A comparative study of mid-life, women nurses working in the NHS and UK care homes

by

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STATEMENT OF ORIGINALITY

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ABSTRACT

This thesis examines the working lives of mid-life (aged 40-55) women who are currently working as nurses. The research focuses on why these mid-life nurses demonstrate occupational and organisational commitment, and compares the NHS and care home sectors. The research explores how the differences in organisational structure, culture and context of these two sectors influence nurses' work orientation, job satisfaction and their motivation to continue nursing, incorporating sociological perspectives relating to commitment and intention to stay.

For this qualitative study, in-depth interviews were conducted with a total of 50 registered nurses, 25 recruited from the NHS and 25 from the care home sector, all of whom had qualified in the UK and had nursed for 10 years or more (mean 20 years). To gain an understanding of the nurses' commitment, biographical and work history, data were collected from the participants at interview.

Findings indicate that the nurses studied maintained a passion for nursing, and for some, this was the reason for moving to the care sector despite, or because of, professional and managerial restructuring in the NHS. However, nurses in both the NHS and care homes demonstrated an instrumental orientation to work, working because they need to earn a living wage. The findings confirm that flexible working conditions are important to nurses' work-family balance but this is not confined to women with children; equal treatment of all employees is an important issue. The thesis also establishes that respecting, valuing and appreciating the contribution of nurses' work is an important factor in nurses' organisational commitment. However, the different organisational structures, cultures and contexts influence nurses' experiences. The type of organisation they work in also affects the public's perceptions of and respect for the work of NHS and care home nurses. The research partially supports Becker's (1960) 'side bet' theory of commitment, that the reasons for remaining in the occupation often outweigh the option of leaving the job or career. The research concludes that nurses' occupational and organisational commitment is complex and organisations must understand and meet the needs of nurses to ensure long-term commitment.
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CHAPTER 1

Introduction

The focus of this research is mid-life nurses who are currently working in nursing. The research focuses on these mid-life nurses’ occupational and organisational commitment, and compares the NHS and care home sectors. This chapter will outline the importance of researching nurses working in mid-life, in the context of an ageing nursing workforce, particularly registered nurses working in care homes who have received little attention from researchers in the UK. The rationale and general aims of the study are given prior to outlining the researcher’s background and experience of working as a nurse in the NHS and in the care home sector. Finally, the structure of the thesis is summarised.

1.1. An Ageing Nursing Workforce

Much has been written about the demographic time bomb that faces nursing and health care as many workers who are now in their 50s prepare to retire over the next ten years (Seccombe and Patch 1995, Seccombe and Smith 1996, Seccombe and Smith 1997, Buchan et al 1998, Buchan 1999, Meadows 2002, Dixon 2003, Watson et al 2003). The nursing and health care profession is experiencing the major challenge of an ageing workforce, within the United Kingdom and internationally (Buchan and Seccombe 2009, 2008). Buchan and Seccombe (2009), in their most recent UK nursing labour market review, indicated that one in three nurses is age 50 or older and fewer than one in ten is under 30 years of age, with one third of nurses aged between 40 and 49 (see Figure 1.1).

Buchan and Seccombe (2009) contended that the current economic climate may postpone the retirement of older nurses and potentially encourage others to return to the labour market. However, they suggested, this will not detract from the large number of nurses over 50 who are predicted to retire in the near future. They also posited that, based on analysis of past trends, older nurses are more likely to work part-time leading to a corresponding reduction in the availability of nursing hours.
The NHS and the care home sector are both vulnerable to the effects of an ageing workforce. In the NHS this is as a consequence of fewer student nurse places in the 1990s (Finlayson et al 2002). In nursing homes it is because the nursing workforce is older than in the NHS (Buchan and Seccombe 2009).

In their compilation of nursing workforce statistics, Buchan and Seccombe (2009: 7) acknowledged that there is a gap in the data and indicated that there are 10 areas where data are needed. One of these gaps is the “dimensions of the growing non-NHS nursing labour market and the flow of nurses between the NHS and other nursing employment”, including nursing homes. This knowledge, the authors asserted, is necessary for effective nursing workforce planning.

Nurses working in nursing and residential homes (collectively known as care homes) have largely been ignored in UK research, with the notable exceptions of Eyers (2003), Perry et al (2003) and Wicke et al (2004) who do not specifically address recruitment and retention of mid-life nurses. This doctoral research will focus on qualified mid-life nurses working in the NHS and care homes to compare their
experiences and perceptions of commitment as this is where a gap in our knowledge exists.

1.2. Nursing in Care Homes
The work of caring for older people tends to be viewed negatively by registered nurses, nursing students, the public and the media (Bowling & Formby 1991, Prevost et al. 1991, Slevin 1991, Stevens & Crouch 1992, Davis & Barnes 1997, Ahmad 1998). It is a nursing sector that is seen as unrewarding, unchallenging and heavy, hard work (Philipase et al 1991, Zukerberg 1991). It is seen as a ‘poor relation’ to acute nursing where the work is viewed as rewarding, challenging, more exciting and valued (Stevens & Crouch 1998). This leads to nurses who work in the care of older people feeling undervalued by their peers, which in turn can lead to poor morale (Davis & Barnes 1997).

The image of care homes for older people is socially constructed and older people are generally regarded through a specific group of negative characteristics - economically unproductive, a burden, having no societal value (Ellis 1999). In my experience, nurses who work in care homes are often viewed with pity by other nurses, as the work is seen as heavy and unrewarding or they are seen as not having the skills, aptitude or ability to work in the NHS or indeed the private sector. This leads to an informal hierarchy within the nursing profession with highly skilled hospital nurses existing at the top and with care home nurses at the bottom being perceived as the least skilled of the nursing workforce. Happell (2002) argued that negative attitudes towards the care of older people impact on nurses working in this area and will impact on the recruitment of nurses to care homes.

In care homes, health care assistants perform much of the work and few registered nurses are employed in individual homes. Nurses working in the care home sector generally experience comparatively poor pay and conditions compared with their NHS colleagues. For example, nurses in the NHS are entitled to generous annual leave and accrue long service days, sick pay, generous maternity pay, a final salary pension and unsocial hours payments. This contrasts with many private care homes where nurses have poor leave entitlements, are not paid when sick or are not paid unsocial hours payments. If they contribute to a pension scheme, this is a private or
stakeholder pension which does not have the same benefits as the NHS pension scheme for nurses. In summary, the aggregate of these constraints and values - the perceived lack of career opportunities for care home nurses and the need for managers in care homes to operate at a profit - leads to an undervalued source of nursing expertise. The lack of value placed on care home nurses and their residents may partly explain the lack of research on qualified nurses who work in care homes.

1.3. Aims of and Rationale for the Study
This doctoral research study was constructed around the comparative intellectual puzzle (Mason 2002) of: ‘why do mid-life nurses working in the NHS and UK care homes stay in nursing?’ The aims of the study were firstly, to investigate qualified mid-life women nurses’ working lives with a specific interest in why and how they demonstrate occupational and organisational commitment and secondly to explore NHS and care home nurses future career plans and whether they intend to stay or leave nursing and/or their organisations. Finally the research aims to compare and contrast the experiences and perceptions of these NHS and care home nurses, to give a better understanding of the working lives of these mid-life nurses.

The rationale for this comparative study of mid-life NHS and care home nurses originates from the lack of research in this area, especially into the working lives of qualified care home nurses and from my experiences as a nurse working in mid-life. Much of the existing research on turnover and retention focuses on care assistants working in care homes, and much of this research has been concentrated in the United States (Bowers et al 2003, Fitzpatrick 2002, Riggs and Rantz 2001, Grau et al 1991, Garland et al 1988), while the NHS has been the focus of recruitment and retention in the UK (Buchan and Secombe 2004, 2008; Buchan 2002, 2007). Whilst there are studies that have considered the working lives of older nurses (Wray et al 2009, 2006; Watson et al 2004, Watson et al 2003; Letvak 2003a, 2003b) and mid-life nurses (Bennett et al 2007), an extensive literature search provided no evidence of studies comparing qualified mid-life nurses working in NHS and qualified mid-life nurses working in the care home sector.

As Duffield et al (2004) stated, most nursing research on commitment to nursing has concentrated on nurses who stay in NHS nursing. Existing studies have focused on
nurses who work within hospitals, community or educational settings. There is a paucity of research focusing on nurses who work in care homes and none so far has explored why nurses who have left the NHS have decided to continue nursing in a care home setting. Neither is much known about the motivation, orientation and commitment of this group of nurses who work in the UK care home industry in general, and especially those who comprise the 40-55 year age cohort. It is therefore of interest to close the knowledge gap and study this particular cohort of nurses, working in two very different organisational settings, and analyse their experiences and perceptions of working in mid-life to determine what affects their occupational and organisational commitment. The research uses sociological concepts to better understand commitment, principally professionalism and the art of caring, managerialism, social exchange and reciprocity.

1.4. Researcher’s Background

The motivation to conduct this study relates to my background in nursing. I worked as a registered nurse in the NHS between 1994 and 2004 and in the care home sector since 2004. Many changes have been observed during this time, including changes to nurse training, recruitment and retention of staff, return to nursing initiatives aimed at encouraging qualified nurses who have let their registration lapse to return to nursing. There has been an increase in overseas nurses practising in the UK, especially from the Philippines, which NHS nurse managers have visited on active recruitment campaigns. There remains a substantial number of nurses in their 40s and 50s who have exhibited commitment to nursing and show little intention of leaving. However, there has been increasing frustration for nurses who battle to give high quality care in the face of staff shortages, increasing workloads and the reduction in junior doctors’ hours. This reduction in junior doctors’ hours has led to the delegation of junior doctors’ tasks to nurses already carrying a full nursing workload (Dowling et al 1996). Nurses frequently say that they enter nursing to care for patients but as they gain seniority this can remove them from direct patient care, to work of a more administrative nature, causing role tensions and conflict (Tovey and Adams 1999).

Having worked for 10 years in the NHS, I chose to leave and work part-time, as a registered nurse in a care home in Surrey, whilst I was undertaking this PhD. During this time working in social care, I have worked with nurses who have left the NHS
because they could not obtain flexible hours to suit their needs and their family responsibilities, nurses that who left the NHS because they were frustrated with the standards of care that they had to give, and nurses who work for both the NHS (full and part-time) and (part-time) in care homes to supplement their income. These personal observations resulted in the motivation to conduct a more systematic study of these factors. The initial idea behind this choice of research topic originated on completion of an MSc in Ageing and Society (Durant 2004), researching the perceptions and experiences of ageism within the health and social care workforce. One outcome of the study was that a significant number of the qualified nurses interviewed had worked as qualified nurses for more than 10 years. Those who had left the NHS had continued to work in care homes as qualified nurses, demonstrating a continuing commitment to nursing.

1.5. Structure of the Thesis

The following three chapters review the literature and concepts pertinent to why nurses (intend to) stay in nursing. Chapter 2 reviews literature on occupational and organisational commitment, theoretical models of commitment and links to job satisfaction, which have been shown to have a positive causal relationship with intention to stay in nursing. The theoretical frameworks that inform this study, including the influence of Becker’s (1960) side-bet theory on organisational and occupational commitment and Meyer and Allen’s (1984, 1991) subsequent refining of side-bet theory, are critiqued in chapter two.

Chapter 3 examines the ways in which the concept of gendered role responsibilities is important in nursing. The chapter considers the concepts of caring and emotional labour and how these relate to the nursing role. It also examines the literature on the inter-relationship between nursing and domestic responsibilities — the work-life-family balance which includes childcare and caring for dependants such as older parents. The literature on the themes of nurses working lives, shiftwork, and nursing careers are reviewed and critiqued.

Chapter 4 examines literature pertaining to organisational structures, cultures and contexts and how they impact on nursing. It reviews literature which focuses on organisational reform and change in general and the NHS and care homes in
Chapter 5 presents the methodological approach of the study. It introduces the research aims, the research design and discusses the research methodology, as well as the rationale for using a qualitative method to investigate the research problem. It gives details of recruitment of participants, issues of access and consent and the pilot study. Ethical issues, data collection and data analysis are discussed. The ontological and epistemological stance of the researcher is critiqued and evaluated.

The next four chapters present the data analysis. Chapter 6 provides biographical details of the nurses who participated in this study, using a work history approach. Data are presented about ages of the study participants, number of years spent in nursing, educational qualifications, marital status, ethnic background, length of time spent with current employer and in current job role, current job role and responsibilities, full and part-time working, working patterns, whether nurses are caring for dependants or not, taking a career break, nurses actively seeking alternative employment and future plans.

Chapter 7 analyses the data in terms of the working lives of the nurses. This includes work motivation, work commitment and work orientation. It seeks to explain the reasons these mid-life nurses remain occupationally committed. The data are compared and contrasted for the two groups of nurses, and the results analysed with reference to the theoretical framework of commitment reviewed in Chapter 2. The themes analysed are professionalism in nursing — altruism and philanthropy, teamwork, the utilisation of professional skills, knowledge, and experience and remuneration. Conceptually, the chapter identifies that nurses are motivated by the intrinsic rewards of professionalism, ideology and philosophy of the caring role of the nurse; they are still passionate about their work and want to make a difference to their patients'/clients' lives. However this is tempered with the financial requirement to earn a living wage and the expectation that their skills, and expertise are rewarded at
an appropriate level financially. The analysis of the data shows some support for Becker’s (1960) side-bet theory.

In Chapter 8 the working lives of nurses and the issue of family friendly/flexible working practices are analysed. Analysis of the working experiences of this particular cohort of female nurses working in mid-life is presented. The experiences of both groups of nurses are contrasted. Conceptual findings include that the definition of work-life/work-family balance as used in the literature does not adequately reflect the work and family lives of these nurses. Parameters of work-life and work-family are often too narrowly defined and exclude the needs of workers who do not have children or dependant adults, yet who expect fairness and organisational justice and equality in terms of flexible working initiatives. The data also reveals that there is resentment of flexible working initiatives among NHS nurses. The importance of shiftwork is analysed as are the career pathways of the nurses.

Chapter 9 discusses the data analysed with reference to the concept of organisational structure, culture and context, for the two different organisational structures — the NHS and care homes, contrasting the lives of nurses working in the NHS with those working in care homes. This includes sections on rationales for leaving the NHS in the case of the care home nurses. The chapter will also analyse the data with reference to the impact of organisational reform and change, the (de)professionalisation of nurses, managerialism and how this impacts on the autonomy of nurses. The effects of nursing leadership are analysed with regard to their impact on nurses working in the NHS and contrast this with the experiences of nurses working in care homes and their decisions to commit to their organisations. Also considered are the important effects of the employing organisation on nurses’ professional identity. Conceptual findings include that nurses in the NHS and care homes are perceived differently by the public and the media; however, nurses in the NHS are highly regarded by the public but not by their organisations. In contrast, care home nurses feel they have a much closer working relationship with and feel valued by their managers, but their work is not highly regarded by the public. The main findings of the research will be summarised in the following chapter.
The discussion in Chapter 10 draws the previous four data analysis chapters on professionalism and occupational commitment, work-life balance, flexibility and organisational structure, culture and context together to better understand why nurses working in the NHS and care homes remain occupationally and organisationally committed. It explicitly compares and contrasts the two groups of nurses. The chapter draws on the empirical data to offer a conceptual model which explains why female nurses, working in mid-life, have chosen to stay in nursing in the NHS or the care home sector.

In Chapter 11, the findings of this study are drawn together. The chapter will discuss the theoretical conclusions derived from the study, and how these link to previous studies. This concluding chapter will consider the limitations of the study, and how this study further advances the professional and academic debate on the occupational and organisational commitment of nurses working in mid-life.
CHAPTER 2

Organisational and Occupational Commitment

2.1. Introduction

The reasons for nurses’ organisational and occupational commitment are complex and varied. Skogsberg (2003) acknowledged that although nurses are leaving the profession, many choose to stay. Several mainly international studies, especially Canadian and American, with a minority in the UK, have attempted to answer this complex question. Gurney et al (1997) argued that interest in nurse retention and intention to stay is driven by researchers’ interest in testing and developing causal models to explain nurses’ intention to stay, commitment, job satisfaction and retention in addition to apprehension over recruitment and retention policies and nursing shortages. Variables have repeatedly shown relationships with intention to stay in survey research. For example, job satisfaction and intent to stay are shown to correlate positively, and the greater the job satisfaction, the more likely nurses are to stay in their jobs. One difficulty, for researchers, is attempting to determine what constitutes job satisfaction. No definitive consensus has yet been achieved as job satisfaction as a concept is complex and idiosyncratic.

Many investigators have concentrated on nurses’ intent to stay in nursing (Tourangeau and Cranley 2006, Sourdif 2004, Tallman and Bruning 2005, Ingersoll et al 2002). Sourdif’s (2004) quantitative research on 108 Canadian nurses supported the findings of earlier studies (Taunton et al 1997, Fisher et al 1994, Gauci Borda and Norman 1997, Lucas et al 1993) which indicated that satisfaction with the work and organisation, work environment and group solidarity had a positive correlation with intent to stay in nursing. Sourdif (2004: 61) focused on “intent to stay, satisfaction with work and administration, organisational commitment and work group cohesion” and argued that retention policies should concentrate on job satisfaction, satisfaction with administration and intention to stay at work. Tourangeau and Cranley (2006) reported that the best predictors of intention to stay were age of the nurse, tenure and general job satisfaction with four statistically important determinants: job satisfaction,
nurses’ personal characteristics, organisational commitment, and work group cohesion and that none of the concepts could be considered to be mutually exclusive.

2.2. Orientations to Work

Before analysing organisational and occupational commitment, an explanation about why social actors engage in work must be given. Much has been written concerning the topic of work orientations. The purpose of work for most people is usually fairly constant in that it satisfies goals such as financial security, the ability to use skills and experience gained throughout their working and non-working lives, and a degree of social interaction (Natale and Rothschild 1995, Sverko and Vizek-Vidovic 1995).

Work orientation, as defined by Vanhanen and Jahonen (2000: 1055) is the “personal and holistic interpretation of our work”. Watson (1987) stated that work orientation is the significance that a person attaches to their work and how they think and behave towards it. Watson argued that the concept of work orientations can be utilised to explain how and why people deal with work in the way that they do. He contended that there is an essential distinction between intrinsic and extrinsic work meaning and the satisfaction derived from either of these orientations (see figure 2.1).

Figure 2.1: Meanings of Work: a continuum (Watson 1987: 87)

<table>
<thead>
<tr>
<th>Work which gives INTRINSIC SATISFACTIONS</th>
<th>Work which gives EXTRINSIC SATISFACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work is an enriching experience</td>
<td>Work yields no value in itself</td>
</tr>
<tr>
<td>Work provides challenges to the individual</td>
<td>Work becomes a means to an end</td>
</tr>
<tr>
<td>The individual develops and fulfils self at work</td>
<td>Human satisfaction or fulfilment is sought outside work</td>
</tr>
<tr>
<td>Work has an EXPRESSIVE MEANING</td>
<td>Work has an INSTRUMENTAL MEANING</td>
</tr>
</tbody>
</table>
Watson (1987) asserted that there are two extremes of intrinsic and extrinsic work meanings and that individual workers are situated at any point along this continuum. However, having the two extremes tends to allocate people into one or the other category which is oversimplifying the real experience of individuals. Their meaning of work may combine both intrinsic and extrinsic elements and the boundaries are therefore often blurred. For example, work may be an enriching and fulfilling experience but it may also be a means to an end for some workers. This has led to the development of the concept of work orientation.

Initially, the concept of work orientation was developed in the 1960s and 1970s primarily by Goldthorpe et al (1968a) in their influential study of ‘affluent workers’. Two hundred and twenty nine assembly line workers at the Vauxhall car plant in Luton were interviewed as part of an examination of social class in 1960s Britain (Goldthorpe et al 1968a, 1968b, 1969). They studied the ways that male workers thought and behaved with regard to their work and deduced that they experienced no intrinsic satisfaction from their work yet did not appear to be dissatisfied with their jobs. They concluded that the workers had entered this type of work for the extrinsic rewards which gave them a comparatively good standard of living and that their orientation, the ‘instrumental’ orientation to work, was defined by their social class and socialisation rather than by the workplace.

As a result of their study, Goldthorpe et al (1968a) identified three distinct orientations to work: the ‘instrumental’ orientation – work as a means to an end, the need to earn a living wage; the ‘solidaristic’ orientation – work as an end in itself with enjoyment of the job and high satisfaction levels; and finally the ‘bureaucratic’ orientation – where workers, in return for financial rewards, provide a service to the organisation.

Work orientation itself is not static, a person’s view of work and work conduct may change as that person develops professionally (Engeström 1990, 1994). This is an ‘adaptive process’ which evolves continually for the worker (Dex 1988, Rose 1988). This has also been discussed by Fagan (2001: 242) who suggested that established economic theory presented an outdated image of orientations and preferences to work.
where they are “assumed to be stable and related to the characteristics external to the labour market rather than any experiences in it”.

2.3. Organisational and Occupational Commitment
The organisational commitment of employees has been the focus of a plethora of research across many disciplines. There are numerous explanations of commitment in the workplace and a certain degree of disagreement and uncertainty exists as to the nature of commitment (Meyer and Herscovitch 2001). Some of the theoretical models are uni-dimensional (Becker 1960, Blau 1985, Brown 1976), others are multi-dimensional (Meyer and Allen 1984, 1991; Powell and Meyer 2004; Angle and Perry 1981). In this section the concepts of organisational commitment and occupational commitment will be reviewed.

2.3.1 Theoretical Models of Organisational and Occupational Commitment
Several authors have developed conceptual models of intent to stay in nursing or causal models of nurse turnover (Price and Mueller 1981, Irvine and Evans 1995, Boyle et al 1999, Tourangeau and Cranley 2006). Price and Mueller (1981) stated that the problem with most models is that they lack inclusiveness as each model varies greatly in the variables that are included. Price and Mueller (1981) asserted that researchers use various models to assess nurse turnover and argued that accurate assessment of nurse turnover was extremely difficult using the existing models, which led to the development of a new causal model. Their model included the following variables: ‘opportunity, routinisation, participation, instrumental communication, integration, pay, distributive justice, promotional opportunity, professionalism, generalised training, kinship responsibility’ (Price and Mueller 1981: 547).

Becker (1960) was one sociologist who attempted to formally analyse and develop a theory of commitment. Much debate about and empirical research on commitment theory has resulted from his work (Ritzer and Trice 1969; Jans 1989; Meyer and Allen 1984, 1991; Cohen 1999; Powell and Meyer 2004; Meyer and Herscovitch 2001). Becker (1960) acknowledged that there had been much discussion regarding commitment to work within sociology, but no formalised theory of the concept or effort to incorporate it into sociological theory. Becker (1960: 33) argued that commitment explains “consistent behaviour” which he defined as men (sic) remaining
in the same job or occupation over a long period of time, leading to what he
determines is commitment. This commitment is a result of side-bets or investments of
the worker so that the reasons for remaining in the occupation outweigh the option of
leaving the job or career. For example, in the case of nurses, the forfeiting of the final
salary pension scheme or having to take a drop in grade to take up a position in a
different speciality, may be too financially costly, or costly in other ways, for the
individual and therefore they stay in their present job.

The term side-bet, employed by Becker (1960) in his paper on the concept of
employee commitment, originates from gambling terminology. A side-bet is a bet that
is placed between opponents (particularly in card games) over and above a main bet
(Concise Oxford Dictionary 1991). If the main bet is lost, then the side-bet is also lost.

In seeking an explanation of “consistent human behaviour”, Becker (1960, p35)
defined his side-bet theory of commitment as “an attempt to explain consistent human
behaviour in a sociological way without the flaws often attributed to the theories just
reviewed”. Becker (1960) suggested that employees’ commitment is secured by the
making of side-bets by proposing that “the committed person has acted in such a way
as to involve other interests of his, originally extraneous to the action he is engaged
in, directly in that action.” Becker posited that a person engages in an act (or acts) of
bargaining and has bet something that he values which was initially not related to his
present course of action but which is dependent upon the person being consistent in
his actions. Becker suggested that any inconsistencies in this line of action will result
in great cost to the person that it no longer becomes an option. As Griffin et al (2005,
p612) stated “side-bets serve to involve other interests so that if a person were to
discontinue a course of action (i.e. employment), it would have adverse consequences
for these other activities” and therefore commitment is maintained.

To put Becker’s explanation of side-bets more simply, a person makes choices about
the world in which he inhabits and the historical context of his experiences. This
entails a person making side-bets, further bets over and above the main bet, which are
based on a main bet or activity being a success. If the main bet is lost then the side-bet
is also lost. Thus, the making of additional side-bets over and above the main bet
creates a greater incentive to commit to the main bet (Changing Minds.org 2010). In
terms of organisational and occupational commitment, this side-bet metaphor is used by Becker (1960) to infer that should an employee lose main bet - the job, then the benefits associated with a job or job role i.e. the side-bets are also lost. Thus, the employee incurs the loss of social bonds, benefits such as flexible working hours, loss of prestige or status, being competent and comfortable in the job role, the convenient geographical location of the job are also lost.

The metaphor of side-bets can be transferred from gambling terminology to mean that if some or all of the employee’s side-bets are lost, then the main bet becomes a victim because the side-bets constitute equally valid reasons for remaining with the organisation and occupation as the main bet. The loss of side-bets can cause the main bet to become a casualty also. Becker (1960) suggested that when aggregated, side-bets constitute a series of acts which are so important that the employee is unwilling to lose them, therefore if the employee does lose them, serious consideration is given to whether to remain in the job, so organisational and occupational commitment can be affected. This can lead to the employee terminating employment with the employer and/or leaving the occupation. For example, in terms of nursing as an occupation if the side-bets are lost, a nurse may decide to leave both the occupation and profession.

Becker (1960: 38) reasoned that not all side-bets are conscious decisions. He asserted that commitment develops without a person realising it until a point when they (may) take stock of their career and realise that they are committed to their occupation via a “series of acts no one of which is crucial but which, taken together, constitute for the actor a series of side-bets of such magnitude that he finds himself unwilling to lose them.” Becker argued that to gain a full understanding of commitment, the person’s social world needs to be analysed to determine what value systems are at work to foster consistency in their actions. For mid-life nurses this may be the perceived value that the public places on nurses, or that nursing was a good career for working class and lower middle class girls (Hallam 2002).
Becker (1960) proposed five general categories that could be used to explain employee commitment. These are:

1. **Generalised cultural expectations** – there are cultural expectations that employees should not change jobs too frequently otherwise the perception will be that as an employee they are untrustworthy and not committed.

