everyone to have…. to know a bit of everything so that when someone isn't there you would be able to cover, there is five of us so -*. She is also aware that patients rely on her, and continued to work when she had a twisted ankle, because she did not want to cancel a clinic for which patients had waited two months. Indeed she can become very close to her patients, and when she left her previous post: *It was just heart-breaking, I had one clinic for patients come they come in every week and you know you get to know them, you really bond with them and some of them cried, it was, even now, I am just - it was the thank-you cards; the presents; it was just - overwhelming and -*

Melody has had good experiences of professional education. She believes that effective communication is central to her role, because of the need to explain things to clients: *I will say, I did a communication in-role development module that was something, I will advise everybody to do that course, it was part of CPD, it changed me so much the way my approach especially speaking to my colleagues, not so much my patients, because with the patients you get the training in the class room; how to approach patients everything, but the relationship, team work, colleagues, you know all that, how can you pick that up? When I did that module, so that () module has really helped me in the way we speak; how you approach; the tone of your voice; body language: you know you never think these things really matter but that particular module taught me so much*... She stresses the importance of informal learning: *As a clinical nurse you really have to open your eyes and open your ears and don't stop learning, because there is so much every day... With my career I would love to do my masters - you know - I really - I like learning, I think it's good, and I would like to do my masters', and I am looking at too, my final goal, I would like to be a nurse consultant, that's what I am looking up to. Oh yes, this afternoon I had a chat with - I was late coming down with a nurse consultant [] and I just admire her so much, I sat in her clinic a few times, Tuesdays, and I just - Oh Gosh! But the way she, you can tell that she knows what she is talking about, the information, how she speaks and how she answers questions from patients and the way she explains things, and even with her, how she examines patients its different, it's completely different… with my time I'll read. I did seek advice from her, I said look how can I develop myself, in my own time is there any books that I can read, any journals, anything I can do and she advised me a book, that I can get from the library, read this? Of course, you are doing everything, you're sitting () when you are free, with one of us which is good, read this book make sure you subscribe to '*Gastrointestinal nursing'*, which I do, so she said then you will be fine. And I attend relevant courses which I do, seminars I make sure - all the relevant ones - I make sure I go*

I love it, I love it, I love my career. Alison: That's great isn't it? Melody: I really enjoy what I am doing, yes, I think working autonomously… So, you really have to think and that is a big responsibility (Alison: it is) but I find that very good, actually, it makes me feel you know you always want to, really want learn more and you want to develop yourself, you don't just sit, () it gives, it challenges you, yes that is it, It really challenges you. She finds that others seek her help in professional matters: *Actually, this afternoon, during my lunch break I was having a chat with someone… she works on medical ward and she said she is fed up with the ward and it's just too much. Fed up on the ward or the ward environment she wants to move out, so I was advising her.* However, her work has caused her anxieties: *Personally, if I have known what I know now about the pelvic floor I wouldn't have had a vagina delivery it's really scaring me now and I think about it every day, I think I am starting to get nightmares. Alison: Do you really think about that every day? Melody: Every day when I see patients when they come in and when they leave it sets me off and I start thinking and for that evening for that evening I will do pelvic floor exercises (laughs) and I start thinking about it, but with my professional -.*

After the recording Melody told me that she had been at her Church and health professionals were invited onto the stage so that they could be publicly thanked. Later her friends teased her for being the first onto her feet, but she did not mind because she is so happy and proud to be a nurse!

Name	Year of registration	Current post	Gender	Age
Paula N	1989	Deputy director of nursing	Female	40s

Paula had always wanted to be a nurse: *I don't remember ever not wanting to be a nurse - I had just very naturally looked after everybody all my life. I'm quite bossy and I like herding people*. Even from quite a young age she was aware of senior roles: *I started to read the '*Nursing Times'; *didn't really understand very much about it - but started then following the Chief Nursing Officer... which is really odd! When I was younger I thought, "Oh my God, that's - what an amazing job!"* However, she hated school and left at 16 without qualifications, but with a place on a pre-nursing course including 'O' levels in the humanities, which she loved. After that she attended a school of nursing.

I was interested in public health right from the very minute of starting, but didn't know what it was... I would never have called it that and I was always interested in people's lives and where they came from and where they going back to. I always spent far too long with patients; always got told off for spending far too long with patients. She nursed for a few years and then did a full-time degree in health studies and entered health visiting and was promoted to nurse consultant.

She loved health visiting and was promoted to health visiting manager but: *my middle manager, the one above me, the service manager bullied me without me realising it for quite a long time, all incremental and then it got to a point where it was no longer viable. And I, so I left that organisation because the organisation made me feel uncomfortable, probably for my registration but I didn't think about it at the time. Alison: You weren't thinking in those terms; you were just thinking that you were - Paula: Yeah, I had to get out, in order for me to survive, it didn't fit, it didn't fit me and I didn't fit that. I still don't think they're right. I think, I think they're still quite a dysfunctional organisation, ten years on but that's up to them. I left because, yeah, I left for personal preservation reasons and it was the best decision because then I came to the health protection agency. So again, I probably would never have left health visiting because I loved the job had it not been for that manager so I've got her to thank in one bizarre respect… Well until I got bullied and then you don't know you're being bullied - that's the problem and then it's, then it's much more difficult to move because then your confidence is completely knocked. (Alison: You don't realise it's because you're being bullied you think it's because you're rubbish.) And it's only far later on when you, you reflect years later that you just think 'Oh how on earth did you ever, ever...how did you ever find yourself in that position?' but, you know, everybody does.* She embarked upon her MSc, where some of her fellow students were involved in public health, and she was fascinated: *I said, 'What's that mean? Who are you? Where do you work?' I'd never heard of it in my life, and I went to shadow them for the day as part of the course, and fell in love with it*. Shortly after graduation one of these students emailed her about a vacancy, which she applied for successfully: *and so, I've got her to thank*! *I don't really worry about stuff too much, er I don't - 'cos I've had my fingers burnt with that bullying. No, um, I just used to move. (Alison: laughs) Well until I got bullied and then you don't know you're being bullied - that's the problem and then it's, then it's much more difficult to move because then your confidence is completely knocked but I think.*

She moved into public health. Of this she says: *I've taken some risks in my career, believe me: I went from a G grade to an I in a completely different organisation. I was a - God only knows how I did that but anyway I did, probably not the right thing to do but I did - So, it's just, it was moon and stars, it was just that kind of nothing could have been planned it just plonked in my lap and I went, "Oh I will give it a go, I've got nothing to lose. I'm bored out of my tree now, I've been doing." Alison: You were bored, the job you were in? Paula: Oh, oh I was really bored. And when I get bored I get naughty!* Of her years as a nurse consultant she says: *I was a maverick, a terrible maverick; it was brilliant! I had the best eight years of my career because... I knew exactly what I was doing, and I pushed boundaries; and I didn't care, and I didn't follow rules and I didn't care*. However, she felt that she had reached a glass ceiling with nowhere to go, so she briefly entering teaching: *Oh, I loved it, every sodding minute of it, and I - because I love teaching.* She was beginning to build up a research and teaching portfolio when a job became available at her present employers.

Now, if I was a deputy director of nursing, but not in [], I would not be in that job. I would never have gone for it (Alison: oh, I see!) because my view is that, and my view always has been that when I look at directors of nursing, and I know loads of them and I work with them, I like to leave! I like to go and see them but I like to leave them because I don't like - it never appealed to me. Their jobs don't appeal to me. Erm, it's too, they're too structured, you're in a massive organisation that is constricting you because you are just another...you're on a treadmill, and you have very little autonomy actually, because there are rules and regulations and targets and financial penalties and the system pushes you. And so, there's this huge thing about the revolving door of nurse directors and it's absolutely true. There is a revolving door. They don't last very long. And so, it, so knowing, so the more senior I got, I became nurse consultant so therefore I was mixing with nursing directors all the time… I think, you know, you just kind of get to a bit of a hiatus, a bit of a kind of this glass ceiling because there was nowhere else for me to go unless I did a PhD which I didn't want to do… I'd reached the top of it. Er I got bored, 'cos I just - I could have done some things, but there was nowhere else for me to go ***nursing*** *wise, I couldn't have become an advanced consultant nurse. You know that's kind of it; clinically that's about it.*

She was now working at national level: *I have to think more strategically about - political messages that we give out, about our own behaviour... my gutsiness, my obstreperousness (if that's a word) and my maverick tendencies probably haven't changed too much*! This organisation was amalgamated with several others, and a director of nursing was appointed, who Paula admired and wanted to learn from. Paula started to deputise for her occasionally: *So, she said, 'Would you go and do this event for me?' I did that for her... fed back, all that kinda thing, like a good girl. I went all good girlish. I went all kind of head girl, all of a sudden, did as I was told because I had my eye on the prize and that's what I do - I can be a really good girl sometimes*. Paula even suggested to her that a deputy director of nursing be appointed and she herself successfully applied for that, her current post. However, it was advertised nationally, and Paula had to undergo a tough interview to be appointed. She also did it openly: *I'd been very open – so with the [*Senior nurse*] Group, …. I was very open from the beginning and said, 'I'm applying for this job, okay?' 'If you are, fantastic, let's support each other through.' And I said, 'May the best person get this because this is a really important job, so if you're with me fine, erm, but if you want to do it then completely fine and I will support you as well.' So, I was absolutely honest about it, and that was the best decision I ever made to do that. Nothing was covert at all and now I'm reaping the benefits because they're all completely with me*. This meant that *I started this job knowing that I didn't have to worry that anybody had shoehorned me in any way. There was none of this 'jobs for the boys' or nepotism*.

Once in post she took a year to feel that she was effective at that level, and that was partly as a result of feedback she was receiving: *Luckily for me I had an amazing boss who let me do it, she let me do it, and she's a medic. Um, and that's the only reason really that I ever came into this job, because without knowing, without realising it, I had the skills to do this job. (Alison: So, when did you realise you did have the skills?) About four weeks ago! (Alison: laughs) Yeah! When I was in it for a year I suddenly felt 'ah, it's okay, I'm not going to get found out'. All this imposter syndrome stuff, I'm not - I don't think I'm going to get found out now. So, I've been in this job now a year and people, the big people in this organisation are beginning to know, 'Oh Paula, right Paula, I know Paula, oh you're Paula.' Then I started to get feedback from people who actually deliberately have given my boss feedback to give to me. (Alison: mm, yes) That's when I started to*