2. **Impersonal bureaucratic arrangements** – Becker suggested loss of organisational benefits such as pension, but contemporary side-bets in this category can include flexible/negotiated working arrangements and childcare facilities.

3. **Individual adjustments to social positions** – although employees may wish to change jobs to improve their social status, they adapt to their current work role to the point where they feel they can perform the role with ease and comfort. The option of changing occupation/organisation becomes less attractive because of the effort involved in learning the new role.

4. **Self-presentation concerns** – Becker, referring to Goffman’s (1959, 1961a) work on presentation of the self, posits that employees present an image of themselves and have to conform to that image because they do not wish to damage it.

5. **Non-work concerns** – these include impacts that changing employment may have on family commitments. Examples may include geographical relocation or increased commuting and their ramifications for the family.

Becker admitted that employees’ commitments are individualistic and often in conflict with each other and consequently that his theory of commitment cannot provide a definitive answer to the nebulous concept of commitment. This has led academics to test the theory. John Meyer, a Canadian psychologist, worked extensively on testing Becker’s side-bet theory and devised and refined models to test Becker’s theory. The ‘three component’ model of organisational commitment was offered (Meyer and Allen 1991). Their three components developed from the work of various commentators on commitment, specifically Becker (1960), Kanter (1968), Marsh and Mannari (1977) and Mowday et al (1982).
Meyer and Allen (1991) conceptualised commitment as:

1. **Affective** – based on personal characteristics, positive experiences at work, and organisational structure. Employees demonstrate commitment because they associate themselves with the goals of the organisation and they stay because they want to.

2. **Continuance** – relates to Becker’s side-bet model in that employees regard the costs of leaving the organisation as outweighing the benefits and stay because they have to.

3. **Normative** – commitment is based on a sense of loyalty, either to the organisation or because of conformity to social norms, therefore an employee stays with the organisation because they feel they ought to.

Powell and Meyer (2004; 174) expanded on Becker’s (1960) and Meyer and Allen’s (1991) earlier work and identified side-bets more comprehensively including two additional categories:

- **Satisfying Conditions** - enjoyment, social bonds with colleagues, positive treatment by managers, content with organisational ideology;
- **Lack of Alternatives** - unavailability of comparable jobs, and possibility of unemployment.

Their study aimed to test Becker’s (1960) side-bet theory using Meyer and Allen’s (1991) three component model of commitment, arguing that Becker’s paradigm had not been successfully tested to date. Powell and Meyer (2004) used survey methodology to investigate the organisational commitment of 146 college graduates in Canada (1000 questionnaires distributed). They stated that their empirical research did support Becker’s side-bet theory and the three component model of commitment but with two caveats: the low response rate placed limitations on their study (and consequently potential causal inferences); and the study measured perceptions rather than conditions of employment.
2.4. Side-bet Theory - Commitment to Work and Nursing

Few studies have assessed the impact of side-bets on nurses’ organisational and occupational commitment. As outlined earlier in this chapter, studies have concentrated on variables that influence nurses’ intent to stay in nursing but Becker’s (1960) theory has been under-utilised. Alutto et al (1973) operationalised the concept of commitment with regard to Becker’s (1960) side-bet theory and Ritzer and Trice’s attitudinal theory (1969) by surveying 395 nurses and 318 secondary school teachers. The aim of their study was twofold: firstly, to demonstrate that the conclusions of Ritzer and Trice’s (1969) research were in part as a result of the way the data were measured in terms of commitment; and secondly, to demonstrate that Becker’s side-bet theory was useful in explaining commitment by modifying Ritzer and Trice’s system. Their critique of Ritzer and Trice’s (1969) measure was that it was “an insufficiently sensitive commitment index” and that it could be improved (Alutto et al 1973: 448).

Alutto et al’s (1973) results indicated that age was a critical variable in corroborating side-bet theory and that commitment to the organisation was greater among older workers in comparison to Ritzer and Trice’s (1969) research which did not demonstrate an age effect. Alutto et al (1973) also reported that a strong positive correlation existed between total years experience in a job role and organisational commitment. They also argued that the middle years of working were more likely to be associated with a slump in commitment and offer the explanation that this may be due to a better understanding of the problems associated with the job and the organisation. The middle years in this research were defined as age 27 to 44 years, but their rationale for this was not explained. Alutto et al (1973) argued in their conclusion that commitment cannot be adequately explained by the ‘socio-psychological’ theory of Ritzer and Trice (1969) as side-bets are an important element of work commitment and critical for understanding it. However, the authors conceded that their samples had different characteristics to those of Ritzer and Trice in that they sampled both male and female respondents, both professional and semi-professional and this may account for some of the differences in the empirical findings.

Cohen (1999) surveyed 238 nursing staff recruited from two hospitals in Canada with the purpose of examining and validating Morrow’s (1993) model of work
commitment and specifically the five common or universal dimensions of work commitment which she asserted were ‘organisational commitment’, ‘continuance commitment’, ‘work ethic endorsement’, ‘career commitment and job involvement’. Cohen’s (1999) participants were drawn from different spheres of nursing; some were registered nurse assistants, the majority were registered nurses of indeterminate grade and ten percent were nurse managers and nurse educators or administrators. Ninety five percent of his respondents were female. Cohen’s (1999) research attempted to validate the work of Morrow (1993) empirically, testing the variables of “demographic characteristics (gender, children, age, education), work experience (tenure, years in occupation, job satisfaction, job tension), work outcome (perceived performance) and non-work domain (life satisfaction)” (p.286). This was compared with another slightly different model proposed by Randall and Cote (1991) who used the variables of Protestant Work Ethic (PWE), career commitment, organisational commitment, work-group attachment and job involvement.

Cohen’s (1999) findings indicated that the model of Randall and Cote (1991) was a much better fit in terms of the data generated in supporting their findings that job involvement is the key variable in work commitment and that workers who experience work positively have greater work commitment. However Cohen (1999) does state that their model was revised to generate the best fit. He concluded that “in work commitment models organisational commitment is an endogenous variable and PWE an exogenous one, while job involvement mediates this relationship” (p.306). However, Cohen (1999) cautioned that the research should be reviewed in light of its limitations. He stated that due to the data being self-reported, there may have been biases and that causal inferences should be treated with caution when data is interpreted because of the sample used. Cohen (1999) suggested that the findings were interesting and useful due to the paucity of data about the association between the different forms of commitment.

Most of the US research on work commitment appears to be concerned with proving or disproving various models (Becker 1960, Ritzer and Trice 1969, Shoemaker et al 1977, Morrow 1993) which have evolved since the 1960s as reviewed in the papers above. These have all been based on quantitative or mixed methods. In addition, Lynn and Redman (2005) surveyed 787 nurses to examine the relationship between
job satisfaction, organisational commitment and the nurses’ intentions to leave nursing, arguing there had been a lack of up-to-date research on the impact of organisational commitment and the shortage of nurses in the U.S. Their results indicated that only organisational commitment was a predictor of nurses’ intention to leave their current role. Lynn and Redman (2005) argued that the findings of their research indicated that organisations wishing to keep nurses should concentrate on reducing the work load of nurses to enable them to have more time to care for their patients, improve administrative (managerial) support, concentrate on improvements in pay and professional development, as nurses who are breadwinners often have no further career options when they reach the top of the hierarchy in nursing. They concluded that organisational commitment does not influence nurses’ commitment to nursing and therefore does not explain the nursing shortage in the US but it does provide insight into the problems of recruitment and retention, which indicates the need for further longitudinal research into this concept.

Gould and Fontenla’s (2006) study is one of the few to investigate the views of nurses about work commitment using a qualitative approach, but is limited to two NHS Trusts. Their findings indicated that flexibility and family-friendly working practices were key to job satisfaction in both Trusts and that nurses in the Trust which had a more developed flexible working policy reported better job satisfaction. Their research indicates that family-friendly working practices were much more likely to contribute to organisational commitment than the opportunities to pursue continuing professional development.

2.5. Job Satisfaction and Commitment within the Organisational Context
Job satisfaction has been shown to correlate with nurses’ commitment and intention to stay (Wilson 2006, Andrews and Dziegielewski 2005, Irvine and Evans 1995, Blegan 1993). There has been a lengthy debate by researchers and commentators concerning the concept of job satisfaction and how it is an intrinsic part of nursing (Lundgren et al 2005). Tovey and Adams (1999) argued that job satisfaction is an essential component of nursing work. However, the difficulty lies with finding an adequate definition of the concept as it is a very personal experience and what can be defined as job satisfaction for one individual may differ from that of others. Locke (1983:1298)
attempted to define job satisfaction as:

"...a pleasurable or positive emotional state resulting from the appraisal of one’s job or job experience. Job satisfaction results from the perception that one’s job fulfills or allows the fulfillment of one’s own important job values, and providing to a degree that those values are congruent with one’s needs."

Job satisfaction is important for both employers and employees. Employees who are satisfied are more productive, committed to their organisation, and more creative in the workplace (Syptak et al 1999). Employers derive the benefits from a more committed worker - less absenteeism, fewer retention problems and therefore fewer recruitment costs (Syptak et al 1999). Patients benefit from a motivated, consistent, experienced and committed workforce providing high quality care (Syptak et al 1999).

Job satisfaction and intent to leave has been studied by researchers in an attempt to find a causal relationship between job satisfaction and intention to either stay or leave nursing or an organisation. Larrabee et al (2003) argued that the main predictors of turnover in nursing staff are intent to leave and job satisfaction, and it is therefore necessary to understand the issues that influence them. Her results indicated that the most reliable predictor of job satisfaction was empowerment. There was also a demonstrable relationship in their study, between intent to leave and a feeling of control over nurses’ practice. Larrabee et al (2003) argued that creating a collaborative workplace where relationships between health care professionals can thrive is necessary to retain nurses. She also affirmed that nurse leaders and managers need to monitor and evaluate satisfaction levels regularly and address the issues that are raised by nurses.

Sourdif’s (2004) study evaluated intent to stay and examined the connections between the predictors of work satisfaction, satisfaction with administration, organisational commitment, work cohesion and intent to stay. Her results indicated that satisfaction with work and satisfaction with administration were strong predictors of intent to stay. She argued that managers need to develop strategies that improve job satisfaction as this could improve intent to stay. Nurses need to be viewed as partners rather than
simply employees; they should be allowed more autonomy, listened to, and recognized as making a significant contribution to the organisation (Sourdif 2004).

Dunn et al’s (2005) quantitative Australian study focused on nurses and their perceptions of their work in terms of job satisfaction/dissatisfaction, which were the aspects of the work that had an influence on their perceptions. The results of their study indicated that the intrinsic features of the job were the most important for nurses’ satisfaction, comprising quality of care provided, teamwork and interaction with other nurses. Interestingly, Dunn et al (2005) argued that age was a significant factor in satisfaction and nurses between the ages of 46-55 years had their work satisfaction decreased by an environment that was constantly changing. The authors posited that this was due to the rapid pace of change in educational technology and information technology within nursing.

2.6. The Work Environment and Work Group Cohesion: teamworking

Having discussed job satisfaction as one of the reasons nurses stay or leave nursing, the nature of the work environment should be acknowledged. The work environment also plays an important role in the retention of nurses and organisational commitment. The work environment can be delineated into several categories, relating to not only the physical environment but also the relationships between colleagues and other health care professionals, and the ability to perform one’s job effectively.

Adams and Bond (2000) in their research into job satisfaction of nurses, surveyed 834 nurses from 119 acute adult wards in 17 hospitals in England. They devised a Ward Organisational Features Scale which they divided into six different groups: the physical environment of the ward; professional nursing practice; ward leadership; professional working relationships; nurses’ influence and job satisfaction. Their findings indicated that the highest correlation occurred between job satisfaction and group cohesion on the ward. The findings indicated that nurses regarded their relationships, both social and professional, with their colleagues as providing high job satisfaction. Conversely, hierarchical structure and practice, the devaluing of work by doctors and senior nurses were found to have a negative impact on job satisfaction. Adams and Bond’s study supports the work of Budge et al (2003) who found that positive working relationships correlated positively with the health of nurses, and
Aiken et al’s (1998) assertion that higher job satisfaction is a result of good relationships, control over the working environment and greater autonomy.

Teamwork is also emphasised as a central tenet of care (Nursing and Midwifery Council 2002). Effective team working is considered to be the understanding of and respect for differing roles within the team, goal sharing and working in a collaborative way (Vanclay 1997). Teamwork is very important in nursing as nurses depend on other nurses and health care professionals for support. Wicke et al’s (2004) small-scale study of 12 qualified nurses in 5 nursing homes explored the perceptions and experiences of teamwork. Their interviews with nursing staff indicated that although teamwork was an aspired goal, the reality was somewhat different. The nurses were aware of shared goals and appeared to understand other members’ contributions but they appeared not to be working as teams. Wicke et al (2004) argued that the prevalence of part-time workers may contribute to fragmented teams and the inability to maintain a cohesive group. The hierarchical structure of management in their study appeared to stifle attempts at teamwork despite nurses desires to participate in a more horizontal, collaborative way of working.

2.7. Remuneration
Finally, the issue of remuneration, or, working to earn a living wage must be acknowledged. The importance of salary has been acknowledged in side-bet theory (Becker 1960) and continuance commitment (Meyer and Allen 1991). However, this requires further comment in the case of nurses. For nurses, pay is not usually one of the main reasons stated for entering the profession or contributing to organisational or occupational commitment. Occupational commitment is often more associated with the intrinsic aspects of nursing such as altruism (McCament 2006, Fahrenwald et al 2005, Lynaugh and Fagin 2000, Smith 1995) and philanthropy (Baer 2007, 2009). However, pay has been linked to job satisfaction and occupational commitment in various studies.

Pay has often been neglected as a variable in studies concerning job satisfaction and nurse retention because it is has not often been found to have a strong positive correlation (Blegen and Mueller 1987). However, recent studies have concluded that pay does have an impact on nurse retention and commitment (Callaghan 2003).
Callaghan (2003) found that nurses were disillusioned with pay as they did not feel that it was sufficient reward for the difficulty of the job. One nurse manager in Callaghan’s study felt that if he had a similar position within the business sector, he would be earning another £10,000 per annum. This supports the findings of the Royal College of Nursing (RCN 2000) which surveyed 400 nurses in Scotland and reported that nurses felt that they were poorly paid in comparison with other professional groups. Two thirds of the nurses surveyed considered that they could find better paid work in a less demanding role if they left nursing altogether.

Reeves et al (2005) surveyed 2880 nurses of grades A to I working in London to examine the factors which prevented nurses from delivering high quality patient care and their impact on nurses intention to leave their employer. The researchers found that nurse centred variables such as travel time to and from work, accommodation and car parking issues had no impact on nurses’ intention to leave. The one exception to this was nurses’ pay which did have a significant impact on nurses’ intention to leave. Nurses who were more dissatisfied with their level of pay had a greater likelihood of reporting that they would leave their employer. Reeves et al (2005) did not offer suggestions as to why this might be and whether this phenomenon is only relevant to London. Nurses have experienced difficulty in many parts of the country in their attempts to enter the housing market, and the situation in London is particularly poor as property prices are amongst the highest in the country. Mullen (2003) stated that a nurse working in London would need to earn £60,000 per annum (greater than three times a nurse’s salary at the time of publication) to be in a position to afford a house similar to that of a nurse based in Manchester.

Barron and West’s (2005) secondary analysis of British Household Panel Survey data from 1999 to 2001 indicated that nurses in receipt of higher rates of pay were more likely to demonstrate commitment. The authors also argued that nurses’ pay is relatively poor because nursing is female dominated and employers (consciously or sub-consciously) are affected by the historical, social stereotyping of nursing as low status, low paid work. This is an attitude which is embedded in society and may act as an obstacle to nurses gaining better pay and conditions of employment (Barron and West 2005). The issues surrounding gender and nursing will be examined further in Chapter 3 of the thesis.
One aspect of the remuneration package that may have an impact on nurses' decision to stay in nursing is pensions. Watson et al (2003) in their study of nurses over 50, found that many nurses demonstrated commitment purely because of the pension scheme that the NHS offers. They also suggested that the NHS pension could be used as a way of encouraging (older) nurses to stay in nursing. The NHS has one of the few final salary pension schemes in the UK so pension entitlement may be a reason for mid-life nurses to stay in the NHS, especially if nurses have been contributing to their pension for a number of years. For the nurses who work in care homes, this may not be such an issue in terms of commitment as they are more likely to pay into a private pension scheme which will not have the same benefits as an NHS pension. It may be important to analyse this in terms of nurses' decisions to move into the care home sector.

2.8. Conclusion
This chapter has reviewed some of the pertinent literature in terms of organisational and occupational commitment and the measurement of concepts that contribute to why nurses stay in nursing. Studies on organisational and occupational commitment have concentrated on developing models of commitment and proving or disproving Becker's side-bet theory (Ritzer and Trice 1969; Jans 1989; Meyer and Allen 1984, 1991; Cohen 1999; Meyer and Herscovitch 2001; Powell and Meyer 2004). What appears to be a gap in the literature is any focus on mid-life nurses' organisational and occupational commitment, particularly those working in the care home sector.

Nursing research that has used Becker's side-bet theory has been limited to hospital nurses (Ritzer and Trice 1969, Cohen 1999). There is little evidence of research that has used the concepts of affective, continuance and normative commitment as a conceptual framework in a qualitative study of nurses, and particularly care home nurses as respondents, in a UK or global context.

Little research has taken a qualitative approach and, of the literature found, most has considered nurses across the age range. This doctoral study aims to fill some of that gap in knowledge and understanding about why mid-life nurses stay in nursing using a qualitative approach to gain an in-depth understanding of the issues that are
important for these nurses in deciding to stay. Whilst this study does not explicitly aim to examine Becker’s side-bet theory of the concept of commitment, it provides a useful sociological concept for explaining mid-life nurses’ occupational and organisational commitment.
Nursing Work and Work-Life-Family Balance

3.1. Introduction
Nursing has always been a gendered occupation. This chapter will examine the ways in which the concept of gendered role responsibilities is important in nursing. The chapter will consider the concepts of caring as a culturally defined role for women and how this relates to nursing. It will discuss issues associated with domestic labour and emotional labour and how these link with nursing. The chapter will also examine literature on the inter-relationship between women and domestic responsibilities – including childcare and caring for dependants such as older parents, work-life (work-family) balance and nursing. The literature on the themes of nurses and part-time work, nursing careers and women’s financial independence will be reviewed and critiqued to demonstrate the complexity of female nurses’ work and family lives and how the private and public roles of these women are negotiated.

3.2. The Concept of Caring
Caring is a central tenet of nursing (Porter 1992a, 1992b). According to Finch and Groves (1983), the activity of caring has been culturally designated to women as it is deemed ‘natural’ for women to care, a position that is sanctioned by the state and society via an ideology that encourages women to look after others within the structure of family life (Ungerson 1983). Abel (2000) concurred with the position that care work is gender biased towards women. It has been suggested that care-giving is naturally associated with, and pre-determined by, the ascribed social position of women; women are biologically and psychologically predisposed to caring (The Women’s Health Council 2005). However, Ungerson (1983) among others, has argued that caring is socially constructed as a woman’s role.

Graham (1983) explored the concept of caring in order to determine its meaning and what caring involves. She indicated that it is difficult to define caring as it is a nebulous concept, but she suggested that caring entails psychological, emotional and physical efforts to look after the welfare of individuals. Caring, she indicated, is not
only defined in terms of women’s personal identity but also in terms of social policy in that the ‘carative’ (Watson 1999) process is essential to the overall health of society and individuals within that society, in contrast to the role of medicine which is ‘curative’ (Watson 1999). Caring is a universal process, a fundamental human sentiment and in more developed societies is one that is designated as women’s domain, a concept which is complex and both socially and economically predicated (Graham 1983). The assertion that caring is instinctive to women and that the paid workplace is men’s natural competitive arena has been criticised for not being an accurate reflection of the norms of society (Glenn 2000).

Cancian (2000) discussed Talcott Parsons’ theory that the workplace is an essentially uncaring, masculine and public domain where rewards are extrinsic and financial, what Parsons terms an instrumental orientation (further developed by Goldthorpe et al (1968a, 1968b, 1969) in their study of assembly line workers). In contrast, the work of women is done in private, is not as well rewarded financially but has intrinsic rewards (the care is rewarding in itself), is essentially feminine and expressive (Cancian 2000). She warned that “because care work includes both expressive and instrumental orientations, it is important for researchers of care work to move beyond traditional sociological dichotomies of feelings versus rationality, or private sphere versus public sphere.” (p138)

Brush and Vasupuram (2006: 184) posited that one of the current difficulties in recruiting nurses in developed countries is that women in advanced economies have greater choice in the labour market and choose not to enter the nursing profession because “caring work is fundamentally invisible and devalued”, often because it is lower paid than other comparable professions (Cancian 2000), and therefore not attractive as a career option.

From the feminist perspective, care work is undervalued and underpaid. Care work is often examined in the context of unpaid work, done by women in the home for relatives and close family members (The Women’s Health Council 2005, Tuominen 2000, Abel 2000, Meyer et al 2000, Davies 1995). Waerness (1992) considered the connection between unpaid care work in the private sphere and the public sphere of paid care work such as nursing. She posited that as paid care work becomes
instrumental, the expressive aspects can sometimes be lost in the professionalisation process. Davies (1995) seemingly in agreement with Cancian (2000) indicated that nurses do face a conflicting dichotomy of the instrumental and expressive orientations to care work. Nurses, on the one hand, subscribe to the professionalisation process, which distances them from the expressive traits of care-giving, however, they are often frustrated by the structural processes which promote professionalisation at the expense of the intrinsic rewards of holistic nursing.

3.3. Caring as an Expansion of Women’s Domestic Role
Caring is seen as a natural extension of women’s domestic work, unpaid work that is performed in the private sphere for their families (Abbott and Meerabeau 1998). Nursing was initially “an unskilled occupation, something that women did in their homes” (Doyal and Elston 1986: 196), a sentiment echoed by Reverby (1987) who confirmed that nursing was considered an expansion of the type of work that women traditionally carried out within the home. As Mitchinson (2001) stated, caring in the form of nursing is seen as stemming from the caring role acted out within the family.

Gamarnikow (1978) compiled an excellent and comprehensive history of the development of nursing, charting its evolution from the mid-nineteenth century, (positioning it within the Marxist theory of capitalism). She suggested that from the outset, nursing represented employment that was deemed suitable for women of all social classes but attracted particularly women from the middle classes. Therefore it became increasingly ‘professionalised’ as these middle class women sought recognition which would ultimately attract other middle class women.

Gamarnikow (1978) argued that because nursing work was concerned with activities that were similar to the domestic tasks that women performed in the home, such as taking care of individuals’ personal hygiene needs and other domestic duties such as cleaning, nursing came to be seen as comparable with the domestic role. This, in turn, Gamarnikow suggested, runs counter to nursing’s desire to be considered a profession because the central activities that are identifiable with nursing as an occupation - the caring aspects of the role - can be considered to be a natural characteristic of a woman’s role and subsequently not valued (Abbott and Meerabeau 1998). Gamarnikow conceded that the “sexual division of labour is a complex analytical
concept" (p98) and that ‘biological determinism’ is responsible for allocating the caring role to women.

Gamarnikow (1978) expanded her historical exploration of how nursing came to be considered an extension of the domestic role through consideration of the patriarchal environment of the traditional family: the roles of mother, father and child are played out within the health care setting. Gamarnikow (1978: 110) stated:

"The ideological reconstruction of interprofessional relations of their transformation into male-female relations operated by representing the nurse-doctor triad as essentially homologous to the family structure. The nurse-doctor-child relations came to be seen as basically male-female relations and the patient became the child. The equation patient=child justified with reference to the childlike attributes and psychology of sick people in general provided an ideological space for turning nurses into mothers and doctors into fathers."

Gamarnikow (1978) traced the origins of this ideological concept back to the 1890s, which is a recurring theme in the literature of that time. She cited examples of this from the ‘Hospital’ journal, which explicitly stated that nursing is women’s work and this is entirely due to biological determinism. As nursing evolved, nurses still performed activities that were done ‘on the body’ but the domestic duties such as cleaning, serving food and beverages were increasingly performed by unskilled maids (Garmarnikow 1978). Hunt and Wainwright (1994) confirmed the domestic foundations of the nursing role and suggested that the nurse was acting in the role of the wife to that of the doctor (the husband) and was responsible for controlling the domestic staff and subordinating herself to the dominance of her husband. In the nursing role, she fulfilled the function of the benevolent mother to her patients (Hunt and Wainwright 1994). These attitudes evoke a very middle class attitude to nursing. It is not well paid because it is a vocation and a ‘calling’ (McKay 1998, Hallam 2000, White 2002).

Rafferty (1996) suggested that the evolution of nursing and the reforms that ensued in the late nineteenth century were less concerned with attempting to change the ideology of nursing work and more with reconstructing a class image of nursing by attracting middle class rather than working class women. Nursing was viewed
negatively due to working class women’s moral standing and image within society (Rafferty 1996). However, this has still resulted in women’s work, skills and nursing being undervalued in society, a position which prevails in relation to some aspects of nursing in the twenty-first century, for example, the care of older people in care homes. Nurses are still subordinate to the medical profession, with many having low status and low pay (Davies 1995), a situation that has been the case since nursing became a paid occupation.

Wilson (2003) asserted that caring and deftness are instinctive to women, skills that are used frequently but not exclusively in nursing or the caring professions. The emphasis placed on these so-called innate skills and the positioning of women in the caring/nursing role is a socially constructed phenomenon. As Gammack (1978) indicated, nursing was patriarchally created for women in the nineteenth century, under the premise of biological determinism, drawing on elements from the woman’s private domestic sphere of caring for the family and organisation of the home.

Hallam (2002: 35) chronicled the progression of nursing from ‘vocational care’ which she described as “quasi-religious to a more secular occupational identity” (2002: 36). Hallam (2002) charted the progress of successive nursing leaders to change what Thackery (1999) asserted is a profession with a poor public image. Hallam commenced by considering the image of nursing post world war two. She argued that nursing was considered one of the most acceptable occupations for young women with a basic secondary education during this period, in addition to working as a teacher, secretary or shop assistant. At this time, nursing was still regarded as hard, dirty work, presented as governed by “rule bound behaviours that promoted self-presentation and appearance, duty and service to the profession as the essence of the nursing self” rather than emphasising professional nursing skills and technical ability and knowledge (Hallam 2002: 38).

Presently, nursing is still dominated by women, with 89% percent of NHS workers being female (NMC 2008). So why does this situation prevail today? Is nursing still considered an extension of a woman’s natural role despite attempts to professionalise? Despite efforts to make nursing more ‘professional’, men are still not attracted to it
and this may be due to low status and low pay. Hughes (1990) summarised this
dichotomy succinctly by concluding that nursing has tried to achieve the impossible
by attempting to professionalise yet retain the essential elements of nursing, based on
the concepts of care and elements of the domestic realm, elements she suggested that
are given added gravitas by the sanctioning of society.

Whilst there has been much debate during the 1970s and 1980s about the
dichotomous identity of nurses, the skilled manual versus the professional, there has
been little activity and attention recently and no empirical studies have been found
that examine whether nursing is still considered, by nurses, to be an extension of the
domestic role and whether they regard this as the case. Waerness (1984: 186) argued
that there was a lack of a ‘conceptual framework’ for sociologists to evaluate
women’s roles within the divergent themes of private domestic work and the public
domain of paid caring work, and stated that therein lies the difficulty when attempting
to construct a theory of care work.

According to Hallam (2002), by the 1980s the gendered stereotype of the nurse as an
angel, battleaxe or doctors’ handmaiden had been rejected by nurses and nurse leaders
who wanted to promote nursing in the public’s consciousness as a profession with
professional qualifications, technical proficiency and nurses as patients’ advocates.
However, as Hallam (2002: 43) stated, nurses’ claim “to care as their own specific
area of expertise” has been eroded by the introduction of national vocational
qualifications (NVQs) for health care assistants, allowing them to provide care that
was traditionally undertaken by student nurses. Davies (1995) termed as the
‘professional predicament’ that nurses are ignored by policy makers because nursing
is a gendered occupation. This has left nurses in a position where they are chasing
professional status, but do not meet all the criteria demanded of professions such as
medicine or law – particularly contested are the specific areas of whether nursing has
a monopoly of knowledge and expertise and has a legally backed monopoly of

White (2002) argued that the term ‘vocation’ is the only way to describe the work that
nurses do and that there is a great deal of misunderstanding in relation to vocational
work. She contended that as nurses are educated and skilled at what they do, nursing
is not just an extension of the domestic role, that it is the *work* (sic) that is the vocational aspect of nursing, although not all nurses “will engage with vocational motivations or actions” (White 2002: 279). On the surface, this appears to challenge the current trend for the elevation of nursing to a profession and indeed White does not discuss this in her paper. However, on deeper analysis, she was not refuting the impetus for the elevation of the status of nursing, indeed she agreed that nurses have been subordinated and not recognised or rewarded sufficiently; what White wanted to see was nurses concentrating on providing the best care for patients and the development of a vocational model of nursing based on the core concepts of caring, service, nurturing and altruism (White 2002).

3.3.1 The Lost Art, or the New Face of Caring?
The debate centering on the caring role of the nurse has developed as nurses’ roles have become more demanding, due to the combination of the rapid pace of technological progress, the advances in medical knowledge and expertise and, ultimately, the ageing of the population. Flatley and Bridges (2008) argued that the more ‘technical’ nursing care is, the higher the associated status of the nurse. Other commentators, cited in this section, have debated whether, as a result of the changing health care environment, nursing is in danger of losing one of its central tenets, the ‘art of caring’.

Corbin (2008) argued that the art of caring, central to the philosophy of nursing, is incompatible with increases in technology and associated pressures of work in contemporary health care contexts. Griffiths (2008), in response to Corbin’s concerns, observed that the debate regarding the increasingly technological role of nurses started in the 1960s with the work of Hall (1963, 1969). Griffiths contended that the challenge for nursing is to reconcile the art of caring with a rapid and continuously changing nursing role.

Allen (2004), in her review of nursing field studies, argued that nurses’ roles are now more suited to the role of ‘health mediator’, rather than the traditional function of providing holistic care. She defined this role as being aggregated from eight functions
that a nurse's role encompasses:

1. Managing multiple agenda;
2. Circulating patients;
3. Bringing the individual into the organisation;
4. Managing the work of others;
5. Mediating occupational boundaries;
6. Obtaining, fabricating, interpreting and communicating information;
7. Maintaining a record;
8. Prioritising care and rationing resources.

Allen (2004:278)

Allen (2004) stated “the evidence suggests that nursing has little to gain by continuing to pursue an agenda of holistic patient care based on emotional intimacy” (p280) and that nurses need to promote what they actually do for the professional development of their occupation. Allen postulated that the role of health mediator reconciles the needs of the health care and organisational system with nursing care.

3.4. Emotional Labour, Emotion Work and Nursing

The involvement of emotions in nursing has been acknowledged and recognised as a complex issue (Bolton 2001). Since the seminal work of Hochschild (1979, 1983) on emotional labour within the airline industry, it has been appreciated that nursing work is not just the physical tasks that nurses undertake when providing care but it is part of the nurses' professional role to do emotion work (Smith and Gray 2001, Smith 1992; James 1989, 1992). Emotion work has garnered growing interest from researchers and there have been several studies into its place within the health care sector, notably nursing and midwifery. In the UK, the concept of emotional labour has been of interest to researchers such as Gray (2009), Bolton (2000), Smith (1988, 1992), and James (1989, 1992) who have investigated emotional labour within the health care setting. In the US, empirical work has been done by Lopez (2006), and in Canada, by Henderson (2001).

Hochschild (1979, 1983) is credited with first using the term emotional labour to describe what had not been explicitly expressed but taken for granted in the roles that service workers perform along with the physical tasks involved in their work.
Hochschild (1983: 440) in an effort to define emotional labour suggested that it involved work to “create and maintain a relationship, mood or feeling”. This was based on ‘feeling rules’ (Hochschild 1979: 563), which had their foundations in social rules. Hochschild (1983: 36) used the terms ‘deep’ and ‘surface’ acting to describe how employees experienced emotions within the work context. Surface acting is described as a superficial reaction towards others, lacking in sincerity because it is only body language that is changed in response to the situation (Hochschild 1983). Deep acting occurs when workers use emotional memories to generate a reaction that is more heartfelt and genuinely felt. However, Hochschild’s theory has been criticised and it has been suggested that there is a lack of empirical evidence to support her concepts (Hunter 2008).

James (1992) investigated the concept of emotional labour in a hospice setting and compared it with the domestic work that women perform in the home. She indicated that the social context or structure within which care is delivered is important, emphasising that within the organisational setting of the hospice, as with all Western health care structures, the predominant model of care is the medical model which values the ‘curative’ ideology over the ‘carative’, giving one-to-one care is seen as problematic. One example she cited is the “tension [for nurses] between organisational priorities and organising individual care” (James 1992: 495). Due to the way the unit in the study hospice was run, it was not possible for a nurse to wash a patient’s hair because of the ‘back round’ schedule which clashed with the patient requesting that his hair be washed. The nurse prioritised the routine and task orientated practice of the ‘back round’ over the holistic care of patients because the prevention of pressure sores, which was the aim of the ‘back round’, was of paramount importance. The presence of pressure sores indicated poor care and poor standards. The nurses in James’ study felt unable to challenge this organisation of care.

James (1992) argued that although the work carried out within the hospice and the home may be considered similar, the home environment offers greater flexibility to care, despite the existence of family routines which can be interrupted in times of crisis. For the staff in this hospice, good care involved the emotional constructs of ‘involvement’, ‘being there’, and the feeling of being able to spend time with patients.
James argued that emotional labour is divided in a similar way to physical work and to that extent, staff are in need of training to cope with the demands of emotional work, a recommendation with which Smith and Gray (2001) concurred. James (1992) posited that the emotional content of nurses' work is invisible, and because it is associated with work that is performed in the private, domestic sphere, it is not given greater recognition. She asserted that emotional labour, with its foundations in the domestic caring role, should not be ignored but valued and developed.

Smith and Gray's (2001) empirical study of students and staff working in hospital and primary care settings followed up Smith's (1992) study of student nurses and emotional labour, with the remit of examining emotional labour in the contemporary health service setting and how emotional labour was defined by current students, qualified nurses, doctors and nurse educators. The researchers found that emotion work was considered to be "part and parcel of the normal routine of nursing" (p44) and like James (1992), socially contextualised, as it was regarded as ensuring that patients felt part of a family. Like James (1992), Smith and Gray (2001) found that students were helped by thinking reflexively following emotion work and that training would assist them in the development of their emotional responses in the clinical environment, something that was missing and possibly still is for nurses. They also linked the issue of mental health and emotional labour, an issue that had not been explicitly examined by other researchers, and suggested that health care workers' mental health was at risk due to the lack of opportunities for debriefing at the end of a period of shift-work. They also acknowledged that this could have the impact of spillover into the private time of individuals in the family/domestic domain. This will be examined further in the review of Wharton and Erikson's (1995) work later in this section.

So far, in the evidence presented, researchers have concentrated on the place of emotional labour in the lives of health care workers and the impact of organisational structures on this emotion work. Lopez (2006), however, sought to give an alternative position. Lopez critiqued Hochschild's organisational feeling rules by suggesting that employers cannot set rules and regulations to manage employees' emotions. Lopez proposed an alternative theoretical framework based on his case study research in
three care homes in the US, that of ‘organized emotional care’ as opposed to
emotional labour. Lopez (2006: 135) considered emotional labour to be a form of
‘social engineering’, through which employers impose strategies to manage emotion
which, Lopez argued, gives the organisation rather than the employee ownership of
feelings resulting in a form of alienation and detachment of emotions. Lopez (2006:
157) supported his proposal of an organised emotional care framework by stating that
“service work organizations do not always impose feeling rules on interactive
workers”. Therefore the concept of organised emotional care is offered with the
caveat that this framework has perhaps less relevance to those employed in the
general (non-care) service sector but has greater applicability to care work.

Bolton’s (2001) study of gynaecological nurses in the UK has parallels with Lopez’s
work. She considered the application of ‘emotion work’ (Bolton 2001: 582) to nurses’
work rather than the label of emotional labour, arguing that Hochschild’s term does
not adequately depict the emotion work carried out by nurses, and makes the
distinction between emotional labour as prescribed by the organisation and the
emotion work that nurses perform to make a difference to their patients. Bolton
termed emotional labour alternatively as emotion management, which more
accurately describes emotion work prescribed and promulgated by organisations. She
argued these are supplementary ‘gestures of caring’ or ‘gifts’, not necessarily implicit
in nurses’ work (Bolton 2001: 581). She also indicated that nurses differ from other
service sector workers in that they are often more autonomous in carrying out their
roles and therefore not strongly monitored in terms of their emotion work, which
creates the opportunity for more authentic emotional responses. However, the
dichotomy of (emotional) caring and professionalism is raised here by Bolton. Caring
work is often difficult emotionally and nurses consciously or subconsciously detach
from emotionally charged situations as a coping mechanism; the professional persona
kicks in and nurses can appear detached.

Henderson (2001: 130) argued that there has been “little debate about the link
between caring and feeling” but argues that workers do have a choice. She explored
the concept of emotional labour in the context of nurses who care for abused women
in the UK and Canada. She introduced the notion that caring can leave nurses
vulnerable. What Henderson proposed is a continuum of ‘emotional engagement’
(p131), which is considered subjective, and "emotional detachment" which is objective. However, she insisted that nurses are not necessarily polarised to one extreme or the other. Henderson's work also supports that of Smith and Gray (2001) in that reflexivity had an important impact on nurses' emotional engagement with patients, the more opportunity nurses had for reflection the greater their engagement with patients. Henderson posited that nurses use emotions as a valuable aid to reflect on and appraise nursing practice. She acknowledged the cost of emotion work for nurses, which is often manifested in stress, burnout and spillover into domestic life – nurses go home and debrief to their partners or families as a way of bringing closure to a particularly stressful event or distressing situation if they have not had the opportunity to do so at work. However, Henderson (2001) stated that nurses gain great satisfaction from emotion work and, critiqued earlier in this thesis, job satisfaction is linked to morale and retention of staff and it is therefore important for employers to recognise and value this aspect of nursing work.

Although, it has not been possible to review all the published work on emotional labour/care/work, it is pertinent to consider the impact of emotion work on workers' domestic (home and family) life. This had been largely neglected by researchers investigating emotion work. The exception is Wharton and Erickson (1995) who explored the relationship between emotion work that women perform when undertaking paid work and emotion work that is unpaid within the family. The research is not limited to nurses but encompasses women workers within a US hospital setting who were married or cohabiting. Wharton and Erickson (1995) indicated that work and the family were considered to be two separate domains yet many recent studies have abandoned this position. They examined two alternative hypotheses, the 'scarcity hypothesis' which proposes that workers have finite physical and emotional resources which are vied for by both work and family, and the 'expansion hypothesis' which postulates that engagement in one arena creates energy and enthusiasm to engage in other spheres. These concepts were first introduced by Marks (1977) and later developed by Bielby and Bielby (1988).

Whilst Wharton and Erickson's (1995) results were not conclusive and not generalisable, they did present a number of interesting outcomes and possibilities. Firstly, they contended that the amount of physical labour and emotional work within
the family unit directly affected how they felt at work, whilst the level of support they received from their partners in terms of engagement in emotion work at home was also significant for women’s well-being at work. The more supported they felt at home, the better they were able to cope at work. Secondly, women who engaged in some form of emotion work in their job role carried out more emotion work at home. Thirdly, women who worked in mainly female dominated jobs (nursing could be included here) had a greater possibility of providing emotion work at home if they were engaging in emotion work in their jobs. In terms of the scarcity and expansion hypotheses, Wharton and Erickson reported that elements of both can be supported by their data.

3.4.1 Ecologies of Practice and Economies of Performance

The concept of emotional labour has also been criticised by Deery and Fisher (2009) because it does not necessarily represent the emotion work undertaken by all employees. They suggested that the premise of emotional labour is that people engage in the ‘deep’ or ‘surface’ acting of organisational values; however, what is not recognised is that tension often exists between professional and organisational goals. Deery and Fisher (2009) and Fisher and Owen (2008) rationalised that midwives (and, by logical extension, nurses) engage in ‘philanthropic emotion work’ – emotion work not solely governed by organisational philosophy, but by professional (and sometimes personal) values.

Stronach et al. (2002), in their study of nurses and teachers, contended that employees experience conflict in their working lives as their professional identity and ideologies battle with policies that govern the performance of their work. The authors termed these conflicts ‘ecologies of practice’ and ‘economies of performance’ respectively, drawing on Goffman’s (1961b) theories of self-presentation. Stronach et al. (2002: 122) defined these concepts as:

“The accumulation of individual and collective experiences of teaching and nursing through which people laid claim to being ‘professional’ – personal experience in the classroom/clinic/ward, commonly held staff beliefs and institutional policies based on these, commitments to ‘child-centred’ or ‘care-centred’ ideologies, convictions about what constituted good practice and so on.”
Deery and Fisher (2009) defined 'ecologies of practice' as the opportunity for workers (midwives, in the authors' case study), to experience more 'authentic' emotion work with patients. 'Economies of performance' were identified as the methods that staff employ to help them cope with the pressures and constraints such as limited resources in the work environment. This, they posited, results in employees economising on their emotional involvement, stifling imaginative practice and ultimately their commitment to patients, as they try to preserve their own psychological well-being. Stronach et al (2002) stated that 'economies of performance' were prevalent in the professional practice of the teachers and nurses in their study. They also indicated that 'ecologies of practice' were collective as well as individual experiences. Deery and Fisher (2009) argued that the work environment needs to be supportive and to value this kind of emotion work otherwise the result is a reduced professional (and I would argue, organisational) commitment. However, Stronach et al (2002) warned against the assumption that 'economies' are always negative experiences and 'ecologies' positive but concluded that:

“Professionalism, then, cannot thrive on performance indicators. It has to rely, in the end, on positive trust rather than be driven by performance ranking. If professionalism is to be 'risked' once more, such a risk will involve re-negotiating an economy of performance from within professional ecologies of practice.”

(Stronach et al 2002: 131)

3.5. Women’s Orientation and Commitment to Work

Much has been written concerning the topic of work orientations. The purpose of paid work for most people is usually fairly constant in that it satisfies goals such as financial security, the ability to use skills and experience that they have gained throughout their working and non-working lives, confers a certain status and allows a degree of social interaction (Natale and Rothschild 1995, Sverko and Vizek-Vidovic 1995).

Hakim’s writing (1991, 1995, 1996, 1997) on women’s orientation to work has been debated and critiqued at length (Bruegel 1996, Ginn et al 1996, Crompton and Harris 1998, Proctor and Padfield 1999, Fagan 2001). Hakim’s (1996) theory of the heterogeneity (diversity) of women has attracted much controversy; her central premise is that women have choices, either career or being a ‘homemaker’ and that
these decisions are made early on in a woman's life. Hakim (1996) stated that women can be categorised as either 'family oriented', 'career oriented' or, if they do not fit into either of these two categories as they have not made a choice, as 'drifters'. As the concept of women's work orientations has latterly been debated as a result of Hakim, much of the research has concentrated on young women who are embarking on their careers and this research has been of a multi-occupational focus, with an absence of research on nurses as a distinct group.

Proctor and Padfield (1999: 152) summarised Hakim's theory succinctly, stating "the sociological core of her theory is that women choose between two life priorities on the basis of their commitment to either career or family." Their paper critiqued Hakim's (1996) theory by employing a qualitative method to interview young women about their attitudes to work, family and the association between them. The interviewees were divided into two groups, single women without children working full-time and partnered women with children in either part-time employment or not employed. Their research initially categorised the women into five different groups. However, the researchers conceded that all the women could not be placed neatly into a distinct group. The conclusion of Proctor and Padfield's (1999) research is that the single women cannot be labelled 'career oriented' as they wanted both family and career which, in terms of Hakim's theory of heterogeneity, would ascribe them to the 'drifter' category which the authors refute as an accurate description of these women. Their second criticism is that for the mothers who had had children early on in their lives, this was a choice but that these 'homemakers' were also interested in having a career. Their final criticism is that work orientation cannot be isolated and analysed without reference to the structure of society.

Fagan (2001) discussed gender, work orientations and working time preferences in Britain, which have resulted from the changes to Western economic structure over recent decades, and has led to an increase in part-time work. Fagan (2001: 241) argued that, "work orientations are shown to be strongly related to occupational status and to position in the life-course rather than simply to gender." She also suggested that money is not the only motivating factor when work orientations are considered. Fagan (2001) argued that work can be rewarding in itself in terms of fulfillment, giving self esteem, satisfaction from knowing that the job has been done well,
allowing social interaction with other adults with common goals, and even in low paid, low status jobs. This gives the worker a superior status above those who are not employed and work orientation is stronger in people who feel their work is valued compared with people who work for economic purposes; their work orientation is much weaker (Gallie et al 1998, Fagan 2001). Fagin’s work resonates with the arguments of White (2002) about the vocational elements of nursing discussed earlier in the chapter.

Tomlinson’s (2006) qualitative research in the service industry investigated the decisions women made with regard to working full or part-time using a life course perspective and again, Hakim’s work is critiqued. Tomlinson used a socio-biographical focus to interview 62 mothers, 34 of whom worked part-time and 28 worked full-time, to investigate why women choose to work full-time or part-time over their life course. The rationale for the socio-biographical approach to the research is that the foci of the study were women’s work histories, career orientations and work-life balance and the reasons for their movement in and out of part-time jobs. The emphasis of the research centred on women, motherhood and part-time work. The women interviewed all worked in the hotel and catering industry. Her results indicated that (female) part-time workers continued to be marginalised through informal discriminatory practices in the workplace by managers who perceived that part-time workers were less committed, leading to restrictions for their career advancement. Tomlinson (2006:82) argued that the “occupational structuring” of part-time work and the extent to which organisations complied with legislation affects the perceptions of managers and full-time staff with regard to part-timers. If legislation and best practice policies were not embraced by managers and full-time staff, this had a negative impact on part-timers’ careers and promotion prospects. This led to part-time female workers experiencing low levels of job satisfaction.

3.6. Combining Part-time Nursing Work and Family Responsibilities

The UK national statistics for working women demonstrate that whilst there has been a substantial increase in the number of women in employment since the 1970s, 50 percent are working part-time compared with one in six men (ONS 2008). Women often take breaks in employment to take maternity leave and provide childcare. They either return to work full-time after a period of maternity leave or, as Martin and
Roberts (1984) asserted after an episode (or episodes) of caring for children, frequently to engage in part-time work. The health care sector has seen a rise in the number of part-time nurses working in the UK over the last ten years, 41 percent of nurses employed by the NHS are working part-time and the proportion of part-time nurses is even higher in non-NHS organisations (RCN 2002).

For many women, part-time work is a solution to combining paid work and domestic responsibilities, and nurses are no exception. The advantage that nursing as an occupation had, from the 1960s until recently, was the availability of shiftwork (especially nightshift work as this often enabled women with children to work without incurring the costs of childcare as partners, spouses and family members would undertake this function). Weekend work and non-contractual (agency or bank) work offered women options for part-time and/or periodic/flexible working. With the introduction of flexible working and initiatives such as Improving Working Lives (IWL) (DOH 2000a), as outlined in section 3.8, the options have expanded and make flexible working, for women with families, in theory, easier than ever before.

Ginn et al (1996) questioned the levels of job satisfaction amongst part-time workers and suggested that women express satisfaction because they have no other option; working part-time is the only way for them to balance paid work and family responsibilities and employers knowingly exploit this. However, as Higgins et al (2000:18) pointed out, there are ‘career women’ who choose to work part-time and do gain a sense of ‘personal and professional fulfillment’ (and identity) but, because of their domestic commitments do not have the time or resources to work full-time.

Walshe (1999) argued that women who work part-time cannot be treated homogenously in terms of their motivations and agendas, and sought to analyse the differences between part-time women workers. Walshe suggested that there are three sources for differences arising in the part-time labour force. First, is the disparity in the nature and quality of part-time work; second, employees have different motivations and agendas for pursuing part-time employment and third, Walshe argued that “part-timers’ orientations and commitment to work may be variable and subject to change over the family life cycle.” (p181). These are important issues to be considered when it comes to the recruitment and retention of nurses and several
authors have identified these challenges (Buchan 1999, Meadows 2002, Buchan and Seccombe 2004).

Burgoyne et al (2006) contended that it is often female parents who work part-time in order to care for children because the cost of childcare is perceived as prohibitive and inexpensive child-care places are scarce. Pahl (1995) asserted that married women have less control over finances and are disadvantaged in financial discourses with their spouse when they are less economically active and mainly provide childcare. Ward et al (1996) in their study of employed women in 1991, argued that women in full-time employment are much more likely than part-timers to be fully autonomous financially, and confirmed that the provision of childcare is a key issue for all mothers who wish to participate in the labour force. The authors indicated that the majority of women with children do not participate in full-time employment, which leads to their position as secondary income provider and consequently poor pension provision at retirement.

However, it has also been documented that women who work part-time (compared with those who do not work) have greater financial independence, and they have an identity outside the home and domestic caring responsibilities (Brannen et al 1994, Lister, 1992). Financial independence contributes to positive mental health and self-esteem (Landau 1995). This is supported by the work of Garey (1995: 416) who illustrated that working women see paid work as “an essential part of their lives and identities” in addition to providing a sense of “accomplishment, self sufficiency, dignity, self-worth and the notion of ‘doing something’”. It also can contribute towards women gaining pension rights and securing a more protected financial future once they retire, but this is less likely for part-time workers (Arber and Ginn 1995).

Employers need to consider nurses presently working part-time, who given the right environment, can be supported and developed to use the skills and experience gained. Evidence suggests that part-time women employees are considered involuntary workers, i.e. those who consider part-time work as a temporary solution to combining work and child-care, are highly likely to return to full-time employment (Stratton 1996). Walshe’s (1999) survey of part-time banking workers supported Stratton’s hypothesis as 41 percent of the women surveyed who were working part-time
expressed a desire that they wanted to engage in full-time work at some point in the future. Grant et al’s (2003) research supported the notion that part-time workers would like to fully engage in the labour market. However, their findings indicated that opportunities within the workplace for part-time workers wanting to work full-time hours were restricted and those who were working part-time and were seeking promotion also found that there were few opportunities in terms of career advancement. The debate surrounding part-time working and career options is outlined in the next section.

Little published research has focused on nurses and their orientation to work. An exception to this is Lane’s (2004) study on part-time careers in the NHS. Her aim was to examine the theoretical explanations of the disadvantages that female part-time workers experience in the labour force in the NHS. She asserted that theorists reside in two distinct camps when debating part-time work. One argues that part-time employees’ commitment to employers is different to that of full-time workers (Hakim 1991, 1995, 1996, 1997) and the other refutes this theory (Jacobsen 2000). Lane’s study involved a questionnaire study of 643 nurses working in the NHS in Wales in 1997. Lane’s (2004: 266) findings indicated that part-time nurses had far more experience than their full-time counterparts yet felt a “greater sense of underachievement” than full-time workers, which the author has interpreted as limited career opportunities rather than a lack of commitment to their jobs. Therefore she concluded that nurses who work part-time do not lack the commitment of their full-time colleagues, but are victims of the organisational structure. Lane questioned managers at the pilot study stage of the research and although they asserted that there was no recognised policy for preventing part-time nurses from working at a higher grade, in practice these grades were only advertised as full-time therefore excluding part-time workers. Lane’s (2004) research concentrated on NHS nurses, did not indicate the age ranges of the nurses she questioned and her results are analysed by grade but not by age, and it is not therefore possible to distinguish how many of these nurses were mid-life or older workers.