realise 'Good God that's taken a year' internally. Up to that point. a few months prior to the interview: *I have been flapping about, I've been making some of it up as you go along, partly because nobody has had this job before.this recognition is quite widespread: So job scouts get hold of me and say '*Would you like to come work in Dubai?*' I say '*no thanks. What a lovely thought; very happy where I am; off you go.*' Some other people have made contact but not that many but it's okay, it's up there and I do my bit and tick the box.*
Paula says that she quickly becomes bored with work: *And I'd done it for eight years and if you looked at my CV I have never done a job for longer than two years at a time in the whole 20 odd years, no never, because I just can't be doing with it, because I'm like, I'm like, is it a magpie. I just, I just go,* '*Oh that looks really good, oh can I do that now, oh that looks*?' *And I don't think about what I'm leaving be'ind, I could leave stuff behind, I don't care, em, I'll just go and do it.* Although always interested in senior positions, she never thought such was for her: *because I assumed that these jobs were pen pushing jobs that were grey suits, that were quite civil service, that you'd have to do as you're told and you'd be, you'd just be kinda treading this big treadmill. And, and that's what I assumed this job was... I'm watching my colleagues and they're in a very, very different place. They're grey, they've visibly grey. I'm sorry, my life's too short. I've got a four-and-a-half-year-old. Um, no I don't want to have my life shortened because I can't sleep at night, because the Chief Executive is on my back. I don't have a Chief Executive like that.* She is happy in her present post, but worries about the possibility of her boss leaving: *I said to [] the other day that I really feel - I said between three and five years minimum that I'd want to be here before I even thought about anything else. Alison: But she will be thinking about succession planning. Paula: She's been thinking about it since the day I started the job, yeah. So, so yeah, so we're talking about it. So, I suppose her job but there may not be her job in five years.*
She has no career regrets: *I went back once. I said I was never going to go back. Don't ever go back. I don't know who says this but I say this. So, I went from [*town A*] to [*town B*]; [*town B*] to [*town C*]; [*town C*] to London and then London for years, London, London, London. Then I went back to [*town A*]; (Alison: mm) but it wasn't a bad career choice because I went back for a reason, but actually what it, what it did for me was to cement why I was in London in the first place because [*town A*] are about 20 years behind, and I was told categorically by my manager that over her cold wet dead body were they ever going to have nurse consultants in [*town A*] (Alison: laughs) and I said, 'Goodbye' er – and I don't think they still have, I don't think they are still! Er, so I came back to London again, and so that wasn't a bad career choice it was just a challenging one because I, I was a maverick but I couldn't get me own way – I couldn't get my way and I don't like not getting my way. And they just weren't listening and I, I think I was, I was ten years ahead of them. It wasn't they were ten years behind everybody else, but I was ten years ahead of them thinking-wise. And I didn't fit because nobody understood what I was talking about. I was talking about population in health and public health and they didn't get it. They don't get it. They still don't get it.*
I left clinical nursing in 19 -, really properly in about 1996, so, and I went into health visiting. Well you know, I went to college for three years but then I went into health visiting in 1999. So I've not been in clinical nursing for a very, very long time but it's the bedrock of who I am, and I... so all the skills of being a nurse – you know - and the attributes of being a nurse are through my core from top to bottom but what I don't see in a nurse director...so we're talking about acute trust's nurse directors or community trusts or even strategic health authority nurse directors, commissioning is that they don't have any freedom. I might be wrong but that's what I saw… I was never ready for this before, I couldn't.. even a year before I wouldn't, I wouldn't have known.' I would have said, 'What you talking about I'm not doing that crap, no I'm not doing that!' I wouldn't have been ready. So, it's just, it was moon and stars, it was just that kind of nothing could have been planned it just plonked in my lap and I went, 'Oh I will give it a go, I've got nothing to lose. I'm bored out of my tree now, I've been doing. She believes that it is important to remain grounded: *my closest colleagues and friends keep saying to me, 'Never lose yourself, never ever lose who you are. Be your authentic self. Be, you know, be, you have to be credible, but be yourself, don't try and be anybody else.' And I know now what they mean. I didn't know what they meant at first, but they, I know now what they mean, and it's absolutely right you have to be true to yourself but that's possible in this organisation. That wouldn't have been possible, I don't think in an NHS organisation…. but I'm now getting to a point where - I feel more confident in speaking up, for what I think is right, and, and that I now know that we're all making it up to some degree. We're all making it up, because somebody has got to make the decision haven't they, somebody's got to take a punt, somebody's got to take a risk at some point.*
In spite of her career success, Paula insists that she has never had a long-term plan; *I fell in, you fall in-and-out, don't you? And I think this is the point, in nursing you fall in and out of stuff, and it's not good enough*. She does not actively look for jobs but she does work very hard: *I have worked my arse off (laughing) for 25 years. I really have worked my arse off. I absolutely love it though... This is not a job; this is my life*! She now tries to avoid taking work home with her, and this has been facilitated by moving out of London. *I knew I wasn't getting pregnant and I lived in London and I said to my husband, 'We've got to move out of London I can't do this anymore. It's driving me – I can't, I'm so stressed out getting to and from work every day. I can't do it.' So we bought this little house in []… just the very fact that I was going on a train out in the open. Back and home. I thought,* , '*We've got to move out of London I can't do this anymore. It's driving me – I can't, I'm so stressed out getting to and from work every day. I can't do it*.' So we bought this little house out in West Byfleet, near Woking and just the very fact that I was going on a train, a train, out in the open. Back and home. I thought, "*How nice is this, I can see the sky, beautiful*." *I couldn't get pregnant for a very long so my job became very more important to me. The minute I got pregnant that was it - finished, gone home, rest, relax and I have done it very well since. Intrinsically weirdly I'm quite a lazy person. It's weird. When I'm not at work oh I can kick back fine, lovely, bring it on. I had a whole year off with him which was the best year of my life, of my life!! Ooh, I loved every minute of it! I absolutely loved not being at work. I never missed it for one sec (laughs). And when I came back I found it, I found that nurse consultant job really difficult, and I never quite settled in again… Since then actually it's changed me, it's changed me forever.* She has to rely on childcare by her parents, indeed she planned that before even applying for her current post. *We had a family meeting with the job description and everybody went, 'Oh fuck.' I went, 'Oh yeah, this is a really big deal. This is a really, really bloody big deal, I have to know you're with me or else I'm not going to go for the job.' They said, 'Right we'll move 'ouse.' So, they moved down, to do childcare, which they do, yeah, and it's worked out alright. So even though I don't know anybody else, by the way, who is in my position with a four and a half year old at this level, no. Everybody will say to me, 'You've got what, a four and a half year old? Jesus!' Most nurse directors are older or they've had kids younger because I'm late aren't I*
She does not look for jobs and is not highly active online: *so, I've got a LinkedIn profile; I've got bits and bobs to hand but, it's not brilliant, it's okay. It's a way in. The only thing, the only, the only reason for LinkedIn is, is, you know, is for scouts. So, job scouts get hold of me and say 'Would you like to come work in Dubai?' I say 'no thanks. What a lovely thought; very happy where I am; off you go.' Some other people have made contact but not that many but it's okay, it's up there and I do my bit and tick the box.* She monitors NHS jobs but: *This is actually, you know, me making sure that we are recruiting properly and we haven't got any grievances further down the line because blah, blah and blah, you know. So that's why I look at them, but I don't have any, I don't have any alerts coming through for directors of nursing anymore.* Instead: *I've never, ever set up an alert with anything ever in my life. I fall in and out of jobs. Mm, oh God, I think I've just been extremely lucky. (Alison: I don't believe in luck.) Well (sighs) erm, right place, right time. I don't actually know, unconscious, subconscious whichever it is. Unless I've got my id you know, my id and superid, whatever it is, something else is controlling me that I've no idea what's going on, I don't know, you know, phew!*

She occasionally ponders her retirement: I'm 45, right; potentially I could retire at 55 'cos I'm on that pre-1995 and I'm going to keep that bugger as long as I can! But to have the option. So part of me just thinks, 'Oh I can't go in ten years, are you joking? That's really weird.' I feel like a ten-year-old. I feel 20 still but my other part of my brain goes, 'Well, um, my husband's South African; we have family who live in Cape Town, and I want to be in Cape Town thanks very much.- but in really weird way, in a kind of ethereal way really because I can't imagine ever not working - I can't imagine being any older than I am! so I mean partly, we dream, me and [] dream every now and again about oh, wouldn't it be brilliant if we could retire but then I immediately think about all the NGO stuff I could do in South Africa. (Alison: So it's not going to be a retirement?) No because I would go and do NGO work because the amount of stuff that can be done in South Africa is huge, so it would just be changing places. I might retire from a job but then I'd have freedom. Aw, I can't wait it would be amazing. So, er, I've already got potential, potential things I can do.

Name	Year of registration	Current post	Gender	Age
Pitchie N	2001	Charge nurse	Male	40s

Pitchie was born in Cameroon. His mother was a nurse and he saw what she did, even helping occasionally, and admired her work. He considered studying medicine, but *getting to education - your orientation became something different which actually didn't lead you to that pathway* so he studied law for two years, but then needed to look for work due to the family's changed financial circumstances. He obtained a job in as a clerk in a civil engineering company. He felt his career was going quite well, and he took further qualifications in stock control. However, he became aware that all his friends were moving away*: I was even the last person in my batch of friends from school because it was like: 'oh no he travelled, he's not here'. Someone else has travelled. You end up making new friends again, all your mates are gone... All my people, they've gone and I came here and met so many people that I didn't even know!* So, he moved to the UK and studied business during the day, whilst working in a supermarket at night to fund it.

However, a friend was concerned about how hard he was working, and advised him to undertake nurse training; Pitchie believed that his immigration status would not allow that but, to his delight, found that he was allowed and that he already had the required academic qualifications, and he applied successfully to several universities to do adult and also mental health nursing, but chose the adult branch because he considered himself *a very handy man, I like practical things.* Initially he was unsure about it, but now he believes that he was led to do nursing: *I just said maybe that's the way God directed me to go but I was not seeing it, until that is, you have to stumble across all this, until you find the right path*. He had to apply for his visa to change his training: *I just sent it to the Home Office. I think that was quickest visa and passport I ever had, (Alison: laughs) it came so quickly!* Pitchie still takes a pride in using his business acumen: the stock control on the ward where he is charge nurse is excellent and he finds that his law background helps with ethics decisions. His only regret is that he did not enter nursing earlier, and possibly would have climbed higher in his career. In spite of all this he still sometimes wishes he had studied medicine. *it's a career which is so rewarding and so satisfactory and you're actually helping other people to gain back their life. And. It's so, so amazing actually, it's not something which erm, you work () and guess work, that's the way it works, it'll work fine, that's it, I don't care. When you're dealing with people which all need a life like you so you,*

As a student nurse he enjoyed a short elective placement on an orthopaedic ward: *I realised that: orthopaedics was a straightforward thing! (Alison: laughs). It's a specialty where a bone is a bone, there's no guess-work in there. You have a fracture, it's a fracture and you can see where the fracture is, there is no guess work. If you have to nail it, you nail it. If the person has to walk, he has to walk, if he can't walk you say he can't walk. If they have to chop off your leg, they'll tell you they have to chop of your leg because they see the damage. But when I look at medical, someone comes in and complains of stomach pain, I don't know how many things are inside your stomach. (Alison: laughs). How do you figure out which one is what? Is it gastritis, is it a stomach ulcer, is it um, um - a rotted bowel? Is it appendicitis? You find a lot of guess work there and a lot of investigation why we think the patient is deteriorating. But I get it on the ward, this one I just have to nail it and I nail it and off you go, you see: two crutches, you're out of the door, very realistic.it was a straightforward thing! It's a specialty where a bone is a bone, there's no guess work in there. You have a fracture, it's a fracture and you can see where the fracture is, there is no guess work!* His second choice would have been a cardiac ward but *I've always had a problem reading ECG! (laughing) I might learn at some point, but it was always one day you can get it, next day; forget it (Alison: I know, terrible, isn't it!) it and that's dropping again and too much up and down. It was good.* He is now settled *it's realistic and it made me happy. I had job satisfaction with the orthopaedics. I stopped here and said I'm not going anywhere, I'll work here and that's it!*

He finds his work satisfying work: *Thanks from the patient. He'll tell you, 'Thank you, nurse, I never knew I was going to walk but I'm walking'! So, I'm helping people, you're seeing a result, you are seeing the results and the people are really happy. Their lifestyles change, people, they're back again to their independence. So!*

He feels the pay is adequate: *You know pay is something people are never satisfied with, however much money they give you - So, it's something which I say, I leave to the specialists. Probably realise that our job, what they pay you, it's, it's commensurate with the job that you do. But being a human being, I would've said probably maybe they would have valued that work more and see if they could do something much better than what you actually receive at the moment. (Alison: mm). Yeah, because you can, imagine you, you say you work – what – about fifteen years I'm working here, physically it's like you're still in the same place, just stagnant, which I must say, is not really enough… It's ok*.

Asked about career decisions, he discussed professional decisions associated with work. He has never had career advice. And yet, he is beginning to become dissatisfied and would now like to chat matters over: *but you always try to look forward, what do you think next, I can do. (Alison: I was going to ask you about that) I can do a managing role, more advanced, or you know, like at one point I was saying I might want to, um, take on the MSc programme, MSc programme but what should I do? So you probably need somebody to advise, discuss, might talk about it at some point. Again, I say if I take that now, where does that take, lead me to? (Alison: yeah), so those are things which are in process. Where am I aiming to? Become one trust manager somewhere, very high up there? ... You want to take more challenging roles as you go along… I do think about the future, not being stuck in one place... Probably at some point I might get fed up with this and say I've managed so much, the same thing has become a routine (Alison: mm). Decisions that I make now I don't really () to make because it's some things I've been doing for years, (Alison: yes) managing the ward, running, doing this, how TCIs come in, how do I manage my beds, who goes out, who goes in, should this be cancelled because I cannot have a bed anticipating that tomorrow that this does not work, this works, (Alison: yes) then I liaise with whoever is involved.*

He does not look on NHS jobs, and does not have professional online presence, of LinkedIn he says *that link I was even trying to do, thinking I might have a go because I've got requests... but do I have time actually to sit down to prepare all these things and really put all those information in*? He and his work-friends ponder their retirement, but only in an abstract way *You see at some point one has to start preparing to retire, what are the things I have to do? You know, I keep thinking. Sometimes we talk here, 'You don't expect me to be running here at some point? Would I be using a Zimmer frame to run to catch up with a patient who is using the call bell?*!'

Name	Year of registration	Current post	Gender	Age
Rosie N	2008	Research nurse, commercial sector	female	40s