3.7. The Work-Life-Family Balance Debate
The concept of work-life balance has become of major interest (Roberts 2007). There have been numerous studies that have investigated how employees reconcile their
working lives and life outside work, and these studies generally concentrate on the impact of work on family commitments (Burgess et al 2007, Wise et al 2007, Whittock et al 2002, Mennino and Brayfield 2002, Tausig and Fenwick 2001, Lewis 2001). The terminology of the work-life balance debate is often problematic; what can be termed work-life balance, often means work-family balance. However, there are those employees who may be excluded from this definition (by self or others) because they do not have either child or adult dependants. It can be argued that family life is defined by each individual and their circumstances and that it is unrealistic to try to classify employees into definable family structures. In this thesis, I will use the terminology in the same way as the authors of the literature reviewed, referring to work-family balance where it is required to delineate those nurses caring for dependants (both adult and child) and work-life balance in a more general way, including those without dependants. Perhaps the best way to describe this is the balance between work and home life which would engender a meaningful description for all workers.

Hochschild’s (1989) study, ‘The Second Shift’ was one such landmark work. She investigated 50 American couples between 1980 and 1988, conducting in-depth interviews and completed observations of family life in a dozen homes to determine the effects of combining work and family life on dual career households. ‘The Time Bind’ (Hochschild 1997) detailed a further study into the work and family life experiences of workers in an American Fortune 500 company. In this empirical study she encountered workers who did not take up the family-friendly working practices on offer. She suggested that there is a degree of ‘role-reversal’ in home and family life for these employees as they perceived home life as a place of strain with not enough time to meet all the demands of family life and regarded work-life as a relief from this. What Hochschild argued is that work is usually perceived as a place of stress and home as a refuge from this.

Roberts (2007) questioned the origins of the work-life/work-family balance debate and why it has assumed importance. He proposed that the origins of the debate lie in the publication of Juliet Schor’s (1991) book, ‘The Overworked American’ which, as its title suggests, appealed to American workers as it indicated they were working too hard and for too many hours (Roberts 2007). Roberts disputed the notion that people
are working harder and longer, stating that there is no evidence for this, but citing a number of combining factors as contributing to this feeling of work-family life imbalance, including the following (Roberts 2007: 339-342):

- Women’s increasing participation in the labour market, which can lead to protests about a lack of time;
- Increased pressure at work – “intensification” (p340) leading to additional work duties and the feeling of greater requirements by employers;
- Uncertainty about job security leading to employees feeling pressurized;
- Shift-work causing disruption to traditional family schedules;
- ‘New Technology’ (mobile phones, mobile computing etc) – creating a perception of greater availability of employees outside of the workplace, to both employers and other employees;
- Increased leisure time but without the corresponding increase in incomes;
- A culture of long working hours.

Roberts contended that not all occupations are facing the same issues and problems, and different occupations and individuals have alternative coping mechanisms (related to class). He concluded by arguing for greater work-life-family flexibility for all employees in all occupational classes.

3.8. Work-Life-Family Balance, Flexible Working and Nursing

Having briefly provided some historical background to the work-life-family debate, I will now consider the introduction of what is broadly termed ‘employee friendly working practices’ within the UK health care sector. The concept of improving work-life balance through flexible working practices has been debated widely (Ansari 1997, Hall and Atkinson 2006). Most of the studies focus on hospital settings, with little empirical work or policy relating to nurses working in the care home sector.
Eikhof et al (2007) argued that employers offer flexible working conditions in order to meet their commercial interests, whilst appearing amenable to the needs of their employees. Dex and Scheibl (2001: 412) indicated that flexible working can encompass such initiatives as

“part-time work, term-time work, job sharing, and extensions to maternity breaks ... career breaks, paternity or parental leave, adoption leave, leave for caring for elderly relatives, emergency leave, workplace nurseries or other help with childcare and the ability to change from full to part-time hours or to work from home for at least part of working hours.”

NHS Employers (2009) include other flexible working practices such as:

- staggered hours - varying normal working hours to suit employees needs (for nurses this may mean working to fit in with school hours);
- compressed hours - working longer days but a shorter working week; shift-work, time off in lieu or banked hours;
- annualised hours - hours are calculated over an entire year giving both employer and employee greater flexibility;
- v-time working - a voluntary reduction of hours agreed by the employer and employee with the guarantee of full-time employment at the end of the agreed time period;
- phased return to work for employees that have taken time out for maternity leave, childcare or illness;
- flexible retirement plans and ‘keep in touch’ options aimed at keeping workers approaching retirement in work albeit, on reduced hours without loss of pension privileges.

The Improving Working Lives (IWL) initiative, part of the NHS Plan, introduced in 2000 by the government, was aimed at employers to ensure that employees achieved a healthy work-life balance through flexible working opportunities (DOH 2000a). There has been a proliferation of research within the UK aimed at elucidating the impact of family-friendly working policies and practices on the nursing workforce (Robinson and Bennett 2007, Ball et al 2005, Wise 2004, Robinson et al 2001) and advocating the benefits of family-friendly working.
Wise (2004) conducted research with nurses and midwives within one large Scottish NHS Trust. Her results indicated that employees were not well informed of the organisation’s policies and that adoption of measures to improve work-life balance was poor, with shift-work contributing to the difficulties of maintaining a healthy work-life balance. Wise reported that what employees within this organisation aspired to was more power to determine their working hours and a solution of self-rostering was proposed. The nurses and midwives surveyed specified that they often worked in excess of their contracted hours, which had an impact on their work-life balance. Ultimately, what was important to the nurses and midwives in this study, which supports other studies on intention to stay, in addition to policies to improve working lives, was the employer’s recognition and valuing of their workforce.

The RCN (2002) conducted a survey of its members to determine whether nurses felt supported by their employers, had healthy working conditions and had access to ‘employee-friendly services’ (p4). The RCN’s findings had similarities to those of Wise (2004) in that nurses’ job satisfaction and sense of well-being were affected by ‘employee friendly attitudes’ (p5). The link between job satisfaction and intention to stay is well supported by empirical studies (Tourangeau and Cranley 2006, Sourdif 2004, Tallman and Bruning 2005, Ingersoll et al 2002). The RCN (2002) survey reported that despite the promises of IWL and NHS Employers’ (2006) commitment to the initiative, even basic amenities were not provided by employers, such as a staff room for breaks, and the provision of employee-friendly practices were distinctly inadequate within some organisations. The survey reported that of the 3560 nurses who responded, more than half were unable to gain access to measures that were designed to improve their working lives, for example, flexible working and leave to care for dependants. A quarter of the nurses surveyed stated that their organisation did not enable them to create a harmonious work-life/home-life balance and that they needed further support in this area.

Robinson et al (2001) reported on qualified nurses, who between four and eight years post-qualification, made the decision to take time out of their nursing careers either on maternity leave and/or to care for their children. The authors contend that although 90 percent of the nursing workforce are female, nursing is not conducive to rearing a
family. A career break can lead to re-entry into the workforce at a significantly lower grade or role than on exit.

In guidelines issued by the RCN (2008) the emphasis is placed on the benefits to both employers and employees in achieving a satisfactory work-life balance. For employers, the report advises that they need to make equitable provision for all employees in terms of flexible working practices, in order to retain nurses of all ages, especially older, experienced nurses. Nurses nearing the end of their working lives should not lose out on their pension provision if they wish to downgrade at the end of their careers. The report suggested that the cost of such measures will be outweighed by the benefits of retaining experienced nurses, and a stable workforce will provide cost savings from reductions in staff sickness and attrition rates.

When it comes to examining the situation in the care home sector, the nurses working in these organisations have been neglected as an occupational group. Most care homes would fall under the umbrella of small and medium sized enterprises (SMEs), with the exception of the larger providential companies such as BUPA. Yet there is no evidence of research in care homes within the UK with regard to flexible working and employee friendly working practices. Dex and Scheibl (2001) examined family friendly and flexible working in 10 SMEs, organisations which they defined as having fewer than 500 employees and although one was described as a Hospital Trust, none of the other companies were health or social care providers. A literature search revealed only one study in which nurses working in care homes were included (Brookes and Swailes 2002).

Brooks and Swailes (2002) used the results of a 1998 Institute of Employment Services survey of 2987 nurses and members of the RCN, working in hospitals, hospices and care homes to examine the effect of nurses' ability to determine flexible working schedules and how this impacted on their commitment to nursing. The authors' primary interest was investigating the impact of shiftwork, in particular nightshift work, and nurses commitment to nursing. Whilst stating that care home nurses were included in the sample, the study does not differentiate between care home nurses and hospice nurses and, as a result, all the nurses surveyed are merged into a homogenous group. Their study therefore gives no insight into the similarities
or contrasts in policies and practices within the hospices or care homes, organisations which are not subject to the IWL initiative or government evaluation of its implementation.

Not only is it pertinent to examine the importance of employee friendly working practices and work-life balance, it is necessary to consider how nurses achieve these in reality, despite the rhetoric of government and employers. For many nurses achieving a work-family balance means taking on part-time work. Whilst employers and the government have made attempts at improving employees' work-home life balance, there are still improvements to be made and not every employer provides adequate services for its workforce (RCN 2002). In addition many employees do not know how to access the information (Wise 2004). NHS Employers (2009) gives guidance as to what constitutes flexible working practices for the NHS. Despite the number of reports and recommendations for practice and policy in terms of improving the work lives of nurses, creating family-friendly working practices and harmonising work-life balance, the emphasis appears to be on those nurses working within the NHS, and those with children or adult dependants. This situation of the perception of unfairness in giving preferential treatment to some employees can create interpersonal and inter-professional tension between employees with and without children if parity is not guaranteed (CIPD 2007). The importance of employee friendly working practices needs to be guaranteed for all workers rather than an emphasis on employees with families. This would ensure that there is equality for all, both women and men, regardless of their domestic situation.

3.9. Full-time Working, Part-time Working, and Career Options

Recently there has been a focus on career choices for nurses and the increasing opportunities available to some, but not all (Robinson and Bennett 2007, Wise 2004, Wise et al 2007, Ring 2002, Robinson et al 2001). Ring (2002) argued that the structural aspects of organisations have often delayed nurses in pursuit of specialist careers. She cited the example of the expectation that nurses in the 1970s and 1980s strengthen the skills learned as students through ward based work, usually in general medical and surgical areas, before they were able to then specialise in a chosen field.
Davies (1995) stated that whilst the initial impression is that part-time work enables women to combine work and family responsibilities, she questioned whether this is at the expense of career choices, citing one outcome of Mackay’s (1989) study which indicated that part-time working for nurses meant disruption of career options. What Davies (1995) did not explore is those women who do not wish to pursue a full-time career and do not necessarily want the challenges and responsibilities that climbing the career ladder involves. This is confirmed by Grant et al (2003), whose study showed that, for some women, the stress and intensity of the work role had caused them to seek lower status jobs and while some were happy with this decision, some had regrets. Nursing can be a very stressful, emotionally demanding occupation and for some nurses, part-time work allows them to maintain their hard-earned occupational status and professional identity, balancing that with family or life balance. Wise (2007) reported that only 10 percent of the nurses and midwives studied expressed a desire to perform the role of their line manager. Ginn et al (1996) argued that women’s working time preferences, when stated, have to be contextualised in terms of family (especially childcare) responsibilities because of the association between paid part-time work and domestic caring responsibilities.

There has been much debate about part-time employees and their commitment to careers and employers (Tomlinson 2006, Lane 2004, Fagan 2001, Hakim 2000, 1996, Crompton and Harris 1998, Proctor and Padfield 1999, Bruegel 1996). Ginn et al (1996) suggested that not only did breaks in careers to care for children limit women’s opportunities for returning full-time to the labour market, it also limited the choices that they have in the labour market. Grant et al’s (2003: 48) research demonstrated that women who return to work following childbirth found themselves in a “restricted labour market” and “experienced the disadvantage and downward mobility associated with women returners”. These women often occupied low paid, low status jobs despite many being keen to use acquired skills and to improve their competence and knowledge (Grant et al 2003).

Coyle (2003) posited that nurses face barriers to career advancement when they opt for part-time work, because line managers perceive that higher grade roles cannot be performed adequately on a part-time basis. This is supported by the RCN (2002) who reported that nurses working full-time were more likely to succeed to senior grades
than those working part-time. Their report specified that this was particularly prevalent in nursing homes where 79 percent of staff who worked part-time were the equivalent of an E grade staff nurse (qualified nurses were graded D to I, D being the lowest grade, I being the highest, prior to the introduction of Agenda for Change in 2004, where bands 1-9 were introduced). This contrasts with only 29 percent of full-time qualified staff working in care homes who were paid at E grade level.

3.9.1 Structured Career Pathways
Whatever an employee’s preference, motivation or commitment to work, whether full or part-time work, the importance of structured career pathways cannot be ignored, yet there is little evidence that a formal framework exists within the NHS or the care home sector for nurses seeking careers advice or support. The Knowledge and Skills Framework (DOH 2004a) was developed as part of the Agenda for Change (DOH 2004b) programme and focused on the skills and knowledge needed by NHS employees to fulfil their role and future careers. However, it does not specifically address structured career pathways. The situation is changing; the Department of Health (2006b) launched a consultation to determine a structure for post-registration nurses suggesting five new career pathways with nurses choosing one particular pathway. The consultation ended in 2008 with the publication of the ‘Towards a Framework for Post-registration Nursing Careers’ (DOH 2008) consultation response report and the proposals for the five career pathways were:

- acute and critical care;
- children, family and public health;
- first contact, acute and urgent care;
- long-term care;
- mental health and psychosocial care.

The pathways appear to be primarily focused on the organisational needs of the NHS, with terms used such as “workforce planning”, “aligning careers with health and service needs”, “identify demand and match with nursing resource” (DOH 2008: 12). The report applies principally to the NHS - “individual responses came from a good cross-section of the profession with trends reflecting the general distribution of staff
across the NHS” (p8). There is an apparent lack of recognition that workforce planning needs to include the increasing labour-force requirements of the long-term social care sector. There is little evidence of published research or policies in the UK on career planning for the care home sector. The Department of Health and Department of Work and Pensions have proposed the ‘Care First Careers’ (DOH 2010) initiative, aimed at encouraging people age 18 to 24 years into social care but this does not tackle the issue of attracting qualified staff into the sector. Registered nurses working in care homes appear to be falling into the gap between health and social care. They are included in the strategies aimed at nurses working in the NHS or in those aimed at social workers and unqualified care workers in the social care sector. There is an increasing need for care home places with nursing care; the number of places has increased, in England, from 180,701 in 2003 to 192,681 in 2009 (Care Quality Commission 2009). This will necessitate a greater number of qualified nurses entering this sector. The sector is already experiencing problems recruiting qualified staff and has a heavy reliance on overseas nurses. A policy of structured career pathways and national level support may be one way of making a career in long term care more attractive.

3.10. Conclusion
This chapter has explored the ways in which the concept of gendered role responsibilities is important in nursing. The chapter considered the concepts of caring as a culturally defined role for women and how it has evolved historically, and in relation to nursing. Issues associated with domestic labour and emotional labour were discussed and how these link with nursing. The chapter also examined the literature on the motivations of women and nurses to engage in paid work, the inter-relationship between women, domestic responsibilities (including childcare and caring for dependants such as older parents), work-life (work-family) balance and nursing. The literature on the themes of nurses and part-time work, and nursing careers was reviewed and critiqued to demonstrate the complexity of nurses’ work and family lives and how the private and public roles of these women are negotiated. Finally, the issue of career development in nursing was discussed. The concepts outlined in this chapter form the theoretical basis for the analysis of the research study presented in Chapters 6, 7, 8, 9 and 10.
CHAPTER 4

Organisational Structure, Culture and Context

4.1. Introduction
Whilst it is not possible to give an in-depth critique of the vast literature pertaining to organisational structure, culture and context, it is necessary to contextualise the organisational structure within which nurses work, both in the NHS and the care home sector. Health and social care workers face problems and issues due to the structure and culture of the organisations in which they work, in addition to the constraints resulting from the organisation of nurses’ work. The chapter will review the relevant literature involved in the discourses of managerialism and new public management, (de)professionalisation, the effects of managerialism on nurse autonomy, the surveillance culture that has resulted from managerialist ideology and the issues of respect, recognition and value of the nursing role.

4.2. Organisational Structure and Culture
According to Watson (2003: 83), organisational structures “are part of the wider social structure of the society in which they are located”. Watson differentiated between organisational structure and organisational culture, the former defined as “the regular or persisting patterns of action that give shape and a degree of predictability to an organisation” and the latter as “the set of meanings and values shared by members of an organisation that defines the appropriate ways for people to think and behave with regards to the institution” (p83). In terms of organisational structure, Watson (2003) argued that there is a duality of purpose for managers and their subordinates because managers seek to impose control through the construction of hierarchies in order to oversee work activities. In contrast, Watson asserted that workers attempt to understand and define their own work routine, form associations and their own order within the workplace.

Organisational culture is distinguished from organisational structure in that it is:

“a dynamic phenomenon that surrounds us at all times, being constantly created by our interactions with others and shaped by leadership behavior, and a set of structures, routines, rules, and norms that guide and constrain behavior” (Schein 2004:1).
Although organisational structures are contextualised by the society in which they are situated, they are also influenced by that society's cultural norms (Watson 2003). However, he clarified this position by stating that the terms structure and culture both allude to the same organisational process and are not mutually discrete. Watson gave the example of bureaucracy where the two concepts of structure and culture are often used interchangeably to describe phenomena occurring within an organisation. Grint (2005) criticised the interpretivist definition of organisational culture, positing that it is idealistic in that it proposes what an organisational culture should be rather than what it actually is.

Handy’s (1985) organisational typology encompassed four cultural types – ‘power cultures’, where power is held centrally but is devolved on a trust rather than rule basis; ‘role cultures’ which are based on rationality with set policies and procedures and are predominantly situated in bureaucratic organisations; ‘task-based cultures’, which are work or venture based and non-centralised; and finally, ‘person-orientated cultures’ which, according to Handy, have a limited role in organisations as they are individual-focused and more commonly found in the culture of the family. In terms of the NHS, the predominant culture could be said to be a role-based culture in that it is a heavily bureaucratic organisation with set policies and procedures. The culture has been characterised as one of mistrust rather than trust (Black 1995). Power has increasingly been recentralised (away from clinicians) through reforms, managerialism, a target driven culture and increasingly bureaucratic policies and interventions (Hunter 2006).

4.3. Restructuring and Reform

The history of the creation of the NHS has been well documented (Lister 2008, Talbot-Smith and Pollock 2006, Klein 2006, Webster 2002, Rivett 1998, Walton 1997). The NHS has been subject to restructuring and reform throughout its existence in order to improve its effectiveness and efficiency resulting in almost constant reorganisation for the last 20 years (Walsh 2003). This constant state of uncertainty, Walsh argued, has caused the system and staff to become cynical, short-termist and change resistant, choosing to believe that the current incarnation of changes will be superseded by further modifications before they have had a chance to implement whatever is on the current agenda. Parker and Glasby (2008, p.450) remarked that this
‘organological change’ within the health care system is not well received by staff at the forefront of clinical service provision, as it infrequently achieves its intended goals, resulting in a “workforce that is arguably change weary and reform wary”. Davies et al (2000) indicated that any form of change in culture and behaviour cannot simply trickle down the hierarchical structure. The “needs, fears and motivations of staff at all levels” have to be taken into consideration if change is to be successful (Davies et al 2000:116).

Restructuring and reforms have not been solely confined to the NHS. The social care sector has seen significant attempts to regulate and control how it functions. Social policy reforms have ensured that organisations have experienced considerable changes (to social care) since the 1980s. The Registered Homes Act (DHSS 1984) was the first example of legislation instituted by the government to regulate health and social care provision. Covered by this legislation were residential homes, nursing homes, homes for people with mental health problems and private hospitals. This was supplemented by the White Paper ‘Caring for People’ (DHSS 1989), resulting from Griffiths Report ‘Community Care: agenda for action’ (DHSS 1988), indicating that local authorities should move away from providing care to commissioning it. The NHS and Community Care Act (DOH 1990) saw market forces taking a dominant role in the provision of care, with the private sector largely replacing local authority care.

The new millennium ushered in the Care Standards Act (DOH 2000b), replacing the Registered Homes Act (DHSS 1984), and aimed to ensure a cohesive set of standards for care homes and domiciliary care. A new inspectorate was announced, the National Care Standards Commission (NCSC), and was replaced almost immediately by the Commission for Social Care Inspection (CSCI). CSCI’s remit was responsibility for the registration and inspection of all care homes within the social care sector. Also introduced were the National Minimum Standards, as part of the Care Standards Act (DOH 2000b), which set out the standards service users should expect from their care homes in terms of quality of care, services and facilities.

Century’ (DOH 2001a); the implementation of the ‘Care Standards Act’ (DOH 2000b); The Healthcare Commission (2004) launched to regulate health care not provided by the NHS; the White Paper, ‘Our Health, Our Care, Our Say: A New Direction for Community Services’ (DOH 2006a) aimed to deliver more personalised care to service users. In 2007 the publication of ‘Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care’ (DOH 2007), proposed collaboration between CSCI, the government (central and local), leaders and providers within the social care sector. The Health and Social Care Act came into force in 2008, amalgamating all the care regulators (CSCI, the Healthcare Commission, and Mental Health Commission) into an overarching regulator, the Care Quality Commission (CQC). The CQC replaced CSCI in 2009, regulating the social care sector and with limited regulation of the NHS. The current year will see a new system of registration for providers of adult social care and full regulation of the NHS in April 2010.

4.4. Bureaucracy in the NHS and Care Homes
Organisational structure, culture and context affect the way nurses’ work-life is experienced. In terms of the NHS, the organisation was traditionally viewed as a bureaucratic and hierarchical structure (Thompson et al 1991). However, this has been critiqued and the assertion made that the NHS has always had different structures of ‘quasi-networks’, ‘quasi-hierarchies’ and ‘quasi-markets’ simultaneously co-existing (Exworthy et al 1999). The term ‘quasi’ is employed because the NHS is not considered to function in the same way that ‘real’ markets do (Le Grand and Bartlett 1993). The NHS has been viewed as a hierarchy and bureaucracy as it has many of the features of a bureaucratic organisation as described by Walsh (1995). These include centralised policy making and resource allocation and authority and responsibility is hierarchical and cascaded down, leading to limited autonomy at the level of service delivery (Walsh 1995). This has been contested by Klein (2006) who suggested that whilst budgets were centrally determined at government level, clinicians were still responsible for their allocation.

In the classical Weberian definition of bureaucracy, the form of legitimate power is ‘rational-legal’ authority, based on the power of the office, which has characterised organisations since industrialisation (Weber 1947). According to Gray and Jenkins
(2007) although authors disagreed on the nature and numbers of these characteristics, there exists a central collection of features, or framework, that defines bureaucracy:

- Work is delineated into specific areas or departments within which responsibility and authority are constrained by rules and policies;
- Bureaucracies are characterised by hierarchical structures with authority cascading in a top down approach;
- Bureaucratic organisations are defined by rules and regulations upon which the operation of the organisation is based and determined;
- Documentation of activities and outcomes are a central feature of bureaucratic organisations;
- In terms of those that manage bureaucratic organisations – ‘bureaucrats’, training is required in the formal processes of managing the organisation and the policies and procedures that govern it;
- ‘Bureaucrats’ – do not have any other function within the organisation other than managing it;

(summarised from Gray and Jenkins 2007).

In terms of the NHS structure, in a classical Weberian sense, the NHS can be defined as a bureaucratic organisation in that it maintains an authoritative hierarchical structure, it is highly centralised, although this is changing with the development of Foundation Trusts (somewhat smaller bureaucracies themselves) which are predicted to be more autonomous (Talbot-Smith and Pollock 2006). Rules and discipline are central features with the recording of actions and outcomes by bureaucrats as an essential feature.

Care homes range from large corporate ventures with in excess of 300 homes within the corporate organisation to individual homes (Small to Medium Enterprises - SMEs) with an owner/manager who has authority and responsibility. The care home sector can be considered to be as bureaucratic as the NHS in some aspects of organisational structure. Brannon (1992) categorised care homes in the US as bureaucratic organisations due to the routinisation of care provided, the proliferation of rules and regulations. Communication of information was extremely regulated based on an
individual’s position in the hierarchy. However, there are studies such as Kane and Caplan’s (1990), which demonstrated that care homes can be places of autonomy and democracy for employees and service users. Care homes are hierarchical in structure, with managers legally responsible for the home, and a group of subordinate staff arranged hierarchically, ranging from senior, qualified nurses to junior, unqualified care workers. However, they are small and very different from the NHS or large hospitals.

In terms of government controlled policies and procedures, care homes are required by CQC to complete Annual Quality Assurance Assessments (AQAA), a self-assessment that necessitates homes to assess how they think they are meeting the needs of service users. Care homes are also subject to key, random and thematic assessments by the inspectorate, the frequency of which depends on the quality of the home as judged by CQC inspectors.

There is a lack of information and research on care home organisation in the UK, although there is more on care homes in the USA (Sheridan et al 1992, Kruzich 1995, Kruzich et al 1992). Very little research has been conducted in the UK with registered nurses or nursing auxiliaries with regard to how the organisational structure, culture and context affects their working lives.

4.5. Managerialism and its Impact on Nursing

There have been many commentators on the reforms that have taken place and continue to occur in the NHS and health care (Klein 2006, Talbot-Smith and Pollack 2006, Walsh 2003). One is the way the NHS has been and continues to be managed. Harrison and McDonald (2008) have documented the organisational and managerial changes to the NHS over the last 60 years, including the concepts within the structure of health care, of bureaucracy, networks and markets and how these have evolved to what is now termed the ‘third way’. Traditionally, post 1948 and up until the 1980s, the medical profession had significant power to influence and control health care delivery (Klein 2006). This changed with the Conservative government during the 1980s. The internal market concept was introduced in the NHS and Klein (2006) argued that power was partially wrested from the medical profession. Klein (2006) suggested that the balance of power shifted from the medical profession to managers
through the creation of NHS managers in an era of what was termed managerialism arising from the ‘Griffiths Report’ on management in the NHS (DHSS 1983). Griffiths proposed redistributing power away from the medical profession in favour of management and from health care providers to patients (Hunter 2006). However, commentators have argued that the government and ministers needed the help and co-operation of the medical profession to ensure that policy was put into practice, thus limiting the effect of managerialism on reducing doctors’ power (Ham 2004).

Hunter (1996: p799) stated that “all developed health care systems operate on the basis of tribalism” and that the tribes that exist within the health care setting comprise doctors, nurses, managers and professions allied to medicine. These tribes have differing goals and values when it comes to providing health care and these goals are sometimes conflicting. Hunter (1996) argued that it is the role of management to facilitate the diverse aims of these groups and to promote cohesion between them, ensuring collaboration and co-operation in terms of the organisation’s goals, in order to provide effective health care and ensure organisational allegiance. Hunter (1996) argued that health care reform has been ‘pandemic’ in recent years and that this reform has emphasised improved efficiency and outcomes which necessitated more effective management to evaluate and monitor the performance of health care professionals, thereby ensuring greater accountability in terms of performance in their roles.

In terms of what this entails for health care professionals, including nurses, Hunter (1996) argued, is that the change in public attitudes, culture and context meant that there has been a transfer towards a more flexible, patient focused health service, away from the control of the medical profession which was considered highly paternalistic and bureaucratic. However, this has not come without resistance from nurses who, having fought for and keenly embraced the concept of professionalisation, have been faced with the prospect of their (limited) autonomy being eroded through increased managerialism and now de-professionalisation and proletarianisation (Hafferty and McKinlay 1993). Hunter (1996: 802) contended that this new managerialism or, ‘new public management’ (NPM) attempted to impose a ‘hybrid’ model of the traditional ‘command and control model’ (control of services by bureaucratic management structures) and the ‘neoclassical market model’ (the purchasing of services by
providers based on supply and demand markets) and has led to increased confusion amongst health care professionals, leaving a legacy of insecurity, low confidence and low trust. This model of health care provision, Hunter (1996:802) argued, creates conflict for staff because they embrace a ‘public service ethos’ whilst NPM was based on a more ‘commercial ethos’, which was anathema to health care staff. McCartney et al (1993) indicated that health care professionals regarded the introduction of managerialism and managers with suspicion, resulting from a lack of understanding of the managers’ role, and regarded cost-cutting as the main purpose of their role.

This in turn has led to problems with recruitment and retention of staff causing stress through increased workloads for a dwindling nursing workforce. Hunter (1996) argued that nurses are somewhat tangential to the issue of decision-making and management of health care because they do not enjoy the power and privileges of the medical profession. However, nurses have been affected by the NHS reforms and NPM because of the introduction of performance monitoring, audit, budgetary controls and managerial controls (Harrison and Pollitt 1994). Although the introduction of NPM and management changes have affected doctors more profoundly in terms of their power base, they have also affected the daily working lives of nurses and have impacted on their professional autonomy (Hunter 1996), something that has had limited exploration.

Hau (2004) conducted an empirical study in a Singapore hospital, investigating the impact of new managerialism on attempts by nurses to provide holistic care to patients. Hau (2004:2) contended that the nurses in his research study were prevented from providing holistic care by the managerialist discourse of eliminating “the natural inefficiencies of bureaucracy” because of the imperative to reduce costs, competition and opening up the health care market. Hau’s research focused on how nurses manage their everyday work demands, with particular respect to resource management in the form of bed availability, within the discourse of new managerialism. Hau (2004) concluded that nurses are subjected to a (managerialistic) governmentality (Foucault 1988), and are limited by constraints of the “pragmatic health care system” (p2) leading nurses to relegate holistic care in favour of task orientated patient care to satisfy the demands (e.g. managerial/performance targets) of their particular organisation.
Beardwood et al (1999) discussed how the process of restructuring the health care system and nursing profession in Canada has been affected by using the subject of complaints against nurses in Ontario as an exemplar. The authors stated that during the rise of new managerialism in the 1980s, power shifted to management from health care professionals (they did not explicitly state doctors) and this evolved in a similar way to the UK in terms of cost cutting, performance objectives and the surveillance culture within the health service (Kelly 1991, Campbell 1994, Nettleton 1995).

Beardwood et al (1999) questioned this new managerialist approach as they contended that the effectiveness of health care professionals could not be measured or costed in scientific management terms. The authors also pointed out that nursing’s ‘humanistic’ core had often been forgotten as managerialist practices emphasise the ‘scientific’ element of nursing because it is quantifiable (Beardwood et al: 368). In terms of complaints, the authors posited that as a result of managerialism, nurses were more acutely aware of the outcomes of errors in care and the subsequent effects on the public. Also, the public are more aware of their rights as consumers and this in turn has eroded the power and autonomy of nurses. The authors concluded by questioning whether the rise in power and knowledge of the public, aided by new managerialist practices, has affected the way nurses approach their work.

Mannion et al (2005) discussed the impact managerialism has had on nursing in terms of improving efficiency, the scientific focus, cost effectiveness and consequently the implication that through these mechanisms the quality of care will be improved. Mannion et al (2005) approached their discussion using health economics as a perspective. Again, the managerialist discourse of surveillance techniques, value for money, performance indicators and cost effectiveness were employed. The authors referred to the ‘audit culture’ (Power 1997) and within this the issue of ‘risk’ is given great significance so that patients have interventions done to them rather than being cared for, as a result of the surveillance culture which nurses find inhibits their practice. Nurses have always been concerned about making clinical errors, however, Mannion et al (2005) support Beardwood et al’s (1999) assertion that nurses become hyper-aware of the consequences of making mistakes in their day-to-day activities as a result of this surveillance. What neither of these articles express explicitly, as they are not based on empirical studies, is that as a result, nurses often feel that they are not giving the quality of care they would like to provide for their patients because they are
acting defensively due to the sanctions which may be placed upon them in the event of a clinical error.

Brooks (1999:41) in his study of night staff, claimed that “nursing increasingly bases its claim to professional status upon managerialist discourse: it seeks legitimacy and power by embracing both a managerial ideology and management practices.” Brooks explored what he termed “the complex relationship between professionalism and managerialism” (p41) and the prominence of the concept of managerialism within the NHS, with specific analysis of a nursing ‘subculture’ using an ethnographic study of night nurses. Brooks (1999: 44) claimed that research has concentrated on the subjects of “marketization, managerialism, and conflicting value systems” whilst being “framed by political and social ideologies” utilising a macro perspective, yet little research has been conducted at the local level of organisations. His findings suggested that there is fragmentation within the nursing profession and that managerialism is not accepted by this ‘subculture’ of night nurses who felt marginalised by the managerialist discourse. They felt they were regarded as less professional and in a negative light by their day time colleagues. Brooks (1999) argued that the night nurses held an antipathy towards managerialism and preferred to continue with the basic nursing tenets of vocation and care.

Whilst much of what Brooks (1999) stated will resonate with many nurses, he may be overly pessimistic with regard to the perceptions of nurses who work on the night shift and their rejection of managerialist principles. Nurses may reject the ideology of managerialism, but they often have no choice but to accept the managerialist discourse as it pervades all aspects of the 24 hour structure of health care. In addition to this, Brooks (1999) implied that night nurses accept without question their colleagues’ descriptions of them as unprofessional and lacking an interest in learning opportunities. However, it can be argued that night nurses have greater autonomy and control over ward routines than their day time colleagues, for example deciding when to call for medical assistance, and would resent managerial interference. What Brooks (1999) does not acknowledge is that whilst night nurses do take their professionalism seriously, learning opportunities are structured around the day-work culture and therefore night nurses have limited access to them because of their night work. Nurses who work nights are often motivated by family circumstances – they work so that
they can provide childcare during the day and avoid costly childcare fees, and are not therefore in a position to take up these opportunities. Training and development opportunities at night are limited and night nurses are expected to attend during the day. Gould et al's (2001) study of nurses in three NHS Trusts reported that certain groups of nurses (those working part-time, weekends only, nights, nurses nearing retirement) experience access difficulties when pursuing continuing professional development courses.

However, Brooks (1999) made a valid argument about the powerlessness of night nurses who are considered to be “professional lepers” (p51) perhaps because they are not as visible as their day time working NHS colleagues. By rejecting managerialism and refusing to work to its principles, it is perhaps the way that night nurses feel they have some control over their working lives. However, Brooks (1999) suggested that by employing a strategy of non-conformism, they were in danger of becoming an extinct subculture, an unlikely occurrence within the current health care context.

Bolton (2003) also discussed the impact of new managerialism with regard to its impact on NHS nurses. Bolton’s qualitative, longitudinal research aimed to assess the effects of NPM on nurses’ working lives. She contended that experienced nurses working in a managerial role have varied feelings about this role, and that there is tension and disagreement accompanying their managerial responsibility. Bolton (2003) suggested that whilst nurses in a managerial role are enthusiastic about certain aspects of the role, they are wary of the new managerialist ideology. She posited that there is a dualistic nature to the role of nurse manager, on the one hand having the responsibility to ensure budgets are controlled, costs are minimised and performance indicators are met, in line with the new managerialist discourse. However, she argued, this can be at odds with the part of the nurse leadership role that nurtures and empowers other nurses under the nurse manager’s control. Bolton’s (2003) research indicated that although senior nurses accepted the managerial role they did not wish to identify with the management role at the expense of a nursing identity, and were very much attached to the “image of the altruistically, motivated caring professional” (p126). She concluded that whilst nurse managers have accepted the management role, there is still some conflict between the demands of the managerialist ideology and the role of clinical nurse. Bolton (2003) argued that nurse managers adapt
managerialist policies to their nursing beliefs and values in order to reconcile the
dualistic nature of their role and that it is necessary to envisage the nurse manager not
in one specific role, but as a “multiple role performer” (Goffman 1961a).

Nurses have had to adapt to a whole tranche of health service reforms over the last 30
years. Both clinical nurses and nurses who work in a managerial role have been
subjected to new managerialist policies where emphasis has been placed on cost
control and budgetary constraints (Harrison et al 1990), although Mitchell (1999)
conceded that those working within the health service have always had to deal with
limited resources.

To conclude this section on managerialism and its impact on nursing, it must be
pointed out that whilst there is a significant managerialist discourse centering on
health care, there has been scant attention paid to the effects of managerialism on
nurses in the social care sector. Commentators have established the effects of
managerialism on social work professionals (i.e. social workers) (Kirkpatrick 2006,
Chevannes 2002), whereas nurses working in social care appear to have either been
subsumed by the discourse on NHS nurses or simply not considered by researchers.

4.6. The De-professionalisation of Nursing?
Since the time of the Griffiths Report (DHSS 1983), the issue of de-
professionalisation has been discussed by researchers and social commentators. The
de-professionalisation debate has centred around the medical profession and its
attempts to maintain a dominant presence and control within the health care
environment (Elston 1991, Harrison and McDonald 2008). Although this debate has
included nurses (Wilkinson and Miers 1999, Davies 1995, Witz 1994, Mackay 1993,
Mowforth 1999), much of the literature still centres on the impact that the NHS
reforms have had on the medical profession and the lasting effects of
managerialisation of the health service.

This section will critique some the literature that has evolved as a result of the
consequences of health service reforms in terms of the de-professionalisation of
nursing. The 1950s and 1960s saw a rise in the types of occupational groups seeking recognition as a profession (Wilensky 1964, Goode, 1969), which was considered by some to be a positive development (Barber 1963).

The concept of the de-professionalisation of nursing was given much attention in the late 1960s (Stinson 1969, cited in Storch and Stinson 1988) and was further developed in the 1970s as professions were criticised for being too powerful and dominant (Larson 1977, Johnson 1972). Haug (1973) contended that professional authority was being progressively eroded by health care consumers who were becoming more aware and critical of their rights, were better educated about health care and not afraid to question doctors' authority. This in turn reduced not only medicine's dominance over its patients, but over other professionals, including nurses and midwives (O'Loughlan 2001). It can therefore be seen that there are different types of factors leading to de-professionalisation – managerialism, 'demanding' consumers, and government policies to encourage patients' choice and rights.

In terms of the debate surrounding de-professionalisation and nursing, Storch and Stinson (1988: 37) broke down the concept into three categories – 'deskilling of nurses', 'proletarianisation' and the 'erosion of professional knowledge and trust'. With regard to the deskilling of nurses through de-professionalisation, Storch and Stinson (1988) building on Braverman's (1974) work, argued that managers attempted to control the exact way in which the work of health care workers, including nurses, was performed. This, they argued, could lead to routinisation and alienation from the role. The authors asserted that this routinisation denigrates nursing's ideals and the skills and expertise of nurses are lost through this process. Storch and Stinson (1988) contended that managers sought more cost effective means of providing health care by increasing surveillance and attempting to assess nurses' work, citing the examples of workload and patient dependency level measurements.

4.6.1 The Proletarianisation of Nursing Debate

The proletarianisation of health care workers has been debated in terms of de-professionalisation by social commentators (Dent 1993, McKinlay and Stockle 1988). Daykin and Clarke (2000) undertook a qualitative study of the impact of organisational change and changes in skill mix on nurses and health care assistants.
The authors posited that using health care assistants in place of qualified nurses led to the routinisation of care work, increased surveillance by managers and therefore ultimately to a reduction in the autonomous practice of nurses and consequently de-professionalisation. Daykin and Clarke’s (2000) results indicated that some of the respondents regarded the role of qualified nurses as becoming removed from the essential care of patients, with qualified nurses increasingly becoming supervisory, technocratic administrators. Daykin and Clarke (2000) indicated that some of the nurses felt this would impact negatively on the quality of care as qualified nurses became removed from the bedside, to be replaced by health care assistants (the implicit assumption here is that the care provided by health care assistants is automatically inferior to that of qualified nurses). Their argument suggested that this would hasten de-professionalisation as qualified nurses’ claim to an exclusive body of nursing knowledge would be compromised. The justification that qualified nurses gave in this study for their claims to this exclusive body of knowledge is that they provide holistic nursing care, endorsed by “enhanced theoretical knowledge” (p354) as opposed to the task-orientated approach employed by health care assistants.

Ultimately, in Daykin and Clarke’s (2000) study, the management within the NHS trust was not influenced by the nurses’ views on the introduction of a new ‘skill mix’. This leads to the question of whether nurses do have any real autonomy when removed from the essential care-giving or ‘body work’ (Twigg 2000, Van Dongen and Riekje 2001) at the bedside? What this does suggest about the de-professionalisation of nurses in light of the reforms of the 1980s and the introduction of managerialism and new public management, is that nurses may have experienced a weakening of a position that was already questioned by some (Freidson 1970). As Daykin and Clarke (2000) indicated, nurses opinions were not valued by management anyway. In the particular Trust examined by Daykin and Clarke (2000), the nurses were forced into working in larger nursing teams, caring for larger numbers of patients, and the role of the primary nurse was eradicated. Health care assistants had their roles expanded and these were governed by clearly defined parameters with close surveillance (by whom is not defined). As a result, the holistic model of nursing care was rejected by management, leading to what Daykin and Clarke (2000: 355) refer to as leading to ‘deskilling’, ‘routinisation’, and a reduction in nurses’ autonomy.
Beardwood et al (1999) cited earlier in the ‘new managerialism’ section, implied that new managerialist practices have increased the divide between registered and non-registered nurses, student nurses studying for a diploma and degree students, and between nurses in managerial positions and clinical nurses who are at the interface between the nursing profession and patients. This, coupled with the power that the public has been afforded through NPM practices—increasing patient rights and choices, the increasing knowledge that the public can access through the internet, have all served to reduce the (limited) power of nurses and have contributed in part to a feeling of de-professionalisation.

In common with the debates on managerialism, the de-professionalisation discourse has concentrated on the effects on the medical profession and nurses working within health care, whereas the debate within the social care sector has focused on social workers (Lymbery 1998, Hugman 1998, Sibson 1990). The de-professionalisation debate has subsumed nurses working in social care into the discourse on the de-professionalisation of NHS nurses.

4.7. Autonomy
Having discussed the effects that managerialism and de-professionalisation have had on nursing, another significant predictor of nurses’ intent to stay is that of autonomy. Autonomy has been shown to be predictive of job satisfaction and intent to stay (Laschinger et al 2001a, 2001b; Larrabee et al 2003). Autonomy can be defined as how much control employees have over their job (Kovner et al 2006). Marshall (1998) suggested that to be autonomous is to be a self-determining actor who is able to express his or her own goals.

Nursing has been described as a self-governing and autonomous profession (although the status of nursing as a profession has been widely debated in Freidson 1970; Witz 1990, 1992, 1994, Davies 1995; Witz and Annandale 2006. However, nurses are increasingly subjected to the edicts of government, the control of managers and the power of doctors, all of whom limit the autonomy of nurses through target achievement, budgetary measures, and reluctance to share knowledge or expertise as discussed in the previous two sections.
What appears to be important from the literature is that autonomy in the workplace for nurses is an important component of their satisfaction with their work and strongly influences their intent to stay. Rafferty et al.'s (2001) large-scale research study indicated that autonomy, decision making, control over resources and working relationships with doctors had a positive relationship with job satisfaction. O'Brien-Pallas et al.'s (2006) analysis of two earlier studies in Australia compared the views of nurse managers and nurses who had left nursing, so that the authors could suggest strategies that encouraged and supported retention. Their results demonstrated the differences in perceptions between nurse executives and nurses who had left the profession. Nurses who had left rated professional practice (which encompassed the provision of quality care), using their skills, and being able to make autonomous decisions, as the most important factors when focusing on retention strategies. In contrast, nurse executives ranked professional practice third, after external values and beliefs about nursing, and legal and employer issues.

The professional autonomy of nurses is a widely debated issue. Timmons (2003) stated that there has been a history of conflict between nursing and management in terms of professional autonomy. Nursing has long sought to achieve a similar degree of autonomy to that of medicine using a similar discourse to medicine in order to achieve this. However, since the 1980s, management has endeavoured to control the autonomy of nursing (and medicine) through managerialist practices (Timmons 2003) as discussed in section 4.5. Timmons (2003) also made the point that management in contemporary bureaucracies aspires to evaluate the performance of the workforce, but suggested that this is difficult for them to do because of the way the work of health care staff is performed and ordered. However, it is easier to exert control over the work of nurses than that of doctors.

Dent (2003) argued that the new managerialist ideology is having an effect on the autonomy (in addition to authority and cohesion) of contemporary professions. Brophy (2008:4) argued that nurses' autonomous control over their work has been challenged by techniques of control, such as "increased audit and monitoring, pressure to redefine nursing roles and purposes to match management agendas and values, and dismantling of operational responsibilities in nursing administrations." This has led to a challenge to the "professional status and integrity of nursing"
(Brophy 2008:4). She stated that nurses can challenge managerialist reforms that are contrary to nursing philosophy; however, she does not elaborate on how nurses can challenge this managerial dominance.

4.8. Nurse Leadership

In terms of nursing leadership and the impact of nurse managers on autonomy, Mrayyan (2004) stated that effective leaders have some impact on job satisfaction, autonomy and intent to stay. Nurse managers also have a significant impact on the working environment. Managers' leadership style has a direct effect on nurse autonomy and managers are considered the core of the management team according to Kosinska and Niebroj (2003).

Mrayyan (2004) investigated the role of nurse managers in the enhancement of the autonomy of 317 qualified nurses using an internet survey. The results indicated that nurses had less input (and therefore autonomy) when managerial decisions were made on their units, and more autonomous decision making when providing direct patient care. The respondents also reported that their managers 'sometimes' encouraged them to be more autonomous. However, the study does not explain what 'sometimes' entails. Mrayyan (2004) contended that nurse leaders are responsible for ensuring the enhancement of autonomy for nurses which would have a direct, positive impact on the quality of patient care. Mrayyan (2004) argued that to attract nurses, organisations must sell themselves as places with autonomous working for nurses and ensure that action is taken to guarantee that it happens.

Fletcher's (2001) surveyed registered hospital nurses' experiences of job satisfaction/dissatisfaction and stress. Her study suggested that job dissatisfaction was linked to lack of recognition and support from managers, especially those in 'upper management' (situated above clinical nurse leaders in the organisational hierarchy). Ribelin (2003) asserted that when nurses leave a job, it is not the organisation they are leaving, rather the manager. Her survey of nurses working in three U.S. hospitals concluded that recognition and support from nurse leaders has a positive impact on nurse retention.
The work of McGuire and Kennerly (2006) on nurse leadership considered the impact of ‘transactional’ and ‘transformational’ leaders in the workplace. Transactional leaders are described as those who control worker behaviour through goal and target setting and reward employees when goals have been achieved. Transformational leaders are depicted as those who use shared visions and ambitions to achieve results and are inspirational leaders who take into account individual employees needs. McGuire and Kennerly (2006) conclude that transformational leaders provide support and recognition for their employees and their actions engender commitment from their staff.

Coomber and Barriball (2007) undertook a meta-analysis of international research to examine the elements of job satisfaction which impacted on the commitment of hospital nurses and found that leadership was a recurrent theme. Part of their analysis included nine research papers which linked leadership and the intentions of nurses to leave or stay and concluded that leadership was a significant factor in the intentions of nurses to leave.

However, the studies reviewed earlier in this section are in contrast to the work of Tourangeau and Cranley (2006) who measured manager ability and the intention of nurses to stay. Their results did not show that nurse leadership had any statistically significant effect on the decisions of nurses to stay employed in nursing. Tourangeau and Cranley (2006) argued that despite this, job satisfaction and nurse manager ability are correlated and that job satisfaction is a definite predictor of nurses’ intention to remain employed.

4.9. The Surveillance Culture
Whilst nurses may strive for greater autonomy and control over their work, there are a number of contradictory trends preventing this, identified by Pollitt and Boukaert (2000) within the health care system. The authors suggested that although there is increasing political control, managers are allowed freedom to manage and cut costs while at the same time trying to raise standards (in theory) and empower and motivate staff, but concurrently increase workloads and rationalise work. Pollitt and Boukaert (2000) also posited that these contradictory trends include a decrease in bureaucracy but an increase in performance indicators and audit, the devolution of responsibility
to individuals and professional groups, yet an increase in control of activities from government.

This section will discuss the development and expansion of the surveillance culture resulting from the rise of managerialism. The surveillance culture has developed not only as a direct consequence of attempts at cost containment and exercising budgetary control, but because of the advent of new technologies, such as telecommunications and computer systems (Traynor 1999). Clinical governance, audit, and the introduction and expansion of government regulatory bodies have enabled managers and the government to monitor the work performance of health care professionals and produce performance ratings to the public in ways that would not have been possible 30 years ago. The audit culture and performance monitoring within the NHS and social care appears to have expanded significantly since the introduction in the 1990s of NHS and social care reforms and the rise of managerialism and has been well documented by Ham (2004). Flynn (1992) indicated that there is now a vast repertoire of instruments and mechanisms to conduct surveillance on health professionals – for example, assessments, clinical audit and governance, and performance indicators – leading to a greater control by management over the delivery of health and social care.

Foucault’s (1977) concept of power can be used to help understand the effects of surveillance and monitoring of health care work. Foucault saw power as widespread and indiscernible, something that had positive and negative effects within social structures. The Foucauldian concept of power was developed to include disciplinary power, which makes individuals observable using apparatus such as (in the health care environment) accountability, clinical governance, appraisal and training. Foucault (1988) described management and organisations as perpetually directing human behaviour and activities via surveillance which is so successful that individuals are not consciously aware it is being exercised and that they are subject to its control.

Hau (2004: 4), in discussing the issue of bed management and patient stays in hospital, stated “cost consciousness and accountability have become disciplinary mechanisms whereby nurses monitor their own performances as cost-efficient
employees.” Hau (2004: 5) argued that “the bed state” (the number of beds available for patient admissions in a particular hospital) has become a significant “structure” in the complex power relations between management and nurses, part of the “network of power”. Hau (2004: 5) posited that this power network influences nurses in terms of conforming to the aims of the organisation and the “bed space as a controlled hospital resource assumes the form of a disciplinary tool”. Hau’s argument has validity as increasingly the performance of hospitals is determined by targets. The four hour maximum wait times in Accident and Emergency departments have a direct impact on bed availability within ward areas and financial penalties for hospitals who close their doors to emergency admissions due to lack of bed availability. These are just two examples of how managers themselves are subject to the disciplinary forces arising from the NHS efficiency reforms.

Mannion et al (2005: 379) employed Foucault’s (1980) concept of ‘power/knowledge’ to argue how nursing has expanded its range of ‘legitimate activity’. They identified that nurses have embraced new roles, such as nurse prescribing, nurse practitioner status and responsibility for discharging patients, have undertaken additional academic and practical training and received financial remuneration for pursuing and accepting these roles. Yet there exists the paradox of increased monitoring of nursing activity as a result. Mannion et al (2005) argued that consequently the art of caring, the holistic and humanistic ideology of nursing, is sacrificed to the managerialist discourse that embraces scientific management and the pursuit of quantifiability.

Timmons (2003:144) contended that “surveillance can only be understood with reference to the wider social and organisational contexts in which it is implemented.” In the case of nursing work, it is an environment increasingly monitored and controlled by managerialist practices and which concentrates on monitoring activity through cost effectiveness measures and performance indicators (Van Eyk et al 2001, Scott et al 1999).

Timmons (2003) investigated the use of new technologies in the surveillance of nurses’ work. He suggested that in complex bureaucratic organisations, such as the NHS, there is a compulsion by management to scrutinise the work of staff. Yet because of the nature of health care professionals’ work and the varying degrees of
autonomy they have over their work, it is difficult to measure some aspects of their work. Therefore, Timmons argued, managers have found it problematic to monitor work performance. Timmons (2003: 146) reported that nurses have challenged the system by what he terms 'resistive compliance', it was not so much that nurses refused to use the new technologies as much as exhibited a "tendency to put off and displace" the use of them and by verbally criticising them.

Yet not all the nurses interviewed by Timmons were conscious of the fact that their usage of computer systems was being examined and that the information gathered was being used as a surveillance technique to analyse their nursing work. Timmons (2003) concluded that the use of new technologies as a surveillance method has not been entirely successful as nurses have subverted management attempts to closely monitor their work and have been able to do this for two reasons. He argued firstly that nursing work has no definitive guidelines set out by the United Kingdom Council for Nursing, Midwifery and Health Visiting (UKCC) (now the Nursing and Midwifery Council - NMC) for how the work should be performed. He argued secondly that labour market forces prevent managers monitoring nurses too enthusiastically because of the problems the NHS has with recruitment and retention of nurses; should nurses be exposed to too rigorous scrutiny? The net effect, Timmons (2003) asserted, is that they may seek employment in an alternative organisation where the atmosphere is more relaxed and there is less of a 'panoptical' approach to regulation of nursing work.