Rosie was born in Africa, and went to university there. Six months after graduating with a degree in sociology she moved to the UK with her fiancé in order to have a short experience of another country. There was an absence of career advice, so she took whatever work she could, a job in retail. She then started her family and found the hours difficult to manage. Meanwhile she found herself building a life here, and drifting away from her African roots; when she visited home, everything had changed. Therefore, she knew that she was staying in the UK, so after three years with the health visitors *I knew I had to leave, 'twas time to develop yourself, that's when the IT boom came, well I thought I'd do something IT related so I enrolled to do software engineering at master's level. But it was a bad choice and I identified that very quickly, within the month... it wasn't my skill set and it needed much more time and commitment. thinking I could learn sort of like programming quite quickly. But I think also it was a bad decision without any guidance just following the boom (laughs). (Alison: Yes) Yes so I dropped out quite quickly within a month I dropped out. She bought national newspapers to job search, and got one as an IT analyst, but found it dull.* She did this for three years, returned to Africa for three years, then came back to the UK: *you always come back and look for work, you think: what am I, who am I, what am I looking for? What job am I gonna do? So, I didn't like not having any profession, any career, any - just nothing to come back to, nothing to build on to* and she became convinced that she wanted to nurse. She had left her husband and children in Africa; she planned for them to attend British schools, and by the time they were old enough for this she had almost finished her two year post graduate nursing programme. *so Umm - I had worked as, I had worked previously as a support worker for nurses and health visitors. Umm - I began to know a lot more about their role and I felt it was, er, quite a responsible role that was recognised and had quite a good contribution to society and also quite respectable; I worked with health visitors (Alison: Yeah) so what they did was very, very – umm - worthy and worthwhile protecting children, and I felt I had the skills to do it. But I still wanted to develop my experience and skills, I went into nursing, I love medicine, loved it, loved learning about things, love developing my experience and competence and knowledge, and I knew I could, that was my character, I like to care for people and make a difference to their day*
Because I always wanted to be a nurse and nursing to me is really caring for people that are ill. (Alison: mm) (laughs) That's my definition of, of a nurse. And that's what I wanted to do. She thought perhaps she would be like her mother who planned immunisation programmes, *so her work influenced my views that she did quite good work within, within her field, so I did like that sort like community, she influenced me - so I knew eventually I'd like to specialise in some community work*. Rosie always knew that her career would not be ward-based, a belief re-enforced by some unhappy ward placements as a student: *I did feel that, in comparison to my colleagues, my, you know, the rest of my class, I had a pretty hard journey in difficult wards, that's what I felt… There was thinking about, in the community, district nursing, just something within the community. Alison: Yeah, Rosie: Yeah absolutely. So, when I had the opportunity in, as a student, to do the, the umm, the community work I did it in [] Alison: mm hmm Rosie: and, I thought was an absolutely great trust, and I would have loved to have worked for them, but err, when I, when I got work it was with the trust that I actually did the your original placement which was err []*
However, she took a post on one of her wards that she had hated as a student*: I got offered a job with the, my very first placement, the one I had the worst experience. Alison: Right. And you took it, you went? Rosie: I took it, because I was advised to - Alison: (laughs) Rosie: because the clinical nurse educators said 'just get a job, 6 months experience, you can move on' ... was their advice they gave me... I stayed a year! (laughs) I stayed a year! In terms of the nursing skills and practise and experience that it gives you, it's amazing [*but it was*] probably one of the worst, my worst experiences*. Although she enjoyed the specialism, she found the work-load overwhelming. *It's just the workload, the work shifts; they do this 12-hour shifts – very, very heavy ward, I think it's like slave labour; I think management know that, they don't do anything about it, they don't listen to staff. And they just accept it. I did it for a year partly because it's very difficult to find work when you're in a job that just takes everything out of you... I did it for a year partly because it's very difficult to find work when you're in a job that just takes everything out of you. Alison: mm Rosie: Completely! I can't, I couldn't even walk from the station home, I could beg my husband 'please pick me up' (laughs) yeah. Alison: Yeah, you were that tired. Rosie: That exhausted. (Alison: And so you, you couldn't, you couldn't be going on NHS jobs or anything like that) Yeah Never! (laughs) Absolutely, and I think lots of the people that stay there, it's because of that! But the variations between some wards and why they... have that opportunity to work in such flexible ways, as opposed to others, I don't understand it, within the same trust! It just doesn't make sense, and everybody knows ... In the NHS no-body is friendly; not because they're not friendly in nature, but they're so under pressure not to help you, no-body helps you or trains you, looks after you, there's absolutely nothing. You're just thrown in - survive. I just was determined to just look for work and when I looked for it, I found 3 jobs at once. And, my ideal job was a community work, but unfortunately when I went for interview I was so exhausted and I thought that the commute to there would be too far... when I got it I turned it down for a research job that was quite near home, it was probably just 15 minutes from home by car - I didn't really want to go into research. It was, I knew about it, but I still wanted to develop my experience and skills, I went into nursing, I love medicine, loved it, loved learning about things, love developing my experience and competence and knowledge, and I knew I could, that was my character, I like to care for people and make a difference to their day. Alison: So why did you go into research job? Rosie: Because I was exhausted and just needed an escape! (Alison: laughs) I needed something easy. Something to look after me. Just* - As she seemed to expect the work itself did not interest her: *so, you're dealing with healthy volunteers. I even hated it more because they were just all healthy (laughs)! We were just doing procedures - It's not really research in terms of developing anything in knowledge, in research.* But there were definite advantages to the role *I did stay a long time partly because it's quite a unique place in terms of it's a really nice company to work for -I've never experienced a job, where you walk out, you can go to the changing room and change 5 minutes before 4, 4 o'clock you're walking out the door! At the NHS the standard was I give the NHS an hour, at least an hour of my time on every shift, without any recognition - no recognition at all*!
In her research post she found a high level of support: *The training was wonderful there; you were trained for 4 weeks! You need to the law, the CGP (Good clinical practice; an international ethical and scientific quality standard for the design, conduct and record of research involving humans).... small things - the training was so comprehensive*. This contrasted with the NHS: *it shouldn't be like that, but I was signed off my drugs in one night. How did it make me feel in terms of security? Every day on the train I'm reading my BNF. Because I didn't feel I should have been signed off.* She could have progressed into nurse management: *That wasn't, that's not where I see myself, and look after Human, you know personnel, look at people's training… That's not sort of like me. And to look at disputes and people's satisfaction... I guess I could do it, but that's not at the stage I was at - I like to be stuck in it. So I didn't want t go more office based and just – manage.*
The lack of ownership of the research further frustrated her: [I left] *partly because you reach a ceiling as well, in terms of, as I say, it's clinical trials, it's not something that you can truly continue to develop* She was escorting a patient for a scan at another research company, *I came quite, quite often into [] because some studies involved PET scanning. So um, I just came, came here, bringing my volunteer. My volunteer would go into the scanner, I would just, you know, hang about, wait for them to have the scan and, talk to the staff. (Alison: laughs) I came a few times, and then [], one of the nurses said 'There's a Job here! Apply, apply!' I wasn't keen at that particular - you know you go through phases - I think looking for jobs it all depends on how happy you are in a particular time and point. At that time I was, I was quite happy, but... the job came and 'Ok, I will just apply because he said apply'. So, I applied - Sometimes you're keen to get out, but*

at that particular point, I was quite happy at []. Quite, quite happy; suited everything. Alison: (laughs) Rosie: in terms of my own personal life. Wasn't ready to leave, 'cos at, (name of previous employer withheld) you fluctuate, sometimes you're happy, sometimes you're unhappy, and - Alison: Right. Rosie: I think looking for jobs it all depends on how happy you are in a particular time and point. At that time I was, I was quite happy, but... the job came and 'Ok, I will just apply because he said apply'. So I applied. The interview was tough *and the other people who also applied were bank workers within this company, so I didn't feel I had a chance. Alison: Yeah. Rosie: I didn't feel I had a chance. So I didn't give it much importance in my mind if I didn't get it, 'cos there were already people they knew who knew more about the workings of this place,* but the manager there had suggested some of the questions that were likely to come up. *Rosie: She, she, she gave me just a hint just to think of examples, because their interview is very example based (Alison: right) And that's very, very difficult, very, very difficult… Give us an example where you find it, where you found challenges and contradictions and things, of, and what you did… But I found it very difficult and it was quite traumatising, traumatising interview in the sense that, if you had to ask a person all these examples and their career, and life, to give an example of a certain situation scenario where they demonstrated this ABC. It's quite difficult, and I found it quite, quite traumatic and I had a really, of the night I couldn't sleep (laughs) thinking about it. And how you came across in quite a difficult -.* The key attractions were that this post offered was that it was convenient for home and she worked office hours, rather than shift working. This meant that, although the pay was better, she actually earned a similar amount because she lost her unsocial hours pay. Also, she missed the vibrancy of working for a big company.

Rosie now feels rather stuck in her work, she is not learning much, and there are few prospects for promotion, but the work-life balance suits her: *I sort of like got the conditions in terms of the work life balance (Alison: Yes) that I, I, I need in terms of family life, and, time for your children and family. I'm happy with that here, but in terms of the work I feel like here I, I'm reaching the ceiling (Alison: yeah), in terms of the work and the challenge and you know, the learning, the learning curve. So I'm not sure - But I'm still sad that I haven't gone into sort of like the career path where I'd develop myself, clinically into some sort of niche area where I have expertise, and maybe I could do some research, and maybe do my masters – 'cos I don't want to do my master for masters sake. I want to do my masters in something I'm interested and passionate about, and really want to research. So I haven't found it yet… Ok I'm going on in age, do I accept that? (short pause) Shouldn't really. (laughs)... I don't have that extra feeling that - that I'm still learning, I'm still challenged.* She is aware that she has priorities other than her own career: *my daughter, firstborn was quite a high achiever and she's not a high achiever because she just has it naturally, because she works hard, and she asks for help... So lots of time I'm doing essays, researching... And coming up to the, even, even the GCSE's she was the 10 A*'s child, but I did lots of input... And A levels, the same. Going into, you know, applying in the medicine process, it's a very challenging time. We had to do lots of preparation in terms of all the extra things you have to do, and - so, helped her with a lot of that. Thankfully now she's in medicine and she's gone! (laughs) And it's now - time for me… I'd like to travel maybe experience, somewhere else, partly because I'm also bored of, life (laughs). There's nothing that offers, there's none much to offer it, doesn't offer anything, so maybe learn about another country, another culture, another system... I could travel. So I'm toying with that idea as well, maybe, we can take it as an opportunity maybe we can go 2 years in Australia, my husband is also a nurse, in fact he's just qualified as a mental health nurse… So it's, it's, it's I'm looking at other places that I know it's going to be much more difficult - I don't know yet. I'm looking - I might find something - Alison: Yeah. Rosie: I might find something, I'm positive. Yeah… I'm positive, I'm positive I think I might find some - It's just that with, with age as well comes the psychology that you know, things, life is passing you by, are you that skilled, cos there's so much competition in young people that's so good and [] and you think, you think that's your ceiling as an older person… once met a patient who says 'after 40's done you're all the way' (laughs)… and err I didn't believe her then, but I'm tending to believe her now because I'm also seeing the, how things are cropping up. But I don't think any severe that can affect me although... I don't think so yet. I'd like to think not, but obviously, there's certain things sometimes that start affecting your, your, your cognitive, what you think is your cognitive ability, maybe it's just confidence as well, I don't know. (Alison: Yeah) But as the moment I'd like to say no to that. (laughs)*

In the long-term she does have a plan: *When I don't have the responsibility and, well, the responsibility and err, of, of, of children and families, I would like to do more charity work and more in, in developing countries. (Alison: Oh!) Cos I'm originally from developing country.(Alison: Indeed!) So I would like to do that. Alison: Yes. Rosie: I'd like to, to go back to a situation where I'm really looking after people who sort of like my services will be quite essential. (Alison: Yeah, yes) And would make a real difference. I'd still like to do that. That was my original plan when I started off (laughs). (Alison: Oh was that your plan when you went into nursing? To go back?) It was my plan even, I think, as, as, as a person at school. I always wanted to do something for really grass roots level, even whether it wasn't healthcare, it was community development, agriculture... you know, environment. I always wanted to work with people who, in, you know. Who I could make a difference to – (Alison: Yeah) in the country where it's sort of like valued your services. I thought, that is my sort of my ideal work. (Alison: Yes. Do you think you will?) I think so -I'd still like to do that. Yeah that would be absolutely amazing*!

Name	Year of registration	Current post	Age
Tanya N	2005	Lead nurse, quality assurance and compliance	40s

Tanya grew up in Africa, and often had to care for her mother who had chronic ill health, which put her off a career in health, preferring first teaching and then business studies. As a girl growing up in war-torn Rhodesia / Zimbabwe, she was not encouraged to study, married young, and started to work in academic administration. She had no career advice, but was inspired by seeing others study, and decided to undertake a secretarial course, funding it herself by taking additional work as a courier. Her career was going well when, tragically, her daughter was killed in a road traffic accident and the following year her brother died suddenly. In her grief she looked for somewhere different to go; she was proud of her school qualifications, which were British, and her secretarial course was taught by two British women whom she respected. Her current employer was also British *he said to me, 'you know what, girls like you, they do very well in England, go there on holiday. You can make something useful of your life' but I didn't know what he meant*! However, she decided to come to the UK for a holiday, leaving her husband and children in Africa. She had enough money for six months and initially did not like London: *I just didn't like it. (Alison I am not surprised!) I didn't like it (Alison: no) because it was like - I just felt - everything not - it was dark, and I used to watch people and I always used to see people are sad.* She did, however, admired the business culture she saw about her. *But then, what happened was somehow in the process, I met these um, Zimbabweans, who were - he was going to open an employment agency in London. And then he said 'oh, he needed help to start up, so just typing documents' (Alison: yeah, yeah) and I said to them 'oh well, I can do that'. I was just doing that; they were paying me and suddenly - I stayed for two months and communicating with my husband and said 'just to see' and now I'm talking to people.*

However, whilst in the UK, she realised that her home was becoming unsafe due to violence, and many of the potential employers were closing. She needed to find work to extend her visa, so she worked as a clerk and a nursing assistant, which was relatively well-paid. She was finding that she had a gift for working with people that others found difficult, and thought that she could help families who were bereaved, and also possibly find healing for herself. She met some compatriots who were applying to study nursing, and they encouraged

her to do likewise, which would have allowed her to stay in the UK, and also bring her family here to safety. She says now that she was ignorant about health and the NHS, yet she enjoyed her training and found the university supportive. She now regrets not continuing on to obtain a BSc or MSc, but feels that, at the time, she did not have a long-term plan, but she stayed in the NHS for security. *So I, I did stay in NHS, erm, mostly for security, (Alison: yes) that's the main thing why I stayed on because of security.*

Once qualified she got a post in the Emergency Department where, as she has hoped, she was able to help bereaved families, *because I just wanted that direct care to people who are having tragedy just like me, so that's the point when I accepted to say 'I can now relate to people who are going through what I went through'. So that's how I got the healing for my daughter, that's the time I stopped talking about it, because I never used to stop talking about it. I could explain to you the death as if it happened yesterday (Alison: I'm sure) yes, but working in Accident and Emergency, it was just like 'here I am, this is the place'. When I come across people coming in after, you know, road accidents, trauma, anything, I can relate to them so it helped, it helped, it worked.*