Traynor (1999: 161) discussed surveillance in terms of Foucault, modernity and organisations. He argued that the most effective form of discipline is that of 'self-regulation' and that is achieved through the close scrutiny and evaluation of daily nursing activities, and the threat of reduction in staffing budgets should targets not be met. This, he argued, includes the development of nursing hierarchies for the purpose of surveillance of nursing team members and the devolvement of budgets to managers, suggestive of increasing autonomy and choice whilst in effect allowing senior managers to exercise power and discipline.
4.10. Respect, Recognition and Valuing Nurses

The issue of respect, recognition and valuing employees has been researched extensively and has been linked to empowerment (Faulkner and Laschinger 2008, Laschinger et al 2001a, 2001b), commitment (Laschinger et al 2001), and job satisfaction (McGuire et al, 2003), which leads to greater tenure and longevity of career in nursing (Mrayyan 2005). Whilst several studies have taken place in North America, there is a lack of research in the UK in both the NHS and in care homes about the question of respect and its link to job satisfaction and ultimately retention of nurses.

Respect has been identified as an essential element in nurses’ work-life quality and can lead to improved job performance and enhance job satisfaction (Milton 2005, Laschinger 2004, Laschinger and Havens 1996). Faulkner and Laschinger (2008), in their study of 500 Canadian acute care nurses found modest levels of respect. This, they contrasted with DeCicco et al’s (2006) study of Canadian nurses working in long-term care and concluded that nurses working in acute care perceived less workplace respect than those working in nursing homes. They found improving perceived feelings of respect led to improved retention of nurses. They argued that in addition to respect being a fundamental element within nursing and nursing care, it is equally fundamental to how an organisation’s culture is perceived and ultimately how successful that organisation is (Faulkner and Laschinger 2008).

Faulkner and Laschinger’s (2008) Canadian study used survey data from 282 hospital nurses to determine the extent of “structural and psychological empowerment” (p214) and the effect these variables had on how nurses perceived respect. The authors posited that “employees who have access to these empowerment structures are more likely to be motivated and more committed to the organisation” (p215). Faulkner and Laschinger employed Kanter’s (1977, 1993) theory of organisational empowerment as a theoretical framework for their study. They utilised Kanter’s fundamental organisational requirements - access to information, support (from peers, managers and junior staff), learning opportunities, formal power and informal power (differentiated from formal power, as relationships with peers and alliances with colleagues that facilitate the achievement of the organisation’s goals) - as the basis for their enquiry. Faulkner and Laschinger’s (2008) study found positive correlations...
between all organisational structures. However, the most strongly linked to nurses’ perceived respect were support from peers, managers and junior staff and informal power, supporting Kanter’s original theory that respect evolves when employees act cohesively as a work-group or team and foster positive relationships through this. Their work also supported Ulrich et al’s (2005) assertion that for cohesive workgroups to be effective, mutual respect is essential. Faulkner and Laschinger (2008) argued that recognition and reward of nursing work leads to feelings of being respected; this is linked to job satisfaction and ultimately to retaining a skilled and knowledgeable workforce.

Badzek and Cober (1996) asserted that the construction of relationships built on trust by nurse leaders with their staff allows nurses a forum for expressing their thoughts, ideas and concerns, (with which Faulkner and Laschinger (2008) concurred) and leads to an empowered nursing workforce. Krairiksh and Anthony’s (2001) study of collaborative care between US nurses and physicians aimed to investigate nurses’ decision-making in collaborative nurse-physician relationships in a variety of health care specialties. The data from 279 nurses indicated that nurses had a high level of involvement in decision-making regarding patient care in contrast to their involvement in any decision-making about their work environment. The authors stated this is due to the opportunities they encounter for making decisions. Nurses who were directly involved with patients on a one-to-one basis (but who made decisions about the work environment) may have perceived decision making as more of a group than an individual activity. Krairiksh and Anthony (2001) stated that for a collaborative process to occur, mutual respect must be evident. The implication could be made here that, based on Faulkner and Laschinger’s (2008) study, greater collaboration and increased input into decision making leads to nurse empowerment and a greater feeling of conferred respect.

McGuire et al’s (2003) US study summarised the findings of survey research into three groups of health care professionals’ rationales for leaving their occupations or jobs. The results emphasised that financial remuneration is an important concern in terms of recruitment and retention of employees but was not a primary concern of the respondents. What they primarily wanted was recognition, respect and commitment from their organisation. Being appreciated and having recognition for their efforts was
more important than financial compensation. McGuire et al (2003) argued that although health care staffing budgets are limited “there are no such constraints on the amount of recognition, support and respect that a manager can bring to bear in creating a supportive culture” (p43) and that health care professionals “want to be recognised for the skills they bring to the job and for the contribution they make to the organisation and to the patients” (p43). When these elements are present, McGuire et al (2003) posited, the requirements for increased job satisfaction are met and this, as had been discussed earlier in this section, is a strong predictor of intent to stay. The empirical research reviewed in this section demonstrates that nurses want to feel that they are recognised and respected for the work they perform and perhaps the desire for professionalisation of nurses has ultimately been motivated by this.

4.11. Social Exchange Theory and Reciprocity

Linked to the concepts of recognition, value and respect for nurses are the theories of exchange and reciprocity. The theory of social exchange originates in the work of George Homans (1958), who identified a set of essential propositions (success, value, deprivation-satiation, aggression-approval, and rationality) to explain social behaviour and interaction between individuals. Homans’ theory was subsequently developed by Peter Blau (1964), who used sociological theory to explain the increasingly complex interactions between social actors within social structures. He contended that social actors form bonds, and that both parties provide 'rewards' which strengthen these bonds; conversely, without rewards, the bonds will be broken. Blau suggested that rewards can be intrinsic, such as respect, or extrinsic, for example, money or work. Blau acknowledged that these exchange mechanisms may not always be equal and that as a result of this inequality, a power relationship develops. He hypothesised that when something is required by one actor who has nothing to exchange, four things may occur: the party can be compelled to help; alternatives may be sought; the party in need may attempt to go without; or finally, the inferior party may subordinate themselves to the other social actor, indebting themselves, which then allows the superior party to get them to do something as they are owed a debt. Blau’s work has been criticised as it concentrates on macro level structures rather than micro level individual interactions which, Homans theorised were the essence of social exchange theory (Ritzer 2000).
The notion of reciprocity is implicit in the theories of social exchange (Gouldner 1960). Settoon et al (1996) contended that social exchange and reciprocity can be used to explain organisational commitment. Emerson (1972, 1976) argued that social exchanges are not always motivated by expectations of reciprocity, but his examples are confined to social exchanges outside the workplace (i.e. gift giving, invitations to parties etc.). He did however, posit that the ‘norm of reciprocity’ - the expectation that exchanges will be reciprocated - is necessary for relationships to survive. Eisenberger et al (1997) argued that in the workplace, two types of social exchange relationships exist - global exchange relationships which exist between employees and the organisation, and dyadic relationships which occur between an employee and their line manager, the level of perceived support having an impact on employee performance, behaviour and commitment.

Relating social exchange theory and the norm of reciprocity to the situation of nurses and their managers and organisations, within the social exchange theoretical framework, nurses expect some form of reward in exchange for their labour and commitment. This exchange can take the form of “rational or emotional, instrumental of intrinsic, and have physical or symbolic value” (Nelson 2000: 40). When there is the perception that there is an imbalance in the relationship of reciprocity in favour of the organisation, what Nelson (2000) described as an ‘asymmetrical relationship’, this social exchange mechanism can disaggregate and lead to employees making the decision to leave the organisation. This is what Berger (1994) termed the ‘mobility principle’ whereby if the weaker actor (in this case, the nurse) in the social exchange is not able to change the actions of the stronger actor (the organisation), the weaker actor can choose to terminate the relationship, what is known as ‘fate control’.

4.12. Conclusion
This chapter has examined some of the literature pertaining to organisational structure, culture and context, in order to contextualise the organisational structure within which nurses work. The majority of the literature focuses on the structure and culture of the NHS and there is no comparable work on the structure and culture of UK care homes. There is an urgent need to address this omission. The chapter has reviewed the relevant literature involved in the discourses of managerialism and new public management, de-professionalisation, the effects of managerialism on nurse
autonomy, the surveillance culture that has resulted from managerialist ideology and the issues of respect, recognition and value of the nursing role.

However, existing studies have focused almost entirely on the acute care/hospital sector, to the exclusion of nurses working outside these organisations and more specifically, excluding nurses working in care homes. There is a paucity of literature about the experiences of registered nurses working with people requiring long-term care outside the NHS. Existing studies concentrate on the NHS as it is the UK’s largest employer and the largest employer of nurses in the UK. This can be to the detriment of nurses working outside this structure and severely limits, epistemologically, the meaning of work and commitment for non-NHS nurses. If we are to advance our knowledge and understanding of how different groups of nurses work within different types of organisations then we should not exclude this expanding workforce from our research agenda. Nurses working in care homes provide health care in addition to social care and their work oscillates between the two. Currently, they appear to be either ignored by the research community or subsumed into a homogenous group of ‘nurses’.

As a result of the literature review exploration I developed the research question ‘Why do mid-life women nurses working in the NHS and care home sector stay in nursing? A comparative study’. The conceptual aims of my research study were to investigate the comparative and contrasting experiences of nurses working in these two different organisational structures, with a specific interest in occupational and organisational commitment. Nurses in both types of organisation have experienced restructuring and reform, bureaucracy, managerialism, de-professionalism, autonomy and the surveillance culture, all concepts reviewed in this chapter. Whilst there is a plethora of literature pertaining to nurses working in the NHS, what is evident from the literature reviewed is an omission when the experiences of care home nurses are considered and there are no comparative studies of NHS and care home nurses working in the UK. This study aims to fill some of this gap in our knowledge.
CHAPTER 5

Methodology

5.1. Introduction
The previous four chapters have provided an overview of the theoretical background and current debates that inform this research study. The focus of this research is the exploration of two groups of nurses working in different organisational environments and aims to establish why they choose to stay occupationally and organisationally committed. This chapter discusses the methodology used to collect data that provide an understanding of the context of the work lives of qualified mid-life nurses.

5.2. The Research Aims and Objectives
This study was constructed around the comparative ‘intellectual puzzle’ (Mason 2002) of: ‘why do mid-life nurses working in the NHS and UK care homes stay in nursing?’ The research aims were:

- To explore mid-life qualified women nurses’ working lives, specifically why they demonstrate occupational and organisational commitment;
- To explore NHS and care home nurses future career plans and whether they intend to stay or leave their organisations and/or nursing;
- To compare and contrast the experiences and perceptions of NHS and care home nurses.

This study of mid-life qualified nurses is an explicit comparison of 25 women, working in the NHS and 25 women working in residential (employing qualified nurses) or nursing care homes in order to explore their working lives and their organisational and occupational commitment and if, how and why this differs. The study aimed to use qualitative interviews to investigate and examine nurses’ motivation and orientation to work by interviewing nurses about their careers, work histories, and their organisational and occupational commitment.
The concept of women’s work-life balance and nursing was explored by asking the participants about how nursing affected their family life and domestic responsibilities, the effects of ‘spillover’, if any, of work into the private domain, or indeed the other way round. The interviews explored with the nurses whether they had considered any alternatives to nursing, whether they considered nursing a vocation, a career or just a job and what their employment intentions were. Also explored were the future plans of these nurses (see appendices 6 and 7 for the interview schedules for NHS and care home nurses).

Analysing nurses’ reasons for long-term organisational and occupational commitment, rather than focusing on the reasons nurses leave nursing, can offer employers and policy makers an alternative dimension to the recruitment and retention debate.

5.3. Research Methodologies
Mason (2002: 18) suggested that the researchers’ intellectual puzzle needs to be "ontologically meaningful and epistemologically explainable." I wanted to explore the social actions of, and social processes that affect, two different groups of nurses - NHS and care home nurses. Mason (2002) suggested that a qualitative approach is particularly suited to this type of enquiry as it takes into account the context of the research phenomena which would be missed by quantitative approaches. The lack of published research as stated in Chapter 1 suggested that this is an area that needs to be investigated, particularly in-depth perspectives of nurses working in care homes. From my own experience, workforce satisfaction questionnaires are often circulated but they do not give nurses opportunity to provide an in-depth opinion or explanation of their experience, nor do nurses feel that such results reflect the reality of working in the health or social care sector. Nurses working in the care home sector are very rarely asked their opinions. My experience is that nurses (and other health care professionals) are sceptical about the motivation behind these questionnaires and are cynical about the outcomes, and perceive that a positive ‘spin’ is being put on the results in order to boost morale. This study attempts to give nurses in both sectors a ‘voice’ and an opportunity to discuss their perceptions and experiences in depth.
As a researcher, my ontological perspective was from the standpoint of perceptions, understandings and ideas. My epistemological approach was informed by the phenomenological perspective. However an iterative approach of moving back and forth between the data and literature was employed, as I deemed this to be more appropriate for analysing the data generated by this research study. As my research question arose from analysing the literature my approach was not purely phenomenological.

5.4. Selecting a Research Paradigm
In addition to the many methodological approaches open to sociologists, there are also a variety of methods employed to collect research data, all with their relative merits and disadvantages depending on the information that the researcher intends to collect. The data in this research study were collected using qualitative face-to-face interviews. The rationale behind the use of this method is that the research problem involves the exploration of the respondents’ experiences and perceptions. The use of qualitative versus quantitative interviews has been well documented in social research. It is recognised that the qualitative interview technique is a key method for this exploratory research (Fielding and Thomas 2001). Bryman (1988) indicated that this method of interviewing elicits respondents’ views without constraining their thought processes.

Seale (1998) indicated that qualitative interviews offer the advantages of being a flexible method of investigating the complexities of respondents’ experiences and perceptions. He posited that qualitative interviews give respondents a ‘voice’, allowing them to give their own account of their views or experiences, with a depth and richness to the data, that other methods such as surveys, do not provide.

Using this method enabled me to ask the same core questions to each respondent with the added advantage of being able to alter the sequence of questions in response to what was being said and probe for further information or clarification. This facilitated in the adaptation of the research tool to the level of understanding of the respondent and allowed me to take account of any responses that provided answers to questions occurring later in the interview guide (Silverman 1993).
Clarke (2001) indicated that qualitative research in the interpretativist tradition, uses an entirely different set of philosophical suppositions to quantitative methods. He maintained that there is not one universal truth but ‘truths’. Versions of reality are constructed by groups and individuals within society and therefore a qualitative approach enables the researcher to get close to the data.

5.5. Ethical Considerations

Sociologists have a duty to tackle, address, and try to resolve ethical issues according to a Code of Ethics (American Sociological Association 1999). As a British sociological researcher, I also have conformed to the British Sociological Association’s (BSA 2002) statement of ethical practice. I have also examined the Economic and Social Research Council’s (ESRC 2006:1) Research Ethics Framework and abided by their six key principles which are that:

1. Research should be designed, reviewed and undertaken to ensure integrity and quality;
2. Research staff and subjects must be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved. Some variation is allowed in very specific and exceptional research contexts for which detailed guidance is provided in the policy Guidelines;
3. The confidentiality of information supplied by research subjects and the anonymity of respondents must be respected;
4. Research participants must participate in a voluntary way, free from any coercion;
5. Harm to research participants must be avoided;
6. The independence of research must be clear, and any conflicts of interest or partiality must be explicit.

Bulmer (2001:49) indicated that there are four main ‘ethical principles’ that govern research about the social world: obtaining informed consent; respecting the privacy of participants; ensuring that data remains confidential; and preventing harm to participants.
Prior to commencing the research study and the pilot stage of the research, I sought ethical approval from both the University Ethics Committee (Appendix 1) and, as respondents who worked for the NHS would be approached, an application to the Local Research Ethics Committee (LREC) (Appendix 2) was also required.

Approval was granted by both the University Ethics Committee and LREC. Documents that were submitted included:

- Recruitment letter (Appendix 3);
- Participant information sheet (Appendix 4);
- Consent form (Appendix 5);
- Interview Guide NHS (Appendix 6);
- Interview Guide Care Homes (Appendix 7).

Through submission of my research proposal to the LREC and the University Ethics Committee, Bulmer’s (2001:49) four ‘ethical principles’ were adhered to. During the research process I abided by the BSA guidelines (2002) including to do no harm, intentionally or unintentionally to the respondents in this study. When conducting the research, Grinyer’s (2002) recommendations for protecting the anonymity of research participants were always observed by the researcher including using pseudonyms, adhering to the British Sociological Association’s ‘Code of Ethical Practice’, and maintaining records in compliance with the Data Protection Act (Cabinet Office 1998).

5.6. Inclusion Criteria

The principal inclusion criteria for this study were:

1. Be qualified and have qualified in the UK (any qualified grade/band);
2. Have been qualified for 10 years or more;
3. Work in the NHS, or a residential care home;
4. Be female and in mid-life (between 40 and 55 years);
5. Work full or part-time;
The participants needed to have devoted enough time to nursing as a career to reflect upon choices made and be still working in an organisation. Nurses who were taking a career break and still registered with the Nursing and Midwifery Council may have considered themselves to be nurses even though they were not working within an organisation. However, these nurses were deemed ineligible for this study as only nurses who were currently employed were of interest as they potentially demonstrated organisational and occupational commitment. Unqualified staff and male nurses were excluded as their motivations to work and experiences may be very different. Male nurses' career trajectories tend to differ from female nurses in that they frequently ascend the career ladder much more rapidly than their female colleagues (Williams 1992, Evans 1997).

The cohort of mid-life nurses aged 40 to 55 was chosen, as this cohort has not been studied in great depth, with the exception of those over 50 (Watson et al 2003, Watson et al 2004, Wray et al 2006). In the pilot study, two nurses aged 53 were interviewed and both intended to work until they were 65, one through financial necessity and the other because she enjoyed the challenges of her job and did not want to retire early. Initially an upper age limit of 55 years was identified, however one nurse who had just turned 56 was keen to participate in the research. An upper limit of 56 years was therefore chosen to include this nurse as she demonstrated that nurses of this age still have between five and ten years of their working lives remaining and have sufficient time left to work and not just 'coast' until they retired. The latter response is consistent with Pickles' (2006) assertion that some women do not want to retire at 60 because they are very much enjoying their work. A similar issue occurred with the lower age criterion. Two nurses (age 38 and 39 years) wished to participate in the study and as they had been qualified for 17 and 18 years, (thereby demonstrating commitment to nursing) and fulfilled the selection criteria in all other ways, they were included in the study. Therefore in respect of age, a pragmatic approach to sample selection was taken.

5.7. Obtaining Informed Consent

Bowling (1997) asserted that the overarching principles that serve to regulate researchers in terms of ethics are that research participants should not be harmed in any way and that informed consent is given by them, in writing. As part of the ethical
approval process, both the LREC and the University’s requirement for ethical approval was obtaining written consent prior to the commencement of the interview. Each respondent was given or sent a participation information sheet (Appendix 4) prior to the interview; this was also consistent with the requirements of the LREC and University ethics committees. Each respondent was given the opportunity to withdraw from the research at any time during the research and this was made explicit in the participant information sheet and on the consent form (see Appendices 4 and 5). At the beginning of each interview, the respondent was asked if they had read the information sheet. Once it was established that they had, they were then asked to read the consent form (Appendix 5), asked to tick the boxes, date and sign the form. None of the participants refused or have since requested to withdraw from the research.

5.8. Gaining Access to the Research Sites and Respondents

Silverman (2000) recognised that gaining access can present a problem for researchers and that permission needs to be sought from the relevant authorities. The issue of access was also recognised by the researcher as a potential problem. In this instance some of the sites identified afforded relatively easy access to the research subjects as I had contacts within the organisations identified as potential sites. A total of 33 care homes was contacted, either by telephone or by letter to the manager, to enquire whether they had any staff that fulfilled the inclusion criteria. Most responded favourably, only one refused to participate, as the manager stated she did not have time to consider the research. However, only 14 of the homes employed nurses who met the inclusion criteria and were willing to participate. In terms of NHS Trusts, contact was made with five Trusts and staff based at seven sites were interviewed.

In the case of the NHS, contact was made with managers of individual departments and requests made as to whether they had any staff that would meet the inclusion criteria. Some of the managers provided me with additional contacts in other NHS Trusts. In the case of the care homes, individual managers of homes were contacted by letter which generated no responses and by telephone which provided positive responses. The research project was discussed with them, a copy of the research proposal was distributed and approval was gained. Staff were then approached and recruited if willing and if they met the inclusion criteria outlined earlier in section 5.6. Some nurses who volunteered were older than 55 (mostly late 50s) and all were
excluded (see section 5.6). The research was then discussed with the participants and
an agreed date, time and location for the interview.

Initial contact was made with 'gatekeeper' managers and subsequent verbal
approaches to the respondents were made once participants who met the inclusion
criteria were identified. A personal approach was adopted once permission to contact
the study participants had been given, as it was believed this would be the most
effective method of recruitment and, although time consuming, would yield more
respondents than a recruitment poster or letter. Following discussion with my
supervisors, I was advised that in their experience posters requesting recruitment were
likely to attract few, if any, participants.

Some of the potential respondents in my current and former places of work were
aware of my study as a PhD research project and offered to be interviewed, which was
useful for the pilot stage of the study as it enabled me to practice and perfect my
interview guide and technique. This led to several other respondents being recruited
by word of mouth i.e. the snowballing method (Byrne 2001). Using my background as
a nurse, I utilised contacts in care homes and hospitals to recruit participants. In
addition I used details of care home telephone numbers and managers' names from
the Commission for Social Care Inspection (CSCI) website, towards the end of the
data collection process, with varied success, to obtain the final few respondents.

5.9. Research Sample

A purposive sample of 50 nurse respondents was recruited to provide data pertinent to
the research subject and equal numbers from each setting were required to enable a
comparison of the two groups. Twenty five participants were from seven NHS
hospitals and 25 were from fourteen care homes in the South East of England. It was
anticipated that each care home may only yield a small number of recruits per home
and this was the case.

Great difficulty was encountered in recruiting nurses from care homes who fulfilled
the inclusion criteria, especially the criterion which stated that nurses should be
trained in the UK. In many care homes contacted, nurses were either above or below
the age limit for inclusion. During discussions with several managers about the
recruitment of UK trained nurses, I was informed that whilst there was no difficulty recruiting trained nurses, those that were applying to work in care homes were nearly all overseas trained. One home visited during the recruitment process employed 14 trained nurses, all of whom were overseas trained or outside the age limit. This home employed only one UK trained nurse who at age 79, was still working two nights per week. When the issue of recruiting UK trained nurses was discussed with the manager, herself overseas trained, she suggested that one of the issues was that UK trained staff can still pick and choose jobs in nursing. She also indicated that she would like to employ UK trained staff. She described her clients as all from a middle to upper class background who would prefer to be cared for by UK trained nurses as they were more likely to understand their clients’ cultural needs and situations. Mindful of this issue, I took particular note of my respondents’ comments on nurse recruitment in the care home sector.

Therefore, the sample ultimately consisted of 50 female workers in health and social care age 38 to 56. The positions they were employed in varied from staff nurse to consultant nurse and nurse managers; the sample included women with and without children, 15 were degree educated, 23 had no post registration qualifications. As I was interested in the experiences and perceptions of both part-time and full-time staff an attempt was made to obtain an equal numbers of part-time and full-time staff in both the hospital setting and the care homes for comparative purposes. However, in the sample from the care home sector, it was not possible to obtain this division as the majority of the nurses interviewed were at managerial level and worked full-time. Further biographical characteristics of the sample are presented in detail in Chapter 6.

5.10. **Pilot Study**

A pilot study was conducted to ascertain whether the interview schedule devised would yield the type of responses that were required to address the research problem or whether further refining of the questions would be necessary. Eight interviews were conducted as part of the pilot study. Three of the interviewees were qualified nurses working in an NHS hospital and five working in care homes.

During the interview process, a ‘guided conversation’ approach was adopted (Lofland and Lofland 1995: 85) employing the technique of asking non-threatening questions
at the beginning of the interview to put the respondent at ease. The first question that was asked was, ‘Tell me about your career to date’. This enabled the respondent to talk about their previous jobs/positions and also put their current position in perspective for the researcher, which allowed a life-course perspective to be adopted.

The interviews with the NHS and care home staff were conducted in either the workplace of the participants or at their homes, at their request, and at a time chosen by the individual participants. All the interviews conducted in the workplace were held in private rooms, however their workplace telephone did interrupt some of the interviews. A resident walking into the room interrupted one of the interviews with a care home nurse. This had the effect of disrupting the interview and both the participant and I lost the flow of the interview question. One of the interviewees in a care home requested that the tape be stopped at one point, as she did not want the information she was imparting to be recorded as it related to her workplace. She felt that the information was very sensitive and she did not want it to be ‘on record’. This request was complied with.

Van Teijlingen and Hundley (2001) indicated that pilot studies are an essential part of good research design. The pilot study identified the questions which did not work as well as anticipated and the interview guides were refined after each interview. For example, during the first pilot interview I asked the respondent to ‘tell me about your career’ to which she responded ‘before I started nursing or just my nursing career?’ When constructing the interview guide I considered that only the respondents’ nursing careers would be relevant but on reflection decided that a complete career history would give a better life-course perspective and I could always concentrate on the nursing career when analysing the data if the other data was not deemed to be relevant. A decision was made that it was better to collect an abundance of data rather than have to arrange another interview to collect data omitted. Initially one interview guide was devised for all respondents. However, following the pilot study, a separate interview guide for the nursing home nurses was devised as the questions did not reflect the differences in the two types of work setting (Appendices 6 and 7). For example, the question ‘why did you decide to leave the NHS?’ was highly relevant for nurses in care homes but not applicable for nurses in the NHS setting. At the pilot stage all the respondents were offered a copy of the transcription, but as none of them
accepted the offer, a decision was made not to proceed with this in the main data collection.

5.11. Data Collection

After gaining permission from the organisation and broad agreement from respondents, the interviewees were approached again and a date and time was arranged with each respondent to conduct the interview. Respondents were given the opportunity to have the information sheet posted to them prior to the interview but not all participants took up this offer, asking for the information sheet to be brought to the interview for them to read.

Achieving a convenient date and time for the researcher and respondent was a hurdle to be overcome. With some of the interviewees, the initial date and time had to be rearranged due to work pressures for the respondent adding extra pressure for the researcher. However, a mutually convenient time was eventually agreed upon and the interviews completed.

The interviews were held at various locations depending on where the participant felt comfortable. Participants were interviewed at home and in the workplace, at hotels and at the university. At all times, interviews took place in a private environment, a place comfortable for the participant and at a time convenient to the respondent. Of the NHS nurses interviewed, 10 interviews were held at their place of work, one was held at the university and 14 were held at the respondents' homes. Twenty-one interviews with care home nurses were held at work, one at their home and three in hotels where we met informally for tea/coffee.

On meeting the respondent at their chosen place for the interview, the respondent was given a brief explanation of the purpose of the research and what the interview would entail and provided with an information sheet (Appendix 4) to read before the interview; this was discussed prior to the interview. The purpose of this was twofold— to answer any questions the participant may have had and to allow the participant to relax, get used to me as a researcher, and to introduce the first question. The participants also signed a consent form (Appendix 5) as required by the University Ethics Committee and LREC. The respondents were also put at ease by general
chatting at the beginning of the interview. Bowling (1997) counselled against giving a
detailed explanation about the focus of the interview in case this encouraged the
respondent to give answers they think the interviewer wants to hear rather than their
own opinions. The respondents were also informed of how long the interview was
expected to take — about an hour, that with their permission the interview would be
recorded for transcription purposes, and that the recording would be destroyed once
the research study had been completed. The respondents were also informed that
everything that was said either on or off recording would be confidential, anonymity
was assured at all times and the respondents were informed that they could withdraw
from the study at any time and without prejudice. It was made clear to the respondents
that the recording device could be turned off at any time during the interview at their
request.

As the interviews progressed, I became more confident and comfortable at using
probing questions and not so dependent on the interview guides (Appendices 6 and 7),
so that the interviews did become more of a guided conversation as described by

Field notes were made shortly after each of the interviews. According to Emerson et
al (1995), making field notes is considered an important aspect of the study as it
allows impressions of the interview and interviewee to be recorded. It also serves as a
reflexive exercise for the researcher in that it provided insights into ways to improve
the interviews. These notes were referred to prior to conducting the next interviews
with different respondents and when writing up the results of the analysis. Field notes
included comments on the location, interview room, the interviewer’s perception of
the respondent’s attitude to the interview — whether they were anxious or relaxed, and
whether a good rapport had been established. Comments also included advice for
future interviews, especially during the first few interviews, as interviewer skills were
being established.

5.12. Reflexivity

It is also pertinent to note the issue of interviewer effects. Hyman’s (1954) classic
American study revealed the effects that demographic characteristics had on
respondents. It has been noted that an interviewer’s race, social class, sex, religion
and age have an impact on the responses of interview subjects (Sudman et al 1977, Padfield and Proctor 1996). In this study all the respondents were, female, mid-life and nurses, characteristics very similar to my own. Two respondents were from a mixed Asian Indian/ White background. It was anticipated that female participants from other ethnic backgrounds would agree to participate; in the event, only one nurse with Black African ethnicity was recruited. In this instance, I felt that my background may have had an influence on the data, because I too was a nurse, and that the respondents felt comfortable with me because I had an inherent knowledge of and empathetic understanding of the issues that they discussed.

As the interviews progressed, I felt my technique improved to the extent that I was able to explore interesting concepts more thoroughly towards the end of the study. However, I do not feel this greater confidence detracted from the earlier interviews but rather enhanced the later ones.

This leads to the methodological issues of subjectivity and reflexivity. The ‘insider/outsider’ perspective is also an issue that requires attention with a view to reducing possible researcher induced bias arising from my position as an ‘insider’ (Hodkinson 2005). Firstly I will consider the issue of the insider perspective. The concept of reflexivity is particularly important in qualitative research and is linked to the issues of acceptance and reliability of qualitative research (Finlay and Gough 2003, Banister et al 1994). It is necessary to acknowledge that (the researcher’s) autobiographical, social and situational factors help to shape and define the outcome of the research (Breuer et al 2002) and that knowledge is co-constructed by the research participants and the researcher (Finlay 2002).

Finlay (2002: 212) suggested that the need for a reflexive account of research is now so widely accepted by the social science community that the resulting dilemma for researchers is how to proceed as the practice of reflexivity is “full of muddy ambiguity and multiple traits”. Finlay (2002) and Maton (2003) warn of the pitfalls of becoming trapped in an endless spiral of analysis of the self, leading to the forfeiting of ‘epistemic discovery’ and insight into the research participants. Maton (2003: 55) further advises that researchers should be wary of less critical approaches to reflexivity such as ‘enacted’ reflexivity, including “sociological, autobiographical and
narcissistic reflection” as these genres of reflexivity are too uncritical, focus too much on the researcher and have little theoretical merit.

With these warnings in mind, I will use the process of reflexivity with caution and focus on inter-subjective reflexivity in this section. In terms of defining inter-subjective reflexivity, Finlay (2002) indicates that researchers reflect on:

“...the situated and negotiated nature of the research encounter ... how unconscious processes structure relations between the researcher and participant” (p215).

Within the context of this research, I will reflect on the dilemma of my research position as an ‘insider’ and an ‘outsider’. Acker (2001) posited that a researcher’s status as an insider (in my case gender, cultural and professional characteristics) may enable easier access to research participants, assisting the researcher to build a rapport with interviewees and provide valuable insights when analysing data. I did utilise my insider status to gain access to research participants as I had contacts within the health and social care sectors who acted as gatekeepers. I was able to negotiate with relative ease access to participants from the NHS by stating my position as both research student and practising registered nurse with a background in acute health care. I also used my position as a registered nurse currently working in the care home sector to gain access to care home participants with relative success.

However, in terms of my relative proximity to the research participants, I would argue that whilst it afforded some distinct advantages in gaining access to participants, the rapport I gained with individuals was dependent on my adoption of a fluidity between student and professional. I emphasised myself as an actor performing the ‘student’ role to try to encourage respondents to be as fully open with their responses as possible yet ensuring the participant was aware of my professional status to convince them I had an understanding of the context within which they were working and to gain their trust. Therefore I was, as Ganga and Scott (2006: 7) suggest, “continually negotiating an insider/outsider dynamic” during the process of data collection. During the analytical process, I again adopted this fluidity, using my insider knowledge of the nursing process and organisational structures to critically analyse the data.

Concurrently, I was adopting an outsider status to maintain a degree of detachment
and objectivity as a sociologist and to consider the theoretical implications of my research as indicated by Glaser and Strauss (1967). Finally, I discovered that one of the methodological limitations of representing oneself as, and being perceived as, an insider during the interview process, was the issue of not probing sufficiently during interviews due to my occupational and organisational knowledge. This became evident during the data analysis process and I would argue is a significant issue for a relatively inexperienced student interviewer. However, this experience will ensure that I am methodologically more aware of this danger in future.

This section has dealt with the element of personal reflexivity in an attempt to illustrate how contextual and situational elements of my position as a researcher may have shaped the research. However, the issue of epistemological reflexivity needs to be addressed. This will be discussed further in Chapter 11 ‘Conclusions’ when I will discuss the limitations of the study.

5.13. Transcription

The aim was to transcribe each interview within 24-48 hours of the interview having taken place. In practice, due to work commitments the transcription process was more protracted, with the gap between interview and the transcription process being up to 72 hours. Each interview took between 8 and 12 hours to transcribe. I personally performed each transcription in order to have a complete working knowledge of the data gained from the respondents. I felt that valuable data, such as tone of voice or pauses in answers, may have been lost if a third party was employed to perform the transcription process. Seale and Kelly (1998) stated that the validity of qualitative data is improved by systematic transcription and I felt that this was only possible if I had a comprehensive working knowledge of the recorded data.

The verbatim method of transcription was the method chosen and this choice meant that the transcribing process was long and often laborious, however all the data was available for analysis. Fielding and Thomas (2001) suggested that if the sample is less than 20 then verbatim transcription should be used enabling all possible analytical applications to be put to use. As a PhD student I felt it was part of the PhD process to continue with a full transcription approach even though the number of interviews exceeded 20.
The recordings were listened to again prior to transcription. The transcription process was broken down into a series of manageable time frames. I discovered that ten minutes of taped interview took an hour to transcribe if the interview had been recorded on my iPod with voice recorder adapter, longer if the interview was on cassette tape as the quality was inferior. From interview three onwards, I used the iPod with a conventional cassette recorder for back up. I experienced one technical issue with the iPod where I could not retrieve data; although the interview had been recorded, the iPod would not play back. This led to resorting to a cassette tape back up and transcription was performed using this medium.

The pace of the interview made a significant difference to transcription time. If the respondent spoke slowly, pausing to think about answers, the transcription process was much easier as the diction of the speaker was much clearer. Respondents with regional accents and quick speech delivery gave the greatest difficulty. These data required repeated rewinding of the machine to enable accurate transcription. Carpeted rooms at the time of interview were also much better environments, whereas rooms with boards or laminate flooring created an echo on the recording.

5.14. Data Analysis

The emphasis of the research is on the personal interpretation and experiences of the participants in relation to the questions asked. The examination of the data collected was also subjected to my interpretation, therefore an interpretive epistemological stance was taken (Oliver 2004).

Wolcott (1990) advised that the choice of voice used by the researcher is one of the most important decisions to be taken when writing up research. Clough and Nutbrown (2002: 66) devoted a whole chapter to “listening and the issues of voice” and question how the researcher can interpret and “make sense of data derived from the voices of others” (Clough and Nutbrown 2002: 82) indicating that it is through the researcher’s interpretation of the data that the ‘voices’ of the respondents are represented, whatever sex, race or ethnicity they may be, and that the voice of the researcher and the respondents are inextricably linked. They asserted that it is the role of the researcher to represent the voices of the participants faithfully and truthfully through the researcher’s interpretation of the data. Darlington and Scott (2002) indicate that
the voice of the researcher will be heard in terms of the methodology used, the research problem and the research process, whereas the respondents’ voices will dominate the analysis section of the report.

Padgett (1998) discussed two aspects that correlate with the question of voice. These are the ‘etic-emic’ voice and the ‘reflexive-nonreflective’ voice. The former dimension relates to how much the research report is written from the perspective of the respondents and the latter relating to how much of the author’s experience and perspective is included in the report. In this PhD thesis, I adopted the emic-nonreflective approach whereby the perceptions and experiences of the respondents are emphasised with some degree of my own interpretation (Holstein and Gubrium 1994). Darlington and Scott (2002: 161) recommend that the researcher adopt “an approach that keeps the researcher in but does not so privilege the researcher’s experiences that the participants’ voices are lost or overshadowed”.

Combining this with an iterative approach to the data analysis, this inquiry attempted to understand the perceptions, perspectives and understandings of why this group of nurses have made the decision to stay in nursing. Sandelowski (1986) indicated that the value of qualitative research lies in human experiences or phenomena as they are perceived and lived by respondents. It is left to the reader of the research to determine whether the findings are valuable. However, Mason (2002) advises against this suggesting that researchers do not present data without commentary or reasoning as this obscures the perspective of the researcher, therefore Mason’s approach was adopted.

The data were initially coded by searching for common broad analytical themes or categories in the respondents’ descriptions of their perceptions and experiences, starting during the interview itself and then subsequently through listening to the recorded interviews twice prior to transcription. I made notes in my fieldwork diary at this stage as these analytical themes emerged. I read the transcripts line by line and divided the texts into these major themes followed.

Data analysis began during the data collection phase. A phenomenological approach to the study was initially adopted, as this inquiry attempted to understand the
perceptions, ideas and understandings of the research participants. As Leedy and Ormrod (2001: 139) stated, the researcher is asking the respondent “what is it like to experience such-and-such?” and by considering the situation from several different perspectives. Themes were therefore identified from the data collected in this study as to why mid-life nurses stay in nursing. Creswell (1998) suggested that a researcher should pursue four steps in a phenomenological approach to data analysis. The first is identification of statements that correlate with the topic, thereby dividing relevant data from irrelevant information. The relevant information is then divided into small sections - for example, a sentence or a phrase that each suggest an individual thought. Secondly, statements are then grouped into meaningful components that reveal the various meanings of the phenomenon as the participants experience it. Thirdly, the researcher then looks for participants’ differing perspectives on the phenomenon as they experience it. Finally, the researcher builds an overall description of the phenomenon as experienced by the study participants. This leads to the finalised result, which is a general description of the phenomenon as directly experienced by the participants ensuring that the focus concentrated on common themes extrapolated from the data regardless of the individuals and the settings involved in the study. I employed this approach with a grounded theory approach (Glaser and Strauss 1967) where the researcher consistently and systematically reviews the data in a circular way providing a continuous growth process when analysing data, leading to a more iterative approach which involved moving between the data and relevant literature.

The next sequential step involved a word-by-word approach to coding the data by searching for emergent key words or phrases (Dey 1993). Although at the time, this approach was labour intensive, this systematic method proved invaluable when coding the data and identifying themes, as I was extremely familiar with and close to the data. The recordings were listened to again to rediscover any important tonal qualities inherent in the speech. Initially, when coding the data and extracting themes ‘open coding’ of data was performed whereby the data was broken down, examined, compared and initial conceptualisations made (Strauss and Corbin 1990). This was then supplemented by ‘axial coding’ where the data was reconstructed, making links between categories (Strauss and Corbin 1990). Finally ‘selective coding’ was applied which enabled ‘core categories’ to be defined and concepts to be refined (Strauss and Corbin 1990). The final established coding framework enabled me to keep a record of
emergent themes and quotes from respondents to be used in my analysis that would indicate what the respondents were voicing. It was also utilised to ensure that emergent themes were not confused or duplicated. The qualitative software package MAXQDA was used as a code and retrieval tool for the data and was a much more efficient tool than coding by hand on paper transcripts. It also allowed multiple and overlapping codes to be retrieved simultaneously.

5.15. Conclusion
The qualitative interview approach allowed the respondents in this study to give detailed career biographies, work histories and rationales for entering the occupation of nursing and reasons for remaining occupationally and organisationally committed. The qualitative interviews provided rich data which made it possible to analyse why this cohort of nurses have stayed in nursing, and the challenges and constraints they encountered when performing their role. The data also provided an insight into the perceptions and experiences of nurses as they tried to reconcile nursing ideology with the managerialist discourses that are currently prevalent in the health and social care environments as identified in the literature review chapters. Using a semi-structured qualitative interview approach also allowed deeper probing of respondents and the opportunity to further explore responses to questions about their motivations to stay in nursing. Using a comparative approach to the research question has shed light on the convergences and divergences between nurses working in the NHS and care home sector. The findings from the data will give an insight into the work lives of qualified nurses working in the care home sector of which little has been published in the UK.
6.1. Introduction

The aim of this chapter is to provide a more detailed background to the study respondents. Providing information about their career histories and information about their personal lives gives a more holistic portrait of the nurses in this study. It allows for a better conceptualisation of the paid work of these nurses as it contextualises their work in respect of their family responsibilities.

This chapter will analyse and contrast the biographical data collected from the NHS and care home respondents including:

- age profiles;
- marital status;
- caring responsibilities for dependant children and/or adults;
- the number of years spent in nursing;
- educational qualifications;
- career breaks (if any);
- time spent in their current job role, time spent with their employer;
- full and part-time working, types of shifts worked;
- whether they are actively seeking alternative employment.

The chapter will also analyse the links between job role, part-time/full-time working and responsibilities for dependants, for example, whether part-time nurses with domestic responsibilities for children are in lower grade jobs.

6.2. Biographical Characteristics of the Nurse Respondents

Table 6.1 gives the biographical characteristics of NHS nurse respondents in order to give a more comprehensive portrait of the nurses who participated in this study. Table 2 gives the biographical characteristics of care home nurse respondents.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th>Number of Dependents</th>
<th>Years in Nursing</th>
<th>Career Break</th>
<th>Time in current job</th>
<th>Time with current employer</th>
<th>Job Role</th>
<th>F/T or P/T</th>
</tr>
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<td>Jade</td>
<td>38</td>
<td>married</td>
<td>2</td>
<td>18</td>
<td>1yr+14m</td>
<td>4 yrs</td>
<td>7 yrs</td>
<td>Staff Nurse</td>
<td>PT days</td>
</tr>
<tr>
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<td>3</td>
<td>22</td>
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<td>2 yrs</td>
<td>5 yrs</td>
<td>Sister</td>
<td>PT days</td>
</tr>
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<td>20</td>
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<td>12 yrs</td>
<td>18 yrs</td>
<td>Sister</td>
<td>PT rotation</td>
</tr>
<tr>
<td>Heather</td>
<td>41</td>
<td>separated</td>
<td>2</td>
<td>20</td>
<td>6mx2</td>
<td>2 yrs</td>
<td>17 yrs</td>
<td>Staff Nurse</td>
<td>PT rotation</td>
</tr>
<tr>
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<td>42</td>
<td>married</td>
<td>2</td>
<td>21</td>
<td>8mth</td>
<td>6 yrs</td>
<td>6 yrs</td>
<td>Staff Nurse</td>
<td>PT rotation</td>
</tr>
<tr>
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<td>42</td>
<td>single</td>
<td>2</td>
<td>20</td>
<td>3 yrs</td>
<td>10 yrs</td>
<td>10 yrs</td>
<td>Staff Nurse</td>
<td>PT nights</td>
</tr>
<tr>
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<td>43</td>
<td>married</td>
<td>2</td>
<td>23</td>
<td>2 yrs gap</td>
<td>5.8 yrs</td>
<td>5.8 yrs</td>
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<td>PT nights</td>
</tr>
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<td>2</td>
<td>27</td>
<td>9mx2</td>
<td>2 yrs</td>
<td>18 yrs</td>
<td>Sister</td>
<td>PT days</td>
</tr>
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<td>20</td>
<td>9mth</td>
<td>12 yrs</td>
<td>12 yrs</td>
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<td>PT nights</td>
</tr>
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<td>4 yrs</td>
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<tr>
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<td>24 yrs</td>
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<td>PT days</td>
</tr>
<tr>
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<td>10 yrs</td>
<td>3 yrs</td>
<td>20 yrs</td>
<td>Staff Nurse</td>
<td>PT days</td>
</tr>
<tr>
<td>Isobel</td>
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<td>married</td>
<td>0</td>
<td>16</td>
<td>18 yrs + husband</td>
<td>10 yrs</td>
<td>10 yrs</td>
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<td>PT rotation</td>
</tr>
<tr>
<td>Sarah</td>
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<td>2</td>
<td>17</td>
<td>mat</td>
<td>1 yrs</td>
<td>1 yrs</td>
<td>Specialist Nurse</td>
<td>F/T 9-5</td>
</tr>
<tr>
<td>Hannah</td>
<td>41</td>
<td>married</td>
<td>2</td>
<td>22</td>
<td>6m x2</td>
<td>9mth</td>
<td>20 yrs</td>
<td>Specialist Nurse</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Monica</td>
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<td>1</td>
<td>23</td>
<td>mat</td>
<td>7 yrs</td>
<td>13.5 yrs</td>
<td>Sister</td>
<td>F/T 9-5</td>
</tr>
<tr>
<td>Hiliary</td>
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<td>0</td>
<td>23</td>
<td>0</td>
<td>3 yrs</td>
<td>12 yrs</td>
<td>Specialist Nurse</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Shell</td>
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<td>0</td>
<td>24</td>
<td>0</td>
<td>4 yrs</td>
<td>18 yrs</td>
<td>Specialist Nurse</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Stella</td>
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<td>0</td>
<td>27</td>
<td>0</td>
<td>6 yrs</td>
<td>8 yrs</td>
<td>Consultant Nurse</td>
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<tr>
<td>Simone</td>
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<td>0</td>
<td>26</td>
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<td>3.5 yrs</td>
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<td>FT 9-5</td>
</tr>
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<td>mat</td>
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<td>27 yrs</td>
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<td>27</td>
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<td>12.5 yrs</td>
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<td>FT 9-5</td>
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<td>1</td>
<td>28</td>
<td>1yr</td>
<td>3 yrs</td>
<td>3 yrs</td>
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<td>FT 9-5</td>
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<td>Joelle</td>
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<td>1</td>
<td>28</td>
<td>mat</td>
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<td>8 yrs</td>
<td>Manager</td>
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<td>31</td>
<td>1yr</td>
<td>5 yrs</td>
<td>15 yrs</td>
<td>Sister</td>
<td>FT days</td>
</tr>
</tbody>
</table>

Key: Children/dependant adults = number being cared for
Mat = maternity leave, time not specified
Husband = husband's job
Gap = gap year(s)
PT = part-time
FT = full-time
Days = eg. 7.30am-3.30pm/1-9pm
Nights = eg. 8pm-6am

Internal rotation = a combination of days and nights
Staff nurse = nurses incl. senior staff nurses
Sister = junior & senior sisters
Specialist nurse = nurse specialists
Manager = manager/matron
Table 6.2: Biographical Characteristics of the Care Home Nurse Respondents

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th>Number of Dependents</th>
<th>Years In Nursing</th>
<th>Career Break</th>
<th>Years in current job</th>
<th>Time with current employer</th>
<th>Job Role</th>
<th>F/T or P/T</th>
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<tr>
<td>Darcey</td>
<td>42</td>
<td>married</td>
<td>2</td>
<td>23</td>
<td>12 wks</td>
<td>20 yrs</td>
<td>20 yrs</td>
<td>Staff Nurse</td>
<td>PT nights</td>
</tr>
<tr>
<td>Shelly</td>
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<td>married</td>
<td>2</td>
<td>23.5</td>
<td>18m gap</td>
<td>7 yrs</td>
<td>7 yrs</td>
<td>Staff Nurse</td>
<td>PT days</td>
</tr>
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<td>married</td>
<td>2</td>
<td>24</td>
<td>mat</td>
<td>4 yrs</td>
<td>4 yrs</td>
<td>Manager</td>
<td>PT days</td>
</tr>
<tr>
<td>Amy</td>
<td>46</td>
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<td>25</td>
<td>1yr x2</td>
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<td>8 yrs</td>
<td>Specialist Nurse</td>
<td>PT 9-6</td>
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<td>10 yrs</td>
<td>19 yrs</td>
<td>Sister</td>
<td>PT days</td>
</tr>
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<td>49</td>
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<td>31</td>
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<td>Team Leader</td>
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<td>2 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Grace</td>
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<td>2</td>
<td>24</td>
<td>mat</td>
<td>7mth</td>
<td>12 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Pauline</td>
<td>47</td>
<td>widowed</td>
<td>0</td>
<td>23</td>
<td>9mth mat</td>
<td>7 yrs</td>
<td>7 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
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<td>1.5 yrs</td>
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<td>Manager</td>
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<td>Claudia</td>
<td>47</td>
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<td>1</td>
<td>28</td>
<td>1 yr</td>
<td>21 yrs</td>
<td>21 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Candice</td>
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<td>divorced</td>
<td>0</td>
<td>24</td>
<td>3yrs</td>
<td>1 yrs</td>
<td>1 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Astrid</td>
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<td>8 hrs</td>
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<td>6 yrs</td>
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<td>Senior Staff Nurse</td>
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<td>32</td>
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<td>5mth</td>
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<td>2</td>
<td>29</td>
<td>0</td>
<td>7 yrs</td>
<td>7 yrs</td>
<td>Staff Nurse</td>
<td>PT nights</td>
</tr>
<tr>
<td>Kim</td>
<td>53</td>
<td>married</td>
<td>2</td>
<td>17</td>
<td>0</td>
<td>9 yrs</td>
<td>9 yrs</td>
<td>Staff Nurse</td>
<td>FT rotation</td>
</tr>
<tr>
<td>Sophie</td>
<td>53</td>
<td>married</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>16 yrs</td>
<td>16 yrs</td>
<td>Manager</td>
<td>FT nights</td>
</tr>
<tr>
<td>Celia</td>
<td>54</td>
<td>divorced</td>
<td>0</td>
<td>36.5</td>
<td>6m+2yrs</td>
<td>2 yrs</td>
<td>9 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Sten</td>
<td>55</td>
<td>married</td>
<td>0</td>
<td>34</td>
<td>0</td>
<td>11.5 yrs</td>
<td>11.5 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Karly</td>
<td>55</td>
<td>divorced</td>
<td>1+grand children</td>
<td>30</td>
<td>7yrs</td>
<td>20 yrs</td>
<td>20 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
<tr>
<td>Penny</td>
<td>56</td>
<td>married</td>
<td>0</td>
<td>39</td>
<td>0</td>
<td>8 yrs</td>
<td>8 yrs</td>
<td>Manager</td>
<td>FT 9-5</td>
</tr>
</tbody>
</table>

Key:
- Children/dependant adults = number being cared for
- Mat = maternity leave, time not specified
- Husband = husband's job
- Gap = gap year(s)
- PT = part-time
- FT = full-time
- Days = eg. 7.30am-3.30pm/1-9pm
- Nights = eg. 8pm-8am
- Internal rotation = a combination of days and nights
- Staff nurse = nurses inc. senior staff nurses
- Sister = junior & senior sisters
- Specialist nurse = nurse specialists
- Manager = manager/matron
6.3. **Age profiles of the respondents**

The age of the respondents ranged from 38 to 56. The average age of interviewees working in the NHS was 43.5 years while in the care homes the average age was somewhat higher at 49.5 years. This is consistent with research that shows that nurses working in the care home sector tend to be slightly older than nurses in hospitals (RCN 2007). The ages of the respondents are shown in Figure 6.1.

**Figure 6.1: Age Profile of All Study Respondents**

In the NHS there was no significant difference in the average age of nurses working part-time (45 years) and full-time (44.5 years). In the care home sector, the average age for part-time nurses was 45 years and for full-time employees was 50.8 years. Figure 6.2 shows the numbers of the respondents, in their 30s, 40s and 50s who are working in each type of organisation. This shows that the majority of NHS nurses were in their 40s and a higher proportion of care home nurses were in their 50s.
6.4. **Number of Years in Nursing**

The number of years spent in nursing ranged from 16 to 39 years. The calculation of these figures excluded time taken out from nursing for childcare for other reasons (reasons cited for breaks in service were moving abroad as a result of husband's work, time out for travelling, and taking a degree). Short periods of maternity leave (six months or less) were not counted as career breaks as the nurses intended returning to their jobs and they did not consider themselves to have left nursing.