After a while, Tanya got bored and saw a band 6 post managing a team of temporary nurses, which appealed because it was business and it *was quite a high-profile job; so I can work with anybody... and I got the job because nobody was applying for it!* Whist she was there she felt that she was working at a skill level higher than band 6, because her colleagues were senior to her. After about 18 months, funding for this post ceased, but a similar one became available in another hospital: *the director of nursing at that time was a fantastic lady and she really liked me. That was a window of opportunity for me, I should've just grabbed it, her mentoring around for me to do whatever I wanted but somehow, I think I was slow because I was busy focusing, you know, with work instead of me, you know, developing in other areas*. The offer was withdrawn due to the costs of the project but *one of the managers then approached me... 'do you mind applying for this job?' I said I don't want to because I don't like wards!... She said 'how come?' I said 'it's boring; I find it boring for me'! But then I think that time it was - because I'd been in A&E and I'd got this team of nurses who didn't work in one specific area, it was all over So it gives me time to really just plan my way out*. This was a post as ward sister on a gynaecology ward, and she applied because of the personal recommendation and: *it gives me time to really just plan my way out and there was a lot of work and investigations happening there, a lot of things that I learned, you know, that can happen.*

She liked the variety of the work, which involved caring for day cases as well as ward work. This gave her ideas about improving efficiency and she would have liked to have studied that for her MSc dissertation. She was concerned about unethical and inefficient practices. *I felt it wasn't supported and the promises that were made were never fulfilled – training, erm, courses, it was difficult to get a course approved.*

Things came to a head when an allegation was made against her, a nurse and a patient *what happened was they just plotted something with her patient. They told the patient what to say about me, so a lie was created*. She believes that the nurse was a known trouble-maker who had not been effectively managed in the past: *so what happens is managers have left because of the nurse* but. As well as being malicious, it badly managed *Some people have got a passion to love but with her, in summary, she's got a passion to hurt which is very sad, very sad. They told the patient what to say about me, so a lie was created and that lie, instead of it being managed properly, it was mismanaged (Alison: mm). Every corner, the wrong thing got to be believed, and it got to be believed to the extent that what I thought was a joke tended to be a nightmare. It costed me a lot (Alison: mm), it costed me a lot, meaning my mental status, my well-being, my chi... everything, because it got to the point where, er I didn't even know what it was all about. Because one day I turned up, after the incident, it was just like now saying a patient has complained that I didn't want her on the ward, that's what the patient was saying. But what I didn't know was this was a well-framed plotted thing. It only came out to surface three years down the line. (Alison: gosh) Investigation upon investigations, I went through a disciplinary process, I went through a nightmare, until it was so bad that, um, you start to have dark thoughts in your mind, because you're thinking, why is this happening? Well, it didn't make sense. Why? What was happening? Yeah. It was a nightmare, Alison! Then I had a breakdown, so I collapsed, I lost my hair. I never used to wear this. (Alison: Is that a wig?) It's a wig, I never used to wear a wig. I lost all my - It's like my hair just fell: At that time, I was being told they didn't want me to touch any patient because I'd caused harm to a patient and I'm thinking 'what did I do to her, I don't even know this lady; I didn't look after her'. The only contact with me and the patient was when I'm called by the doctors to say this patient is complaining and I'm going there as a unit manager to speak to a patient, and then (long pause) It costed me a lot (Alison: mm), it costed me a lot, meaning my mental status, my well-being, my chi - everything, because it got to the point where, er I didn't even know what it was all about - Investigation upon investigations, I went through a disciplinary process, I went through a nightmare, until it was so bad that, um, you start to have dark thoughts in your mind, because you're thinking, why is this happening? Well, it didn't make sense. The investigation was done and they pulled a big report like this. When I read the investigation document, I wept, I cried, I was hurt. What hurt me was that staff were lying through their teeth. People I had supported, you know, you carry people to support, they were giving statements like, um, I don't like Muslims, I don't like, erm, black people, I'm a coconut*[2]. It took a year to have a disciplinary meeting and another two years for Tanya to be cleared: *the HR lady was sitting in that disciplinary, came to me later and apologised. She said 'every time I saw you after that disciplinary meeting, I've never felt so wrong because I could see an innocent person just being torn into pieces… And then she said to me 'but the truth is that day, all the documentation, they wanted to dismiss me'. Alison: But why? Tanya: That was the question, why! Up to today I don't know Alison.* She mentioned in passing that she believed this was racially motivated, but also says that this is the only time she feels she has been the victim of racial discrimination. She tried a support group for BME women but: *I said but I didn't like it because she - the approach was not for me.*

After that she had several months off sick with depression and fibromyalgia. On her return, despite some individuals being supportive, she did not feel safe to work clinically, *ward because if people can lie, what more will they do if I go back*? She considered studying to be a health visitor, but felt that she was not yet emotionally ready for it: *So, it was quite a time where I would, rise up, one moment you can see I'm happy but another moment you can see I'm low.* Instead she worked in compliance. This is 2 years after the closure of the allegation and was followed by the consultation, during which some nurses were made redundant. Indeed, it was suggested that she should be down-banded because she was working in women's health yet did not have a midwifery qualification. She feels that she was not made redundant partly because she was protected by a few senior nurses, some of whom seemed to feel bad about the allegation. One such worked in governance. She worked for there a while, preparing for the mergers following the consultation. From there she moved to a branch of governance dealing with, ironically, complaints. *He's the one who'd been given the dirty job to investigate me and he felt so bad, every time he sees me. He said to me, 'What do you want to do?' I said 'I don't know but I wouldn't mind managing complaints for you'. He just said, 'Are you mad?' I said 'no, I'm not, I just want to manage the complaints, if there is anything for - you know - 'cos otherwise I don't really feel confident to go to the ward, it's too early for me.* She likes this work, which is interesting, complex, and detailed; she works

[2] Coconut: a derogative term describing someone who is of black skin but, allegedly, demonstrates the behaviour and attitudes of a white person

autonomously alongside senior managers. She enjoys the challenge of gaining people's trust and getting to the bottom of what actually happened.

Tanya has pondered suing the employer about the allegation: *Some people they will feel happier with money. Maybe I'm one of those strange people whereby that money would look like dirty money to me. It's like something that I don't know, that might continue to attract bad things in my life. I know people complain, 'Oh, you know what, I'm not getting enough' I think sometimes it's about what you do with it, isn't it? And I feel contented with what I'm paid, the reason being.... I am in a position where I see myself blessed. I have what - I'm living on it comfortably, (Alison: yes) I'm contented. I didn't stretch myself to be what I'm not. I plan my life with what I have. If I have to make extra, there's always room for hustling (Alison: chuckles), there's always room for business because with that business mindset, I do catering. I don't know. So, I just said 'you know I wanted answers'.* She is motivated by her religious beliefs. *And every day… I actually read the book of Proverbs so it's the wisdom I gain… That's the one thing I desire, more wisdom would help.* She supplements her income by catering for functions, because she loves cooking. She feels that, since coming to London, she spends money unnecessarily, and would like to stop this. She believes that she has skills that valuable in Africa, and would like to return there to work, unpaid, after her retirement.

She is endlessly interested in learning: *Because as a nurse, when I was a nurse, I would always say today I want to learn something from a patient I look after, every single one of them, the difficult ones, the quiet ones, the boring ones, the talkative ones, I have to learn something. But I think it's um, we don't give ourselves time to reflect on those things.* She is still pondering studying for her MSc: *I was trying to identify courses in governance. There's a course, that's mentioned there 'Understanding governance' or something but it never had a date on it, I don't know if that course has ever run. There was a course at, erm, [] University and the time I wanted to do it they said no, they're not doing it so I've been told there is a governance module as part of the MSc. But I'm not sure which, which MSc the module comes in. So, I would love to do, to really expand in governance, just to be a governance person because I feel that with governance you, you have such an important role. Because some of the things you identify, the managers on the ward might not have time to look at them and think about them. The consultants themselves, some of the things that are reported they would not have known about them, that junior staff did. So I really want, my focus at the moment, I really want to work on my courses in governance, and just to be actively involved in governance.*

She thinks her future is likely to be in governance, and she is not currently job-hunting. She reads job adverts in the nursing press and checks the *NHSjobs* website and watches her senior colleagues, to see how managers work: *because I work with the band 8a and 8b and these managers that are interacting they are quite senior managers. So, my first process now, I always say, 'you know what? I'm not going to be thinking like a band 7'! I have to learn, if they say things I will have to learn so in a way. You know, when I did my nursing, I actually did a five-year plan. (Alison: chuckles) I did a five-year plan and one of the things I put down was by the time I get ten years in NHS; I want to be a director but then I didn't know a director of what! NHS is massive! So, I used to think 'OK director of what?' I used to have this lady boss and I was a band 6 but I was being managed by the Director of Operations, who was managing band 8 but I'm being directly managed by her. I had a budget of £2 million plus in band 6. So, I used to question 'band 6, why am I this level' and I used to go to the Operations Director report meetings so I'd email her and say, 'Am I supposed to be coming for these meetings?' and she'd just say, 'I want to see you in that meeting,' so I would just turn up, and I did learn a lot.* It appears that the allegation finished such ambitions: *So, before this - er what I explained to you what I went through - I used to operate with targets, this time I want to be doing this.* She is an avid reader: *People love – maybe - other things; clothing, for me it's the books, there's something about books. Stephen Covey's book, 'The 7 Habits of the Most Effective People,' I got a copy in 2000 even when I was doing my training; I used to read that book all the time... sometimes I might feel quite low. I have to be honest, after the experience [*of disciplinary action*] I tend to be quite depressed at times, days where I just feel low. So, in my library, I just go and open a book so I can read something and it will cheer me up*.

She remains aware of her job security: *like let's say – God forbid, I don't what the career goes – let's say there'll be another consultation, they say they don't want this role, I can easily just go back to clinical, you know, or something else. But one thing I've learned is you need to be connected, you need connection to people because whatever I'm interested in, you might even know who needs somebody but sometimes I think in isolation, you are on your own. You don't know what is happening and when you are affected by these situations, it does hit you very hard. There's a lot to learn, yeah, there's a lot to learn!*

She is beginning to plan her finances for retirement, and also to think about saving for her children's futures *now it's about being satisfied, it's about making a difference with what I do, and then also investing, living, inheritance for my kids. So, I'm working on that one because the plan I've got in my head it is quite crazy. Because I read that there's a point whereby your investment should be three quarters of your salary (Alison: gosh) you know three quarters of what you earn should be your investment because if you calculate that in ten years' time, it's a lot of money. Because it would, the discipline to do it, if I manage to save three quarters of my earnings in a year, then it's easy. The difficult part is the first year… I said immediately I turn 47, I'm going to do that. By the time I'm 57, even if it means to pay off the house.* She feels that much money is spent unnecessarily, and tries to avoid this. *When I retire, I'm not going to be a sitting at home person, not me. (Alison; no I had a feeling that is what you were going to say!) Not me! Because I do have, sometime I think, not even I think, I believe I will do it as long as I focus and I put my thoughts into it, I'll do it… I still want to do, there's some projects I do want to get involved in, erm, back home. One of the things I have always felt, you know, feeding children, at a specific age and at the moment I don't really know how I'm going to do that. Because a lot of people have studied charities back home and there's some charities that start and don't go anywhere and I don't want to do that. I want something that will stay. I want something that will stay. So I still do, now and again, think and be involved if there are functions with people, I do go and see and be part of it but I would love to be involved in the health of a woman, part of having women in gynae because in the African culture there are still a lot of beliefs where people use potentially dangerous products for their well-being.*

Name	Year of registration	Current post	Age
Trudy X	1989	Social worker	40s

Trudy was unhappy as a nurse and agreed to take part in the research but declined to be interviewed: *I don't feel I want to revisit over 30 years ago.*

Trudy never wanted to be a nurse, but when she left school at 18 she was too young to commence training in social work, *so instead of waiting, I started my nurse training and undertook a diploma in nursing, and then trained as a midwife*. She moved to work in the community, which she much preferred. She identified that her patients with leg ulcers were not benefitting from modern treatments, and so introduced new methods, and went on to train other nurses and also General Practitioners in these methods.

Her husband's employer was moving out of London, so she and her husband moved with them. She obtained a post, working part time and in a lower band, but *however, when the grading system came into being it made a huge difference to how I was able to practice e.g. When I worked in [] I was pivotal in introducing a new treatment for leg ulcer management and trained over 20 nurses in using a Doppler to improve assessments. I also arranged training sessions for local GPs. When I moved to [] I worked part time on a lower grade and even thought I had the experience I was not permitted to assess patients, support with leg ulcer management. This increased my frustration towards nursing.*

Nevertheless: throughout my time working as a nurse, the desire to be a social worker remained. At the age of 38 it was make-or-break; nursing was changing. In order to progress further I would need to complete a nursing degree. I made the decision to train as a s/w and qualified at the age of 40. I have never looked back. She does not regret her time as a nurse, but she also feels that she would not enter nursing now.

Had I not retrained I think I would have given up nursing. I, like many of my generation, look back at the 'good old days' of nursing when nurses nursed and cared for patients. I have been chatting with nurse friends and the majority say they would not now go into nursing today because of the changes. We are all of similar ages and often say ' we wish we could go back to the good old days of nursing'.

She worked as a medical social worker, based in a hospital: *I loved being a hospital social worker; I hated working as a nurse in hospital*!

Raw data from *Survey Monkey*

The charts below show the data from the survey of nurse participants and manager/educator participants. These are shown side by side because most of the questions were the same. There was also some biographical data, which are not shown here, to protect the participants' identity. Theritten comments are also provided

Early career decisions

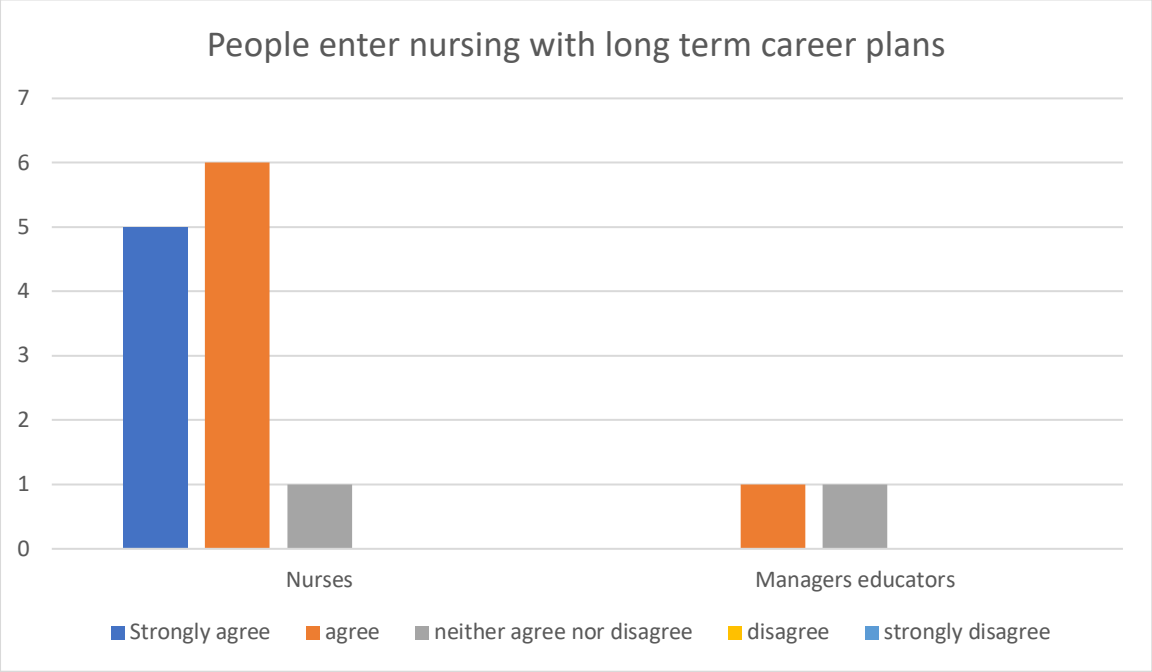

Table 3.1 Entering nursing

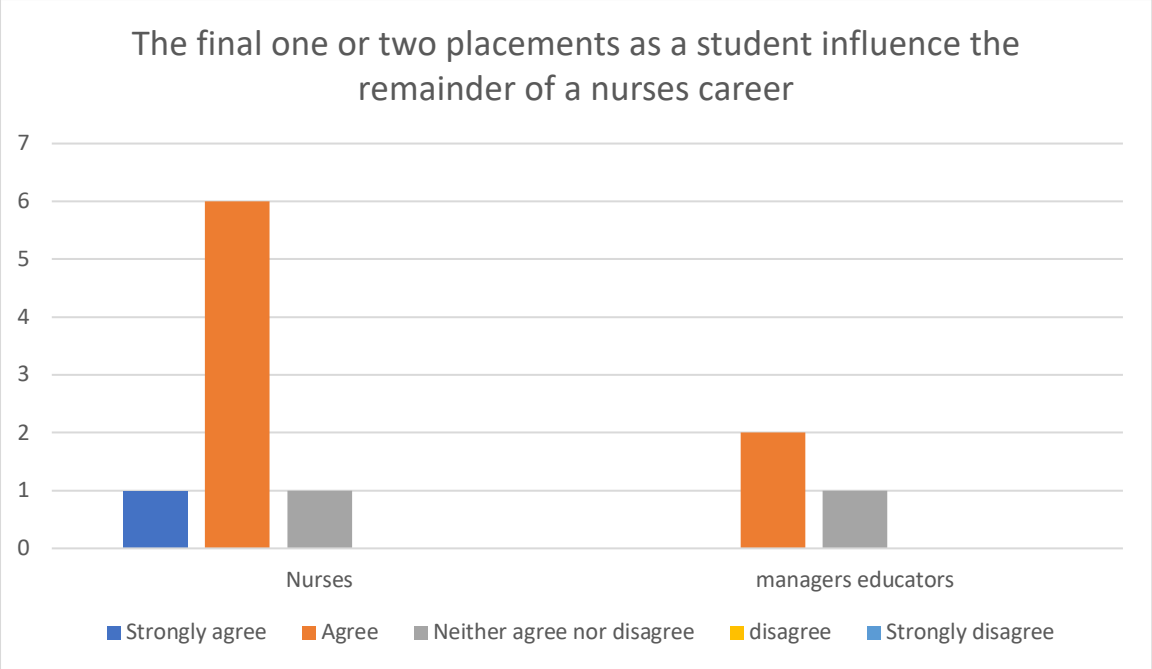

Table ap 3.2 Influence of clinical placements

Early career decisions would be easier for those with a clear vision of what they wanted, however I still believe that a rotational programme for newly qualified nurses can help in deciding early career decisions as they spend time in different specialisms ie 3-6m months, unlike when they are training, the experiences are different. (Nurse respondent #12)

Final placements are often chosen by the student and so are common ly linked to their likely career path. (Nurse respondent #7)

Placement experience is crucial about career choices within the speciality. Why are some specialities more attractive in terms of working conditions: shift pattern, patient: nurse ratio, training and mentoring? (Nurse respondent #6)

I was certainly influenced by final placements. Gave me the knowledge that I wished to focus on the medical area rather than surgery and to further specialise in a sub area of medicine in future. (Nurse respondent #5)

Sometimes people take up a career for job purposes or as a stepping stone without any long-term plans, while others do, aiming to go further and higher up the scale; I cannot really speak for people. (Nurse respondent #4)

My career has evolved over years and I have made new decisions as I have gone along. (Nurse respondent #1)

Most nurses think they know what they want to do eventually when they enter nursing as a student, though whether they actually end up doing this is another matter! (manager / educator respondent #5)

Personally, I didn't have a career plan in mind at the outset (beyond wanting to be a nurse, of course). In my final placement all I knew was that I had had a lot of surgical experience so wanted to do some medical wards once qualified. Beyond that, I don't think I knew where the career would go. I do recall someone telling me that "the career found you rather than you finding the career! (manager / educator respondent #4)

My last placement influenced where I worked after I qualified, but I have since left that area. (manager / educator respondent #3)

My 1st ward placement was colorectal & I felt strongly from then on that this was an area that I wanted to work in, to "do" better. (manager / educator respondent #2)

Working as a nurse

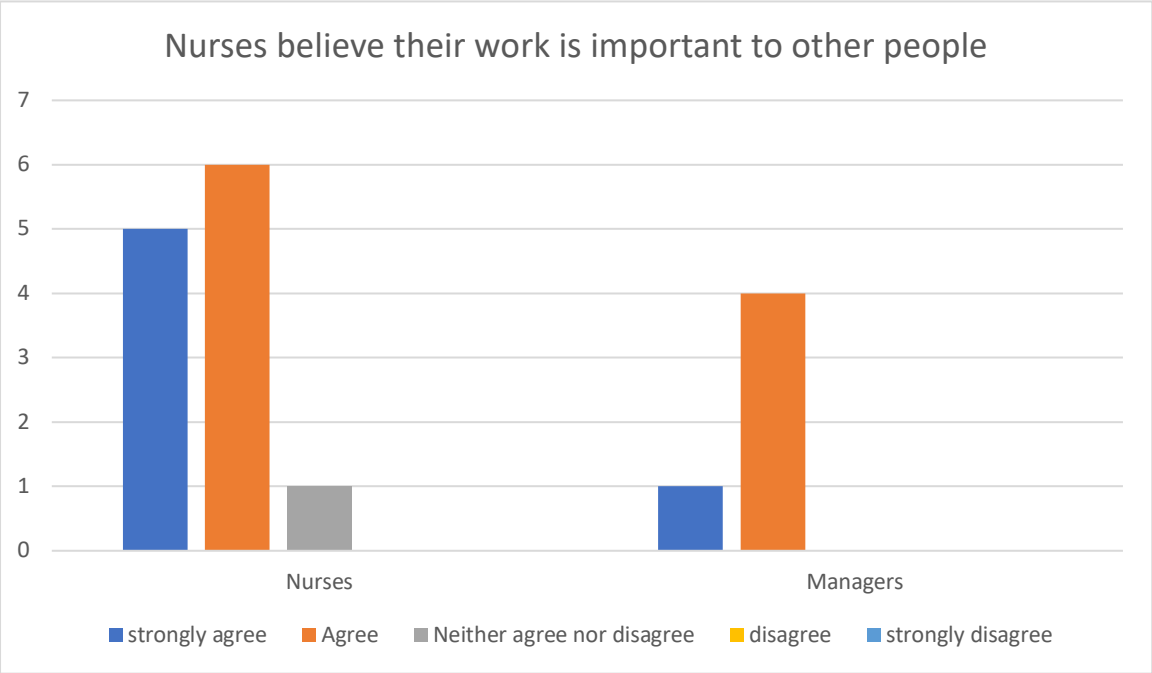

Table ap 3.3: Nurses believe their work is important

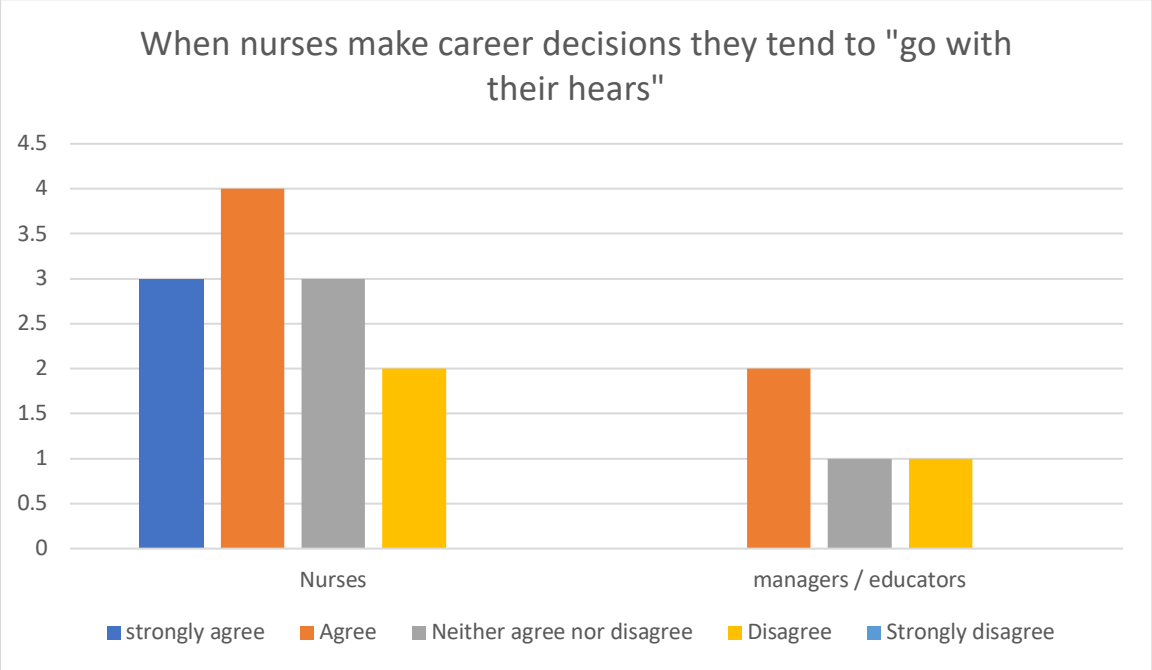

Table ap 3.4: Going with their hearts

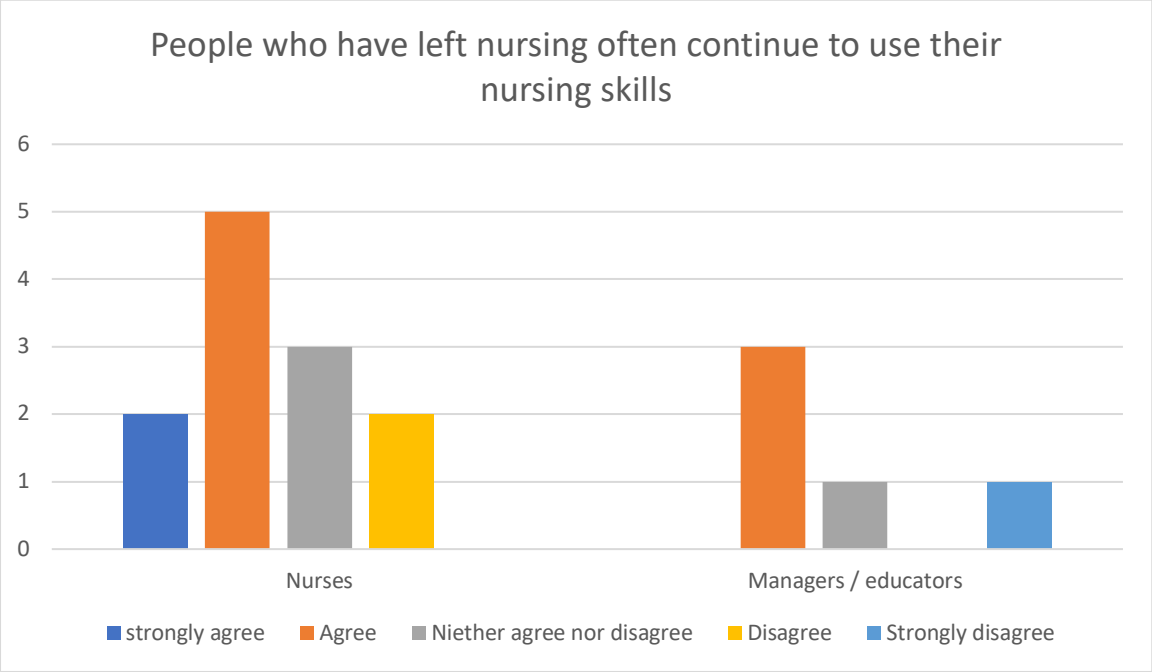

Table ap 3.5: Continuing to use nursing skills

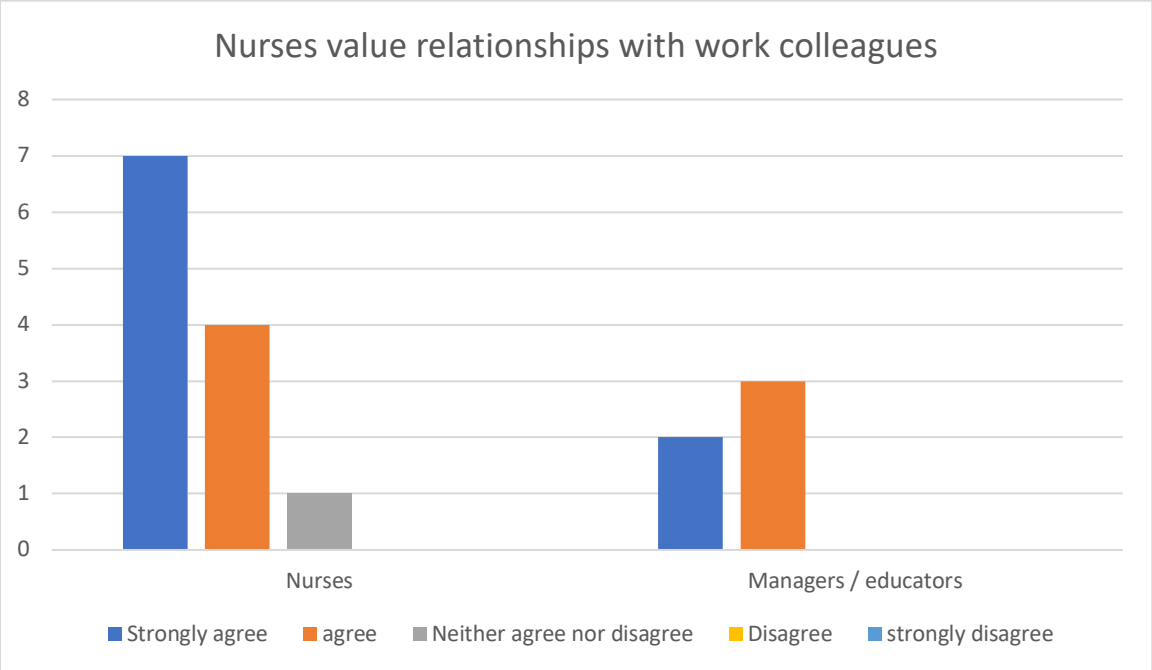

Table ap 3.6 Valuing relationships with colleagues

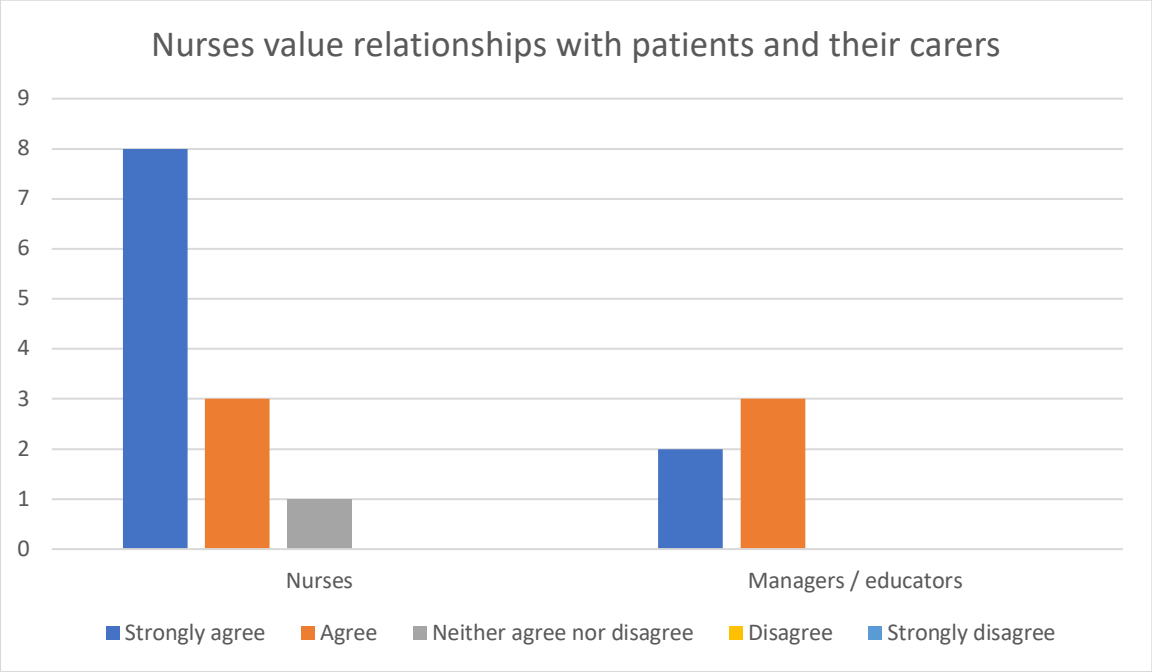

Table ap 3.7 Nurses value relationships

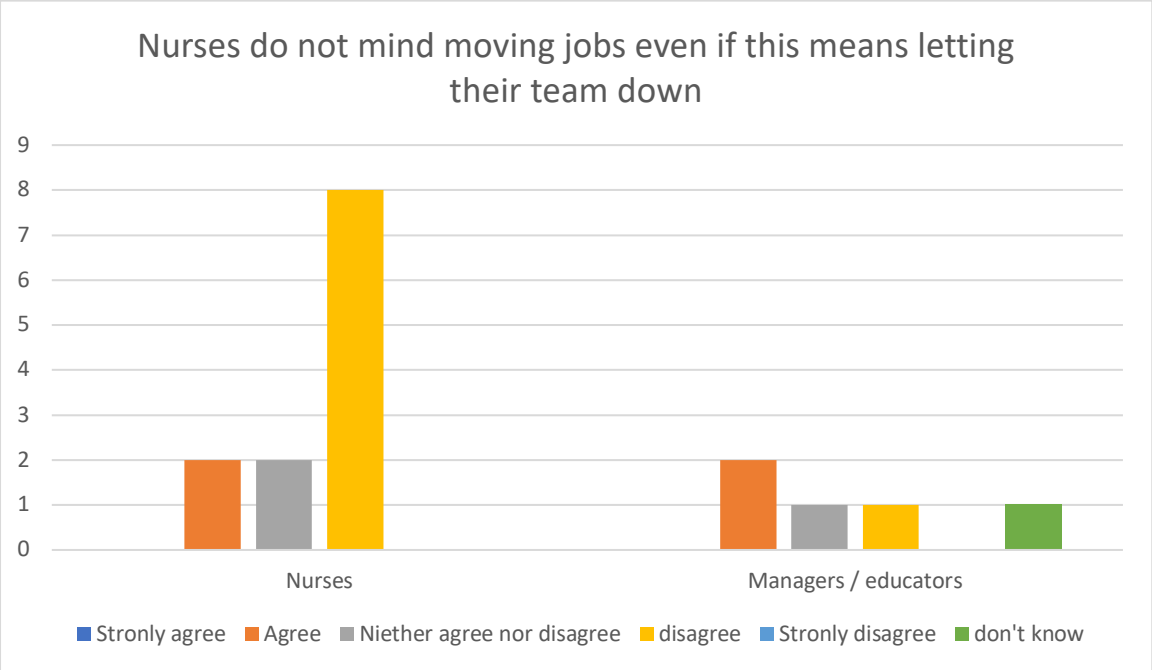

Table ap 3.8 Nurses do not mind…. letting down their team

I would move jobs for better working conditions, pay or closer to home. I would give my team enough time to find a replacement, thus not letting them down or affecting patient care. (Nurse respondent #11)

Nurses need to feel valued and for their contribution which, in a lot of cases, is above and beyond as they work over their paid hours, take no breaks all to do as much as they can for patients. I am not sure how much management and the profession advocate these facts for nurses. (Nurse respondent #6)

My team is what keeps me in the role. If I go on secondment, feel guilty for leaving them. If worked as part of a different team may have moved roles / positions at an earlier time. But the fact been on same ward / role for past 17 years. Without the team job satisfaction be very different. (Nurse respondent #5)

Nurses will value relations for team work and treatment purposes as these makes their job somehow easy. Some nurses will continue to use their skills where necessary, but not as routine. (Nurse respondent #4)

On-going career decisions

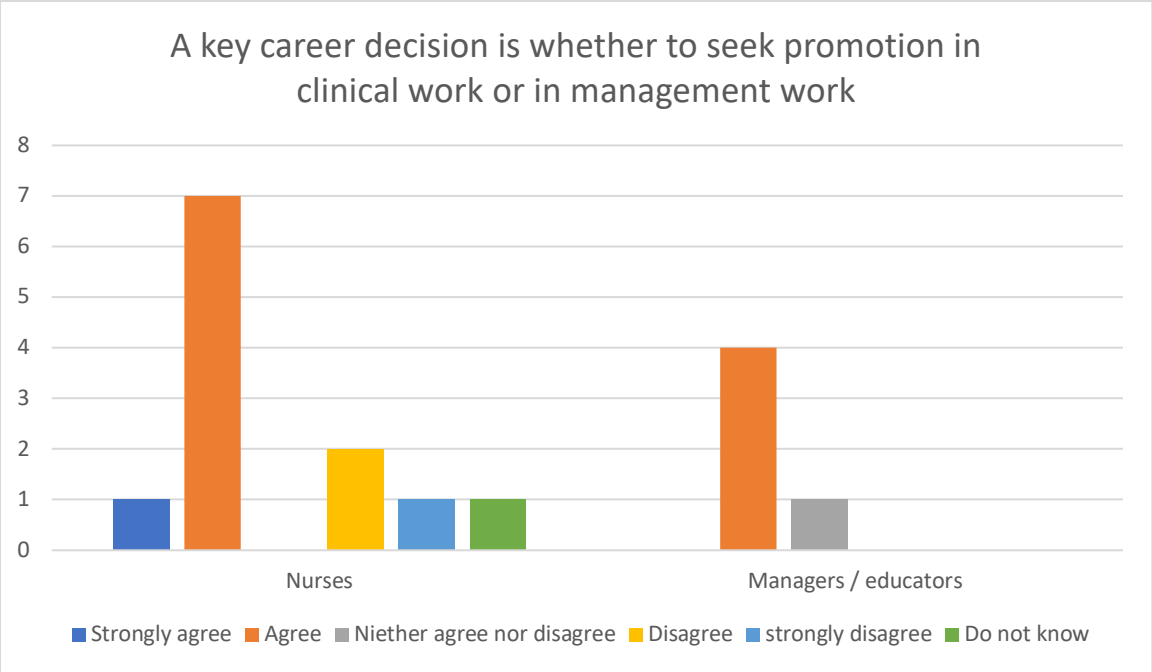

Table ap 3.9 Clinical work or management

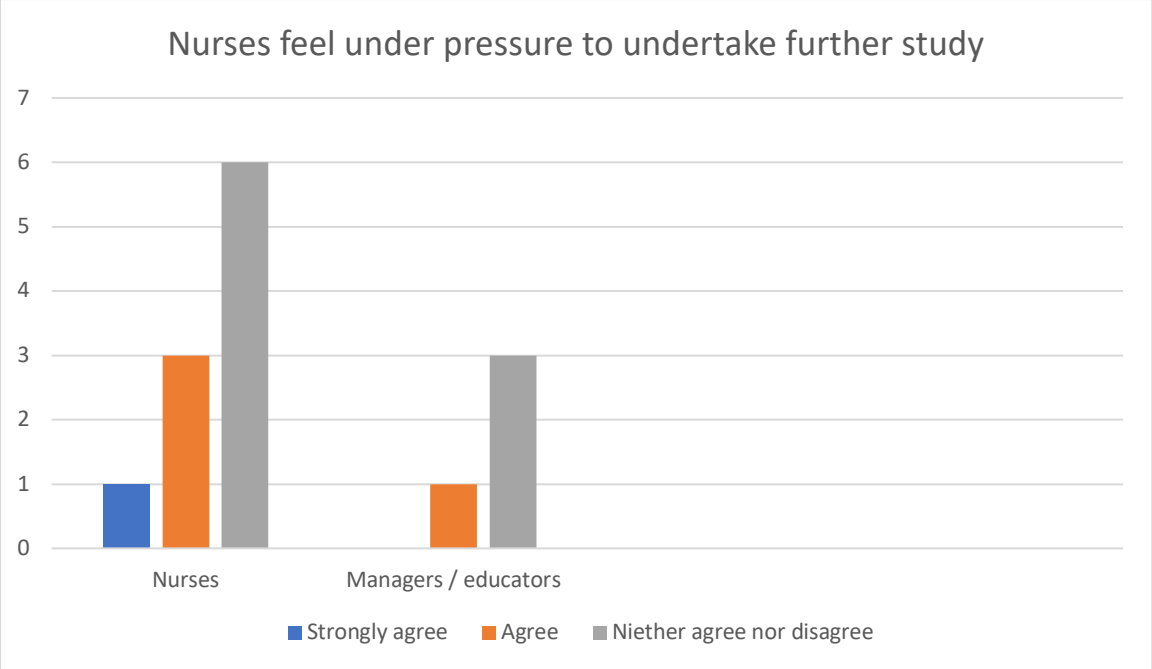

Table ap 3.10 Further study

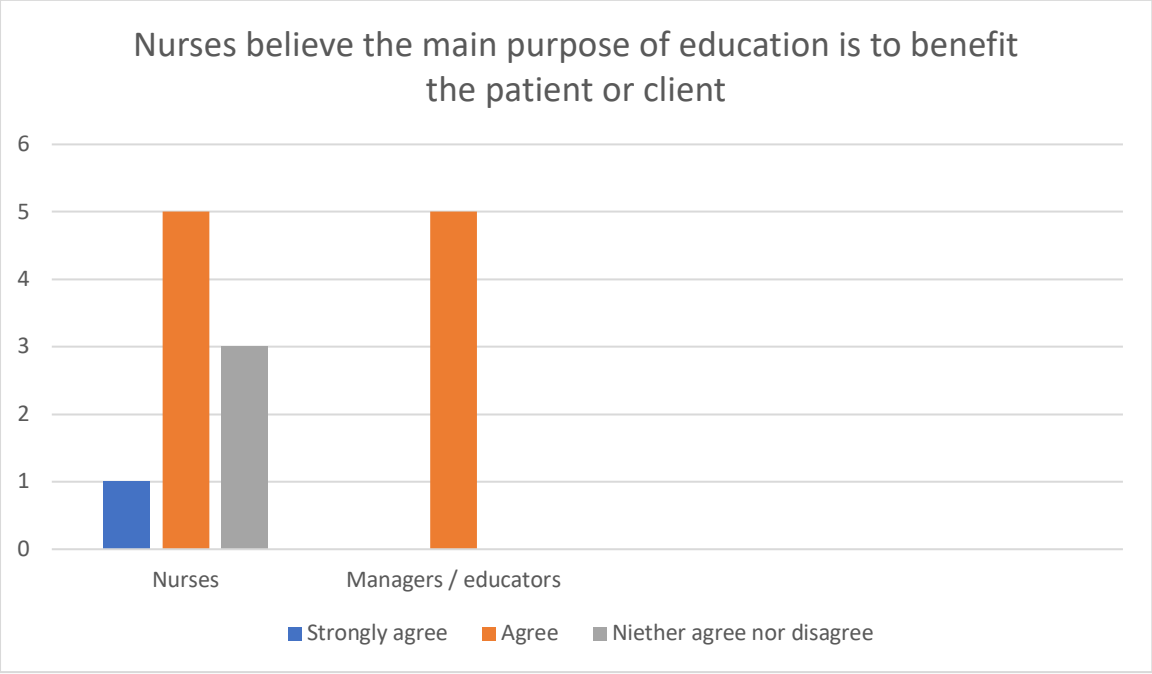

Table ap 3.11 Benefit to patient or client

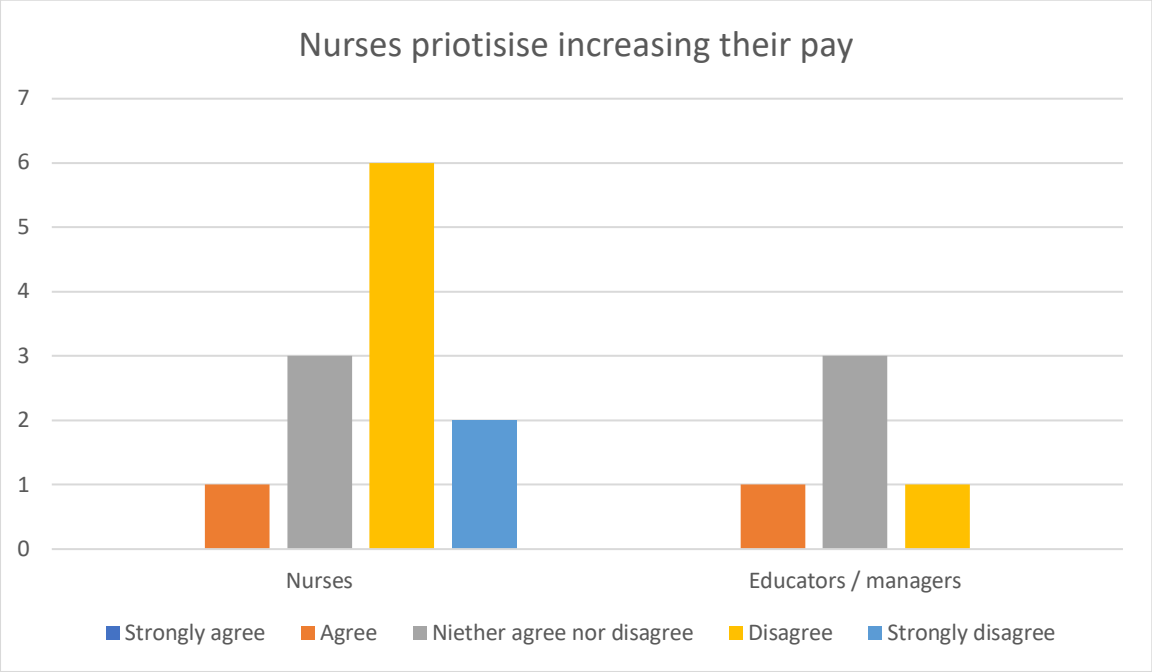

Table ap 3.12 Prioritise pay

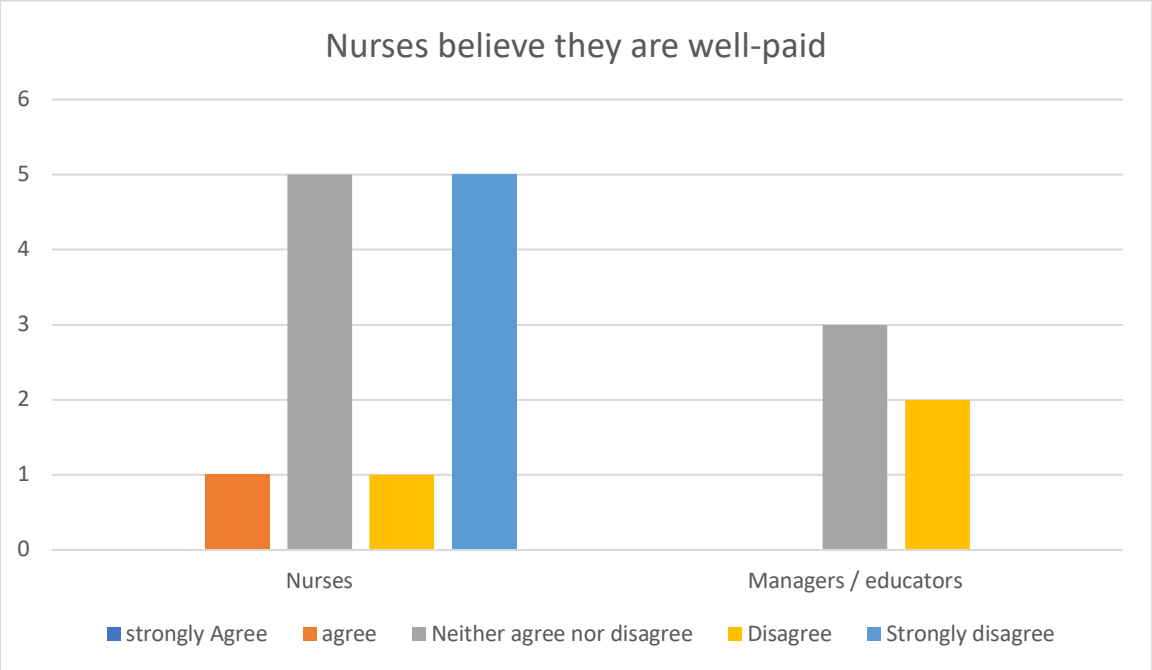

Table ap 3.13 Well paid

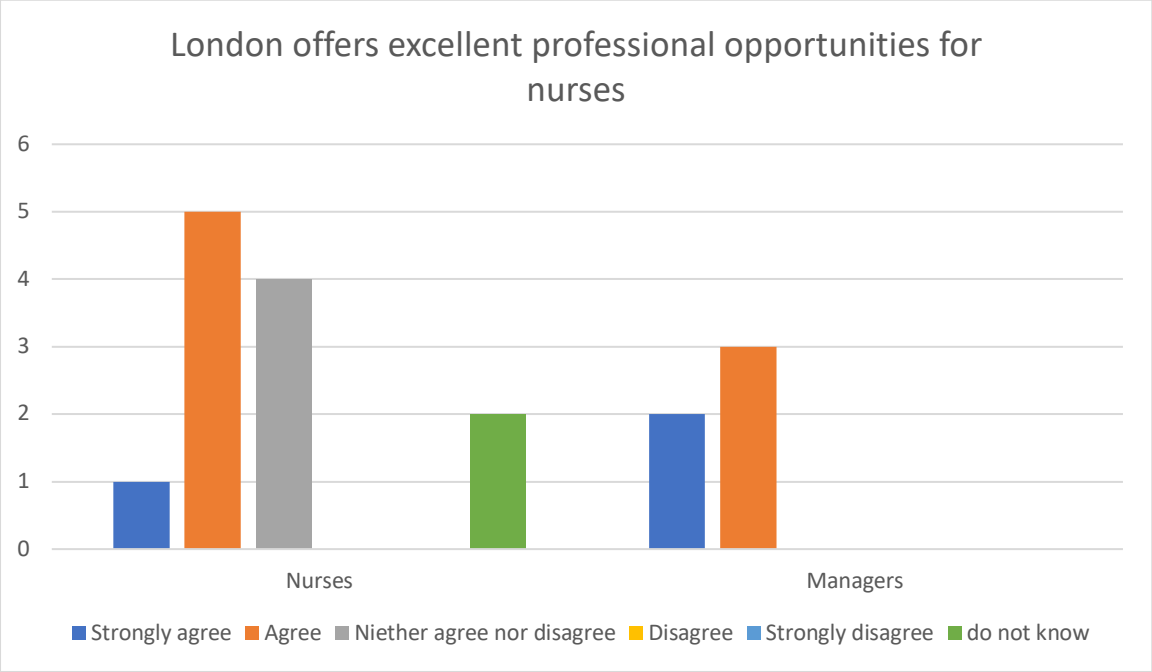

Table ap 3.14 Professional opportunities

I think it is an awful waste for the government to spend money on training nurses and then on qualification there is no structured and supportive educational training and mentorship programme for newly qualified nurses and also an attempt to place nurses in their chosen specialities. If this was the case with me I would still be a nurse in the NHS because this is what I wanted to do – give high quality care to patients and be rewarded and supported to do that (Nurse respondent #6)

London is now fully [sic] of many nurses climbing up the career ladder with limited experience but in senior positions. CNS nurse now is not like we're very experienced nurse who had done there [sic] time on the ward and doing shifts, these days seems anyone can apply. This is observation from a London perspective and appreciate is very different in other parts of the UK. (Nurse respondent #5)

I think changing career progression with Matron roles and CNS, advanced practitioner roles means wider choices than just clinical vs managerial. (Manager / educator respondent #2)

Worries

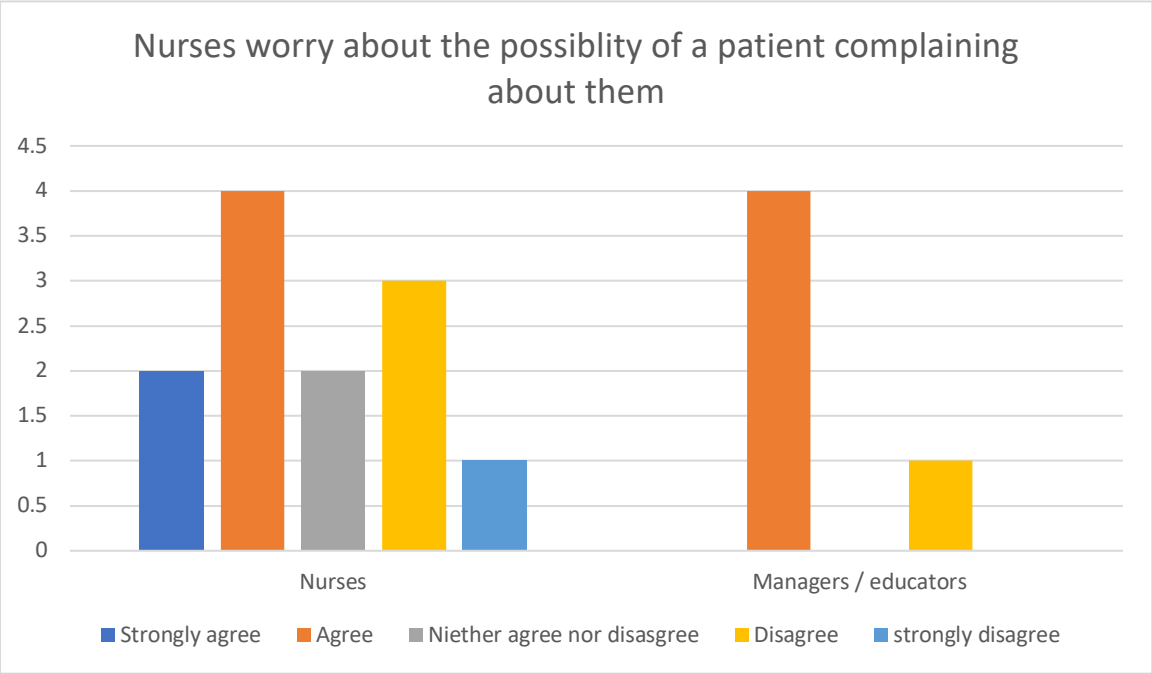

Table ap 3.15 Patient complaints

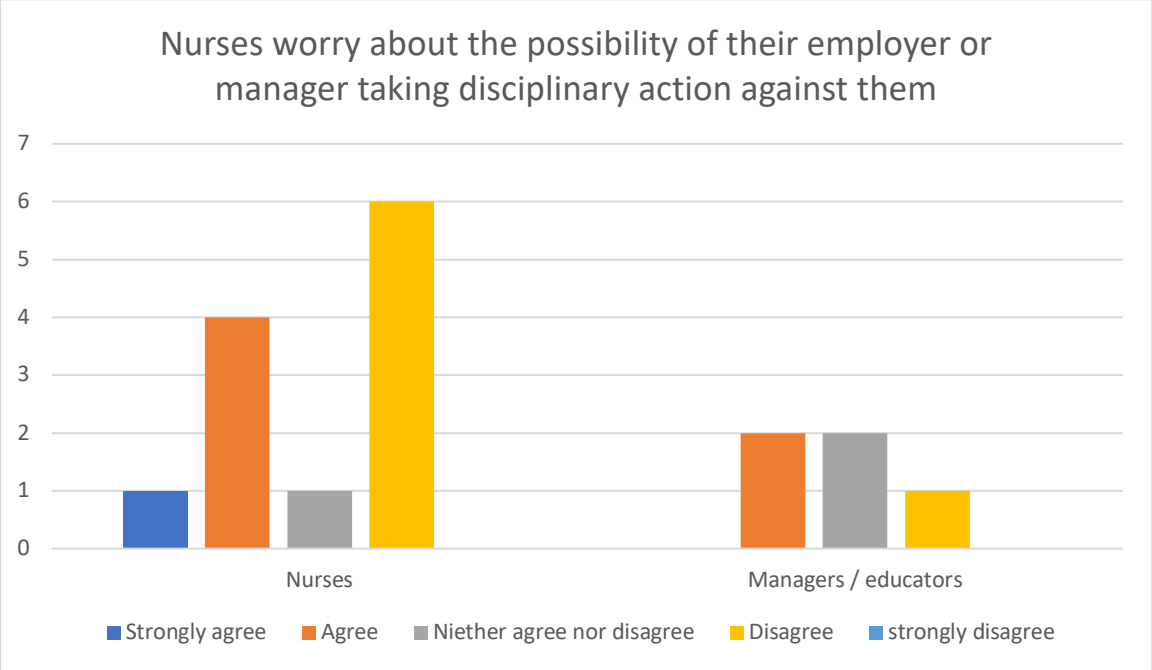

Table ap 3.16 Disciplinary action

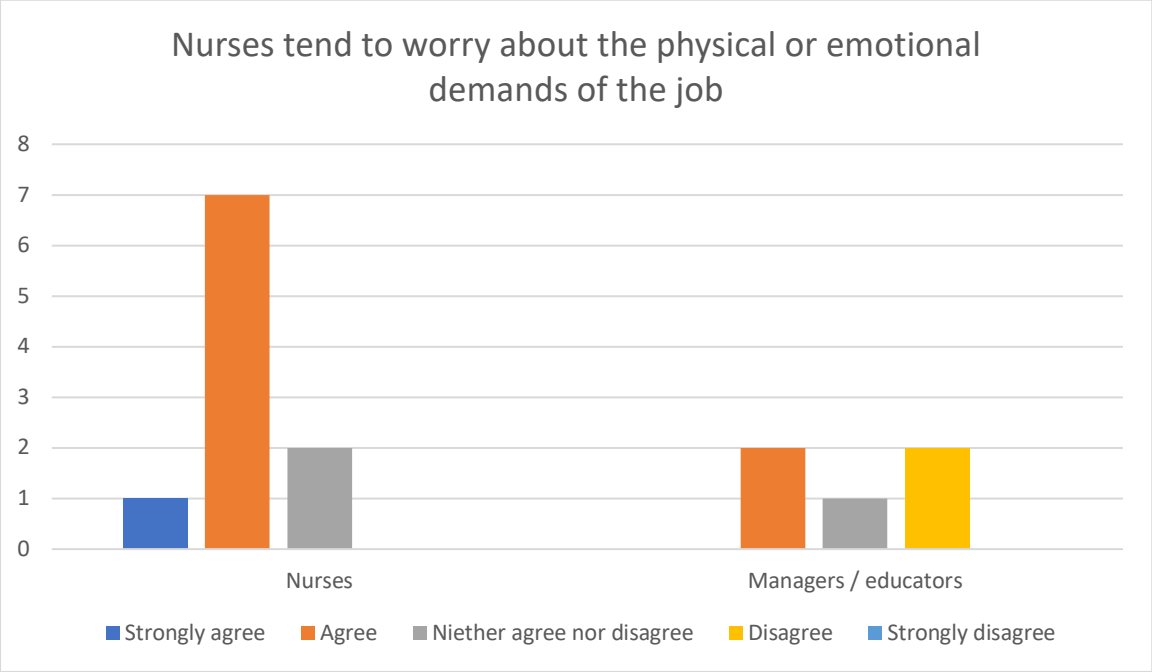

Table ap 3.17 Emotional demands

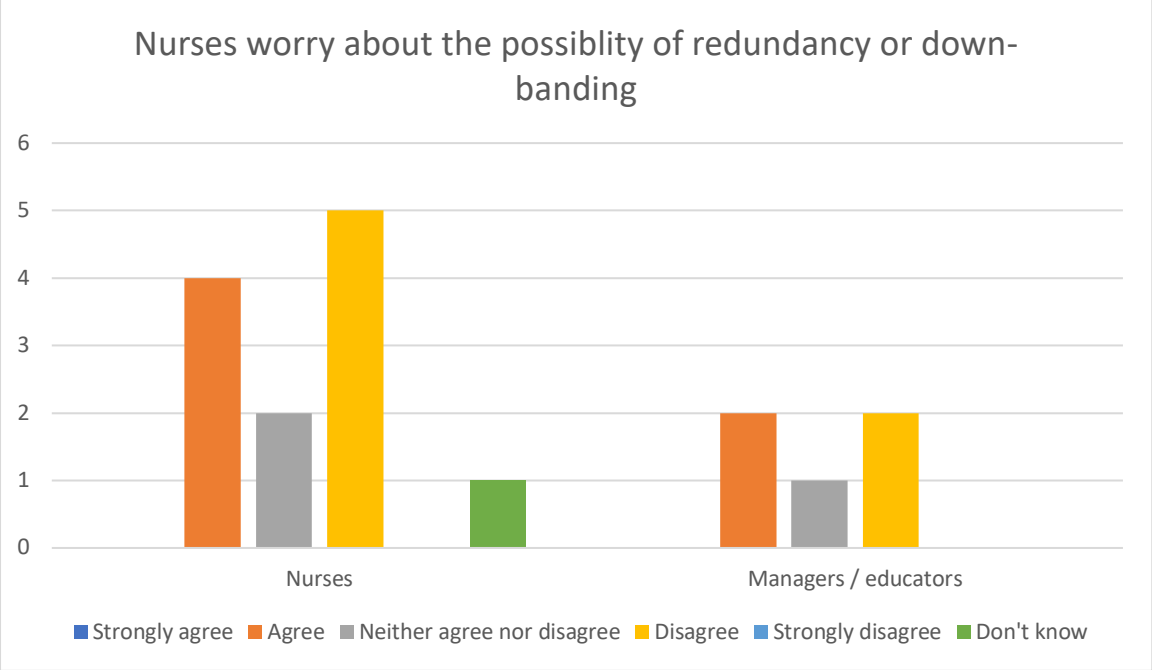

Table ap 3.18 Redundancy and down-banding

Nurses worry always, especially complaints from patients and family and worry of disciplinary especially where there is lack of good management support (Nurse respondent #12)

The reason why nurses may worry about complaints and disciplinary action is because they know that not everything, that is required of them is physically possible to be done because of the pressure of their workload, therefore they will have to prioritise on covering their back with the paperwork side and neglecting direct patient care, which is part of the frustration. (Nurse respondent #6)

I worry about getting something "wrong" and not doing the best for my patients, so there is a moral worry about not always doing the best I can. (Manager / educator respondent #4)

Retirement

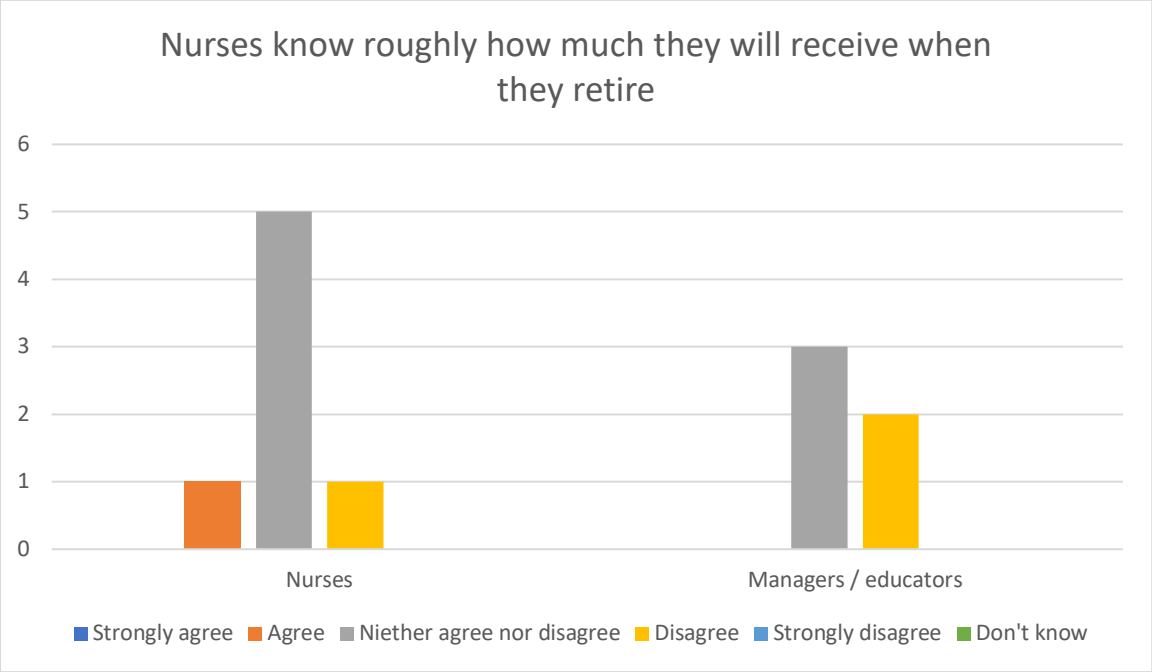

Table ap 3.19 Retirement funds

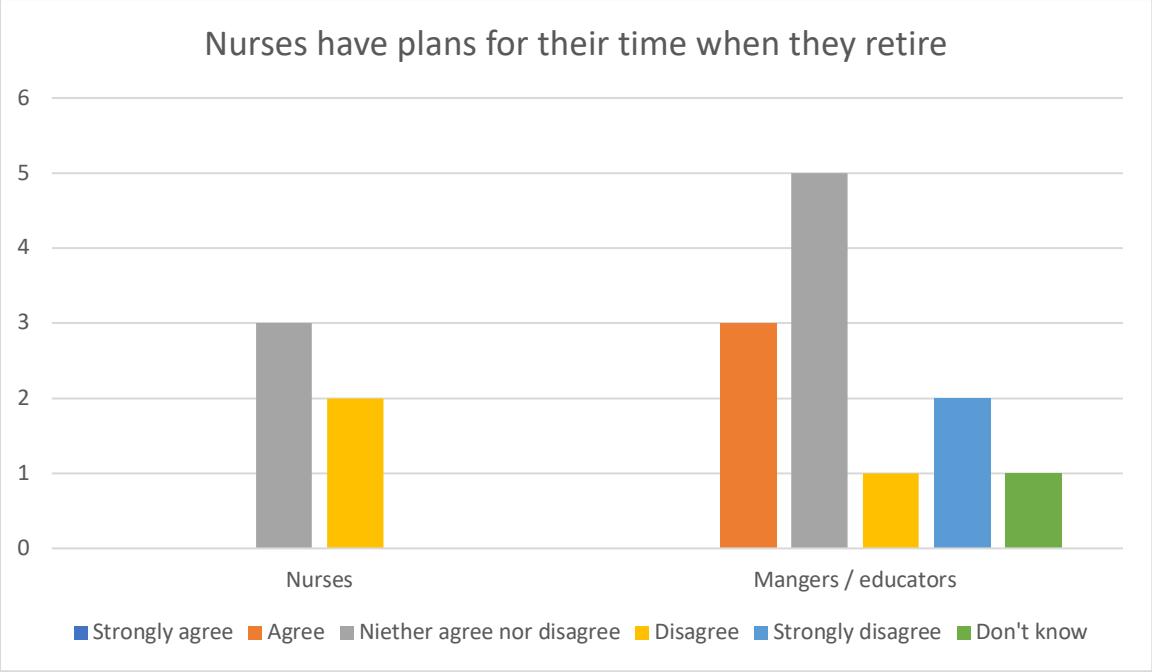

Table ap 3.20 Retirement plans

In my experience the key desire most nurses would want to pay off their mortgages and travel the world and for nurses coming overseas they would want to spend more time home (Nurse respondent #12)

Sadly, I don't think that far as I cannot calculate how much pension I will receive on retirement. (Nurse respondent #6)

Don't like to think about it! (Nurse respondent #5)

I have become better informed about retirement plans and pensions, however I was ill informed early in my career when I should have made different decisions (Nurse respondent #1)

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