The average number of years spent in nursing for nurses working in the care home sector was 28 years and for nurses working in the NHS was 23.7 years. Figure 6.3 indicates the number of years spent in nursing, divided into 5 year bands and by type of organisation. The majority of nurses in the care home sector have spent somewhat longer in nursing than their NHS colleagues, which is primarily explained by the fact that the nurses in this sector tended to be older.
Figure 6.3: Years Spent in Nursing by Current Type of Organisation

6.5. Educational Qualifications

Nurses had gained their nursing qualifications via different routes. Three had gained entry via the two year, practical skills based, enrolled nurse (EN) route, which was popular in the 1970s and 80s before all qualified nurses were expected to undertake a ‘conversion’ course to gain the more academic, registered general nurse qualification (RGN). All the nurses working in the NHS had achieved RGN level with some undertaking the conversion course to attain this. In contrast, three nurses working in care homes had not undertaken the RGN conversion course and were still qualified to EN level.

The majority (n=39) of nurses had trained as state registered nurses (SRN) or registered general nurses (RGN). A minority (n=4) had taken the registered mental nurse course (RMN), registered learning disabilities nurse (RNLD) course (n=2), registered sick children’s nurse (RSCN) course (n=2) to qualification and enrolled nurse (n=3). Only one nurse had participated in the Project 2000 qualification, a new
system of training started in the late 1980s, and was one of the nurses who had spent
the shortest time in nursing.

Table 6.3 indicates the level of education and occupational job role comparing a) care
home and b) NHS nurses. Care home nurses had primarily lower qualifications, only
6 out of 25 had gained qualifications at diploma level or above. In contrast, NHS
nurses had much higher qualifications, 16 of the 25 NHS nurses had qualifications at
diploma level or above.

Table 6.3: Highest Educational Qualification for Nurses by Occupational Role
and Type of Organisation

a) In Care Homes

<table>
<thead>
<tr>
<th>Care Home</th>
<th>EN</th>
<th>SRN/RGN/RMN/RNLD</th>
<th>ENB/RMA/Post Registration</th>
<th>Diploma</th>
<th>BSc/BA</th>
<th>Masters</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>25</td>
</tr>
</tbody>
</table>

b) In the NHS

<table>
<thead>
<tr>
<th>NHS</th>
<th>EN</th>
<th>SRN/RGN/RMN/RNLD</th>
<th>ENB/RMA/Post Registration</th>
<th>Diploma</th>
<th>BSc/BA</th>
<th>Masters</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>6</td>
<td>1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>25</td>
</tr>
</tbody>
</table>

In this sample of NHS nurses the higher the educational qualification, the more likely
the nurse is to be in a senior role (specialist nurse or manager). All NHS nurses in
senior roles had been educated to diploma level or above. However, in contrast, in
care homes, 11 out of 16 nurses in senior roles had qualifications below diploma level
illustrating that educational attainment did not correlate with seniority in care homes.
6.6. Marital Status

Two-thirds of the women in this study were married. Only 4 of the 50 women interviewed had never married. Four were widowed, nine were divorced, one was separated, and one was married but living apart from her husband (Table 6.4).

Table 6.4: Marital Status and Whether Caring/Not Caring for Dependant Children/Adults

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
<th>Dependant Children</th>
<th>Dependant adults</th>
<th>No Dependants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, living alone</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>31</td>
<td>62</td>
<td>17</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Married living apart</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>10</td>
<td>20</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Single, living with partner</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
<td>26</td>
<td>2</td>
<td>22</td>
</tr>
</tbody>
</table>

Marital status and the presence of dependant children is considered of interest as it gives a more comprehensive picture of women nurses working in mid-life. Nurses may experience role conflict between work and their domestic lives even if they do not have children, as explored in more detail in Chapter 8. Just over half of the nurses (n=26) still had children living at home and 18 of the nurses were in married relationships, (Table 6.4).

6.7. Ethnic Background

Recruiting ethnically diverse participants proved difficult as the nurses working in both the NHS and especially in care homes who were from ethnic minorities tended to be trained overseas. Of the 50 nurses interviewed, only three were non-white British; two respondents described their ethnic background as Anglo-Indian and one as Black African.
6.8. Length of Time with Current Employer and In Current Job

In terms of time spent with the nurses' current employer (e.g. an NHS Trust or a specific care home), the length of time NHS nurses had spent with their current employer ranged from one year to 27 years with an average of 11.5 years. For nurses working in the care home sector, the length of time ranged from 5 months to 21 years with an average of 9.3 years.

The greater length of time spent with an NHS employer may be because nurses in the NHS stay with the same NHS Trust, but have greater opportunity for changing job roles because of the size of the organisation. For example, Hannah, a specialist nurse had been with the same NHS employer for 20 years but had only been in her current job role for 9 months (see Table 6.1). She had moved around the Trust in different job roles and was in her current role as a result of organisational restructuring.

Nurses working in the care home sector worked within much smaller structures and had less opportunity to move roles within their organisation. This may result in changing employers with the aim to try to achieve promotion. In this study, only three of the 25 care home nurses had changed roles within their organisation compared with 16 nurses working in the NHS.

The time that nurses had spent working in specific roles/jobs varied from 21 years as the longest tenure to two-and-a-half months for the shortest tenure. The average time spent in the job role was 8 years for nurses working in the care home sector and was 4.5 years for NHS nurses. An explanation for the longer job tenure among nurses in the care home sector may be because of the nurses interviewed. Thirteen of these care home nurses were managers or matrons and possibly had no further promotion opportunities in the case of stand alone homes, and/or did not want to progress to group home management (if the home was part of a large group as in the case of nurses who worked for BUPA). The average length of tenure in their current job for managers in care homes was 9 years, with 3 of the managers working in their role for over 15 years. In the NHS only two managers were interviewed and their tenure was much shorter, at 2 years and 3.5 years.
6.9. **Current Job Role and Responsibilities**

The jobs in which the nurses worked ranged from managerial to staff nurse roles. In the NHS, a wide variety of specialities were covered – intensive care, theatres, orthopaedics, ophthalmology, general surgery, paediatrics, gerontology, medicine, practice development, community, and neurology. In care homes, the nurses worked in different roles such as practice development, training and some were more specialised in terms of mental health provision and dementia care. Four of these nurses had trained in mental health rather than via the general nursing route. The sample also contained two learning disability nurses (one who worked in the NHS and one who worked in a care home) and two registered sick children’s nurses (who both worked in the NHS).

There were 7 categories of job role described by the respondents (see Table 6.5). The specialist nurses are kept distinct from managers and although they had managerial responsibilities within their role and have similar hierarchical positions (bandings in the case of the NHS), it is important to indicate their differing roles.

<table>
<thead>
<tr>
<th>Current Job Role</th>
<th>NHS</th>
<th>Care Home</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager/Matron</td>
<td>2</td>
<td>13</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Consultant Nurse</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Specialist Nurse</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Sister</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Team Leader</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Senior Nurse</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>9</td>
<td>5</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>25</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The job roles were condensed into four categories to simplify the data and illustrate the numbers who are in (i) management (managers and matrons), (ii) were specialist nurses (including consultant nurses), (iii) sisters and (iv) those who were staff nurses but not considered to be sisters (team leader and senior staff nurses) (see Table 6.5).
6.10. **Part-time and Full-time Working**

When recruiting nurses for this study, the intention was to achieve parity not only in the numbers of nurses recruited who worked in the NHS and care homes, but equal numbers of part-time and full-time nurses working in each sector. This proved relatively easy within the NHS due to the large pool of available nurses that met the inclusion criteria and who were willing to take part in the research. However, the situation in the care homes sector was very different. Those who met the inclusion criteria were mainly working full-time hours and tended to be in the role of matron or manager of the home. Therefore, only six of the nurses interviewed who were working in care homes were engaged in part-time employment (see Table 6.6).

<table>
<thead>
<tr>
<th></th>
<th>NHS</th>
<th>Care Home</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-time</strong></td>
<td>12</td>
<td>19</td>
<td>31</td>
</tr>
<tr>
<td><strong>Part-time</strong></td>
<td>13</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>

6.11. **Working Patterns**

About half of the nurses both in the NHS and the care home sector worked 9am to 5pm (n=26) due to their level of seniority and their job role (see Table 6.7). This is to be expected of nurses in their 40s and 50s with over twenty years of nursing experience. However, the nurses in this study worked a variety of shift patterns – internal rotation (n=4), day shifts only (shifts between the hours of 7am to 9pm for example 7.30 am -3.30pm, 1.30pm to 9pm, 7am – 7pm) (n=12), night shifts exclusively (n=8), and 9-5 Monday to Friday (n=26).

<table>
<thead>
<tr>
<th>Shift Pattern</th>
<th>NHS</th>
<th>Care Homes</th>
<th>Total Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-5 only</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Days only</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Night shifts only</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Internal Rotation</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>
The majority of nurses working 9 to 5 only were senior nurses or managers in both the NHS and care homes (see table 6.8) and all were working full-time. This would be expected at this level of seniority. There were no junior nurses working full-time in the NHS (see table 6.8a) but in the care homes four out of the 7 junior staff worked full-time shifts (see table 6.8b). It is common for nurses in more junior roles to be working shifts unless flexible working patterns had been negotiated with employers. The data from this study suggests that senior nurses are more likely to be working full-time as these positions tend to be advertised as full-time roles.

Table 6.8: Working Pattern of Respondents by Job Role and if Full or Part-time by Type of Organisation

<table>
<thead>
<tr>
<th>Job role</th>
<th>Working pattern</th>
<th>FT</th>
<th>PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>9-5 Days</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>9-5 Rotation</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Days</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sister</td>
<td>9-5 Rotation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Days</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>9-5 Rotation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Days</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nights</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

b) Care Homes

<table>
<thead>
<tr>
<th>Job role</th>
<th>Working pattern</th>
<th>FT</th>
<th>PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>9-5 Days</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nights</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>9-5 Rotation</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Days</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sister</td>
<td>9-5 Rotation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Days</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>9-5 Rotation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Days</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nights</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>19</td>
<td>6</td>
</tr>
</tbody>
</table>

The majority of nurses working part-time in the NHS were junior nurses, (see table 6.6a). However, these were not solely women who had children of school age as they included two women in their 50s whose husbands had retired and they were working for a degree of financial independence. All four women working part-time nights in the NHS had children of school age and were utilising night shifts to accommodate childcare needs and all were working as junior nurses. Of the three nurses that were working nights in the care home sector, two had children of school age and were working nights to combine childcare needs with paid working. Therefore in both the NHS and care homes, the data indicates that more senior nurses, managers and specialist nurses, tended to work 9 to 5 and are full-time. The nurses with children tended to work part-time to accommodate childcare or dependant adult needs and are in more junior roles. Older ‘junior’ staff, who have worked part-time for several years
are also less likely to undertake, or have access to promotion as indicated by Lane (2004) and Grant et al (2003) discussed in Chapter 3.

6.12. **Nurses Caring for Dependents**

Mid-life nurses are no different from many other women in the workforce when it comes to combining paid work with caring for dependents. The majority of the women in this study had had children (n=39) proportions which were similar in both the NHS and care homes (n=19 in care homes, 20 in the NHS). Of the 39 nurses who had had children, 28 were still caring for children living at home (12 care homes, 16 in the NHS) (Figure 6.4). In addition, two nurses who had no children were caring for a dependant adult, one nurse in each sector, giving a total of 30 nurses currently caring for dependants. Of the 19 nurses working part-time, only four had no dependants. In contrast, of the 31 nurses working full-time, under half (n=14) were caring for dependants (8 in care homes, 6 in the NHS). Figure 6.4 shows that in both the NHS and care homes, nurses who are working part-time are much more likely to have dependants.

**Figure 6.4: Whether Caring for Dependents by Type of Organisation and Full-time or Part-time**
Of the 30 nurses caring for dependants, by far the most common job role was that of staff nurse with 11 women with children working as staff nurses. Explanations for this include that women in this study have acquired flexible working arrangements that suit their childcare needs and may not want to change this at the present time. The data illustrates that nurses in this study were more likely to be in a managerial role if they did not have dependant children. In all other roles the nurses, especially staff nurses, were more likely to have children (see Table 6.9).

Table 6.9a: Current Job Role within the NHS and Caring for Dependents

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Manager</th>
<th>Specialist Nurse</th>
<th>Sister</th>
<th>Staff Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>9</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 6.9b: Current Job Role within the Care Homes and Caring for Dependents

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Manager</th>
<th>Specialist Nurse</th>
<th>Sister</th>
<th>Staff Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 6.9b indicates that managers in care homes were less likely to be caring for dependant children probably because nurses were older in this sector and their children were no longer dependant. It also indicates that nurses with dependants make up a significant proportion of staff nurses in both the NHS and the care home sector. Figure 6.5 gives an overview of the type of job role by organisation, part-time or full-time working and whether the nurse is caring for dependents. The most common type of job role in the NHS for women with dependant children is that of part-time staff nurse. Two nurses were and working part-time in the NHS and these had both gone back to work after having the longest career breaks for children (10 years and 18 years). Both had husbands who had retired and both stated they wanted an identity outside the domestic sphere.
In terms of full-time working in the NHS, there was no difference in job roles for nurses with and without dependants. No staff nurses were working full-time in the NHS. Similarly, in the care home sector, the most common role for a nurse working part-time and looking after children was that of staff nurse. The most common job role for nurses working full-time, whether or not they were caring for dependants was that of manager. For those working full-time and caring for dependants in the care home sector, the predominant role was that of manager.

**Figure 6.5: Whether Caring for Dependents by Job Role, Part-time/Full-time hours and Organisation Type.**

6.13. **Taking a Career Break**

The majority of nurses (n=38) taking part in this study had taken some form of career break, mainly for maternity leave and child-care purposes. However, only four nurses had had a significant amount of time out of nursing (over 5 years); two nurses had accompanied their husbands abroad because of their jobs and were also caring for
children, one for three years and one for 18 years, two had taken time (8 years and 10 years) out of nursing to care for children. Half of the nurses (n=25) only had brief periods out of nursing, usually short breaks for maternity leave, i.e. six months or under.

Twelve nurses stated that they had not taken any time out of nursing (although three of these had had children so must have had maternity leave, but did not consider maternity leave as time out of nursing). The majority of nurses in this study had not taken any significant time out of nursing with only 6 nurses taking more than 2 years out of their careers to pursue other options. It is difficult to quantify accurately the amount of time that nurses had spent on short breaks from nursing as many stated that they had taken 'just maternity leave' and could not remember with any accuracy how little or much time this had been (for most it was between 3 and 12 months for each child). Table 6.10 indicates the number of nurses who reported a career break and the reasons for this, with 'other' relating to nurses taking time out for travelling, pursuing higher education and working in occupations other than nursing.

Table 6.10: Career Breaks by Reason for Break and by Type of Organisation

<table>
<thead>
<tr>
<th>Maternity</th>
<th>Childcare</th>
<th>Other</th>
<th>Husband</th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>10</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Care Home</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>12</td>
<td>5</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>

The most common reason for taking a career break was maternity leave or to care for children (n=31). The key overall message to emerge from the data is that although the majority of nurses had taken a career break, these were not significant breaks in that they were for maternity purposes and the nurses still perceived themselves as nurses at these times as they intended to return to nursing after maternity leave. This suggests that these nurses demonstrate a strong commitment to their occupation.


In the NHS, only one nurse was actively seeking alternative employment and this was as a result of restructuring in the organisation. The role she was working in was made obsolete as a result of the restructuring process and she was offered an alternative role which she accepted, but she was not happy in this teaching role because of the lack of
patient contact. This nurse was seeking a job in the community but still in nursing. None of the nurses interviewed working in the NHS were considering leaving nursing.

Five care home nurses were actively seeking alternative employment. Two nurses working for the same care home organisation were looking for alternatives because their organisation was in the process of being sold and they did not know whether their positions would still exist under the management of the new owners (so were making contingency plans should their roles be redundant in the future restructuring of the organisation). One manager of a care home, which was part of a larger group, was seeking alternative employment because she was unhappy with her employer and one manager of a care home was planning to move abroad, but both were intending to stay in nursing. Finally, one care home staff nurse was considering leaving because her husband was starting his own business and she was contemplating assisting him with the start up (but had no definite plan). Therefore four of these five care home nurses were planning to stay in nursing.

6.15. Future Plans

The concept of future plans was explored with the nurses in this study as I was interested in finding out whether nurses would continue to demonstrate organisational and occupational commitment in the future. Four nurses in their mid 50s working in care homes were planning to retire from their current positions and employers at 60, but were not necessarily planning to give up work altogether. Nor were they necessarily planning to leave nursing but ‘downsize’ to ‘bank work’ in nursing (where they work on an ad hoc basis when needed for an organisation) or voluntary jobs. Two nurses in the NHS were planning to retire within 5 years, one who was in her mid 40s and one in her mid 50s. One wished to work for the church and not stay in nursing but this was a long-term plan as she could not afford to do this at present with three dependant children.

However, none of this cohort of nurses had very definite career plans for the future and indeed the majority had not had any definitive career plan throughout their nursing careers; their careers had been ‘snowball’ careers (a phrase used by one of the nurses in the study), driven via interests in specialities, ad hoc opportunities,
restructuring within organisations, family needs, husband's employment and redeployment and simply not knowing what they wanted to do so opted to stay in their current roles. This is demonstrated by 11 of the nurses in this study who said that they did not know what their future plans were.

For the majority who were planning to stay in nursing, 11 were planning to stay in the same role. This is due, in part, to a self imposed 'ceiling' whereby the next promotional opportunity would be into management and removed from clinical services and patient/client contact; this was anathema to most nurses in this study as they expressed a desire to remain in contact with patients. Figure 6.6 shows that there were differences in the future plans of nurses working in the two types of organisations.

Figure 6.6: Main Future Plans of Nurses by Organisational Type

More nurses in the NHS were seeking promotion than in care homes but this may be explained by the younger age of the NHS nurses and greater promotional opportunities, whereas more nurses working in care homes planned to stay in the same role than nurses in the NHS. One nurse in the NHS was planning to increase her hours as her children became more independent. Two nurses in the NHS and three in the care home sector planned to decrease their hours. A small number of nurses in both sectors (NHS = 2, Care home = 1) planned further educational qualifications in the form of a first degree or a master's degree. What is evident from the narratives
and the data is that the majority of these mid-life nurses had no definite career plans and were still continuing a ‘snowball’ career.

6.16. Conclusion

From the overview of the sample presented in this chapter, nurses working in care homes were on average 6 years older than those working in the NHS. In terms of the number of years spent in nursing, nurses working in care homes, on average, have spent two years longer in nursing than those in the NHS.

Nurses have demonstrated diverse entry routes into nursing, many gaining post-registration qualifications as they have progressed in their careers. As expected, staff nurses in both groups had the lowest educational qualifications. Combining work and childcare may cause role conflict and the addition of studying for further educational qualifications at this stage, may not be an option for these women as it is time and resource consuming. The abundance of women with children in staff nurse posts may be a result of lack of opportunities for part-time work in more senior roles.

In terms of time spent with their current employers, nurses in the NHS have spent on average two years longer with their employers than nurses in the care home sector. This may be due to greater opportunities for promotion or changes in job role within an NHS Trust compared with a care home, especially if the care home is not part of a large group. One of the problems care home nurses face is that there are limited career opportunities compared within the NHS. However, this may be advantageous to care home nurses in one respect as they have greater flexibility in the labour market. Although their field of care is specialised, the roles are less so, often the roles of staff nurse, deputy manager or manager are their only choices. This means that there are more generic job opportunities in the care home labour market. The theme of career pathways is analysed in Chapter 8.

Mid-life nurses working in the NHS often have limited options in the labour market as they have reached a level of seniority and have specialised in a particular field. This leaves them with fewer job options should they wish to leave but maintain their grade and level of pay. Specialist NHS nurses can be limited in their career options once they have reached the pinnacle of seniority within their specialty. This can cause NHS
nurses to remain in their roles due to the absence of alternatives. Paradoxically, care 
home nurses stated that they had greater flexibility within the labour market because 
of the limited career options. They considered that whether staff nurse or manager, 
they had greater freedom to change employers because of the generic nature of their 
role.

Many of the nurses in this study had what could be termed ‘snowball’ careers and 
appeared content to continue in this way with a quarter of nurses (n=12) not having 
any notion of what they would be doing in 5 years time. Even in an unstable labour 
market (mergers and closures were threatening to affect NHS Trusts in the South East 
at the time of interview), nurses did not appear concerned about their job security. The 
predominant opinion was that there were always jobs for nurses in the labour market.

The majority of nurses in this study were planning to remain in nursing and with their 
employers. Even among nurses who are in their 50s, the majority were considering 
staying in nursing and not retiring at present. The majority of nurses were considering 
opportunities for promotion, with this option more popular for nurses in the NHS. 
Again this could be because of the greater opportunities for career advancement 
within the NHS. Care home nurses were more likely to say they plan to stay in the 
same role. This stability of job roles suggests continued commitment to nursing as an 
occupation and their employers. The concept of occupational commitment will be 
analysed in detail in Chapter 7 and organisational commitment in Chapter 9.
CHAPTER 7

Professionalism and Occupational Commitment

7.1. Introduction
The reasons nurses stay in nursing are complex and varied. Although nurses are leaving the profession, a majority choose to stay (Skogsberg 2003). As established in Chapter 2, research has demonstrated a causal link between job satisfaction, occupational commitment and intent to stay. The interviews in this study established that professionalism and the central tenets of nursing ideology were an important facet of job satisfaction for nurses working in both the NHS and the care home sector. One of the essential concepts that emerged from the nurses’ narratives and which served to ensure occupational commitment was a passion for nursing work. Yet the desire to be regarded as a professional was tempered with a sense of vocationalism - using the art of caring - and nurses considered this to be an essential component of being a ‘good nurse’.

Another main concept to emerge from the data that correlated with job satisfaction was teamwork. Even if the nurse worked outside a nursing team, as was the experience of many specialist nurses, teamwork was still an important element to their work. It allowed nurses to share professional knowledge and experiences and engage in debriefing processes. The utilisation of professional skills was the another central concept that emerged from analysis of the data. Nurses regarded updating skills and knowledge as essential to their professionalism although not all nurses appeared to be able to access continuing professional development courses other than mandatory training. The concept of remuneration, as discussed in Chapter 2 has previously been shown to have links with intention to stay. The majority of nurses in this study reported that financial reward was an important consideration and a primary motivator to engage in work (Reeves et al 2005). However, it cannot be taken in isolation as an indicator of occupational commitment as argued by McGuire et al (2003).

The data analysed in this chapter relate to the concepts of professionalism, the art of caring, the importance of teamwork to the professional environment, how nurses as professionals want to use their skills, knowledge and experience to make a difference
to patients' lives and the job satisfaction that resulted from this. This chapter will demonstrate that it is evident that nurses are still passionate about their work and this leads to the experience of the intrinsic rewards of job satisfaction which provide an explanation for occupational commitment. Finally, the concept of remuneration and the need to earn a living wage is analysed. The experiences and perceptions of nurses working in the NHS and in care homes will be analysed and explicitly contrasted. In addition to the nurses’ pseudonyms, their ages and job roles are given after all extracts from their interviews.

7.2. The Caring Role – Making a Difference, Passion and Altruism
Nurses in this study discussed the caring/nurturing side of nursing and their aspirations to make a difference to their patients’ lives and care. They provided support and advice, utilised their skills, knowledge and experience which benefited their patients and they feel good about themselves in return, demonstrating that reciprocity (Emerson 1972, 1976) was important to nurses in this study. These elements ensured that nurses not only enjoyed their role and derived job satisfaction but that their training and experience was being utilised effectively.

7.2.1 Making a Difference in the NHS
Nurses working in the NHS discussed how they enjoyed their roles and how enjoyment of the job and making a difference to their patients’ lives was a fundamental part of their commitment to nursing. Making a difference emerged as a primary motivator and led to a sense of enjoyment and ultimately job satisfaction for nurses working in the NHS.

“The motivation’s mainly enjoyment, not enjoyment [pause] the actual sort of doing the job I do, um, and it is the feeling of helping people I think. They all sound so corny these phrases. But it is. You feel you’re doing some good. I think that’s what it is. I feel it’s a really worth-while job to be doing and it’s something actually that does have an effect on people’s lives, it changes things or people. You can, by doing even the most small things at work, when you’ve made a situation easier or you’ve eased somebody’s pain or whatever the situation is, you actually have a huge impact on that person’s life at that time and probably in the future.”

Felicity, 40, NHS Sister.
It is their constant presence, 24 hours a day, that nurses perceived as making a difference to patients. According to one nurse, it is providing not just the nursing care but the demonstration of, often unquantifiable such as demonstrated by emotion labour/work (Hochschild 1997; James 1989, 1992; Bolton 2001), actions that make the patients’ experience bearable.

“My commitment to nursing’s still there because I do think nursing can make a difference. I think that nursing is what makes a difference to patients. That wherever a patient goes, whether it be outpatients, whether it may even be their GP surgery, you know when they go into the clinical areas – go into surgery, whatever, I think nurses are the people who really make a difference.”

Hannah, 41, NHS Specialist Nurse.

The patients had a fundamental place in the working lives of nurses. It was essential for nurses that patients remained central to their work in order for nurses to feel that they were doing a worthwhile job. This led to enjoyment of the work they were doing and to a sense of job satisfaction. (Blegen 1993, Tovey and Adams 1999).

“Well, without the patients, I actually feel there would be nothing to come to work for. Well, obviously there is but there wouldn't be. Because it's, that enjoyment aspect will be gone.”

Colleen, 47, NHS Specialist Nurse.

For one nurse, working in rehabilitation, the theme of making a difference to patients’ lives emerges as a central element of her enjoyment of the job and subsequent commitment to nursing. She discussed the value, to her, of getting to know patients.

“I enjoy working with people […] I enjoy that feeling that I make a difference to somebody, hopefully. And the actual discussing them really and learning about people, I think that’s something I’ve really valued over the years is just being able to talk to people and see what experiences they’ve had and things.”

Sheila, 43, NHS Specialist Nurse.

Nurses demonstrated that making a difference contributes to job satisfaction and to commitment and how integral patients, teams and the hospital itself were to a sense of job satisfaction. A nurse who worked part-time in an different NHS Trust rehabilitation unit illustrated her commitment to nursing as an occupation and
explained her enjoyment of working with older patients who are referred to her unit for rehabilitative care.

“I think - I suppose where I work, the job satisfaction I get is if someone is coming in that perhaps mobility is very poor and I can help improve their mobility, I'm part of the team that can improve their mobility. [...] So that's the sort of satisfaction I get. [...] It's a tricky question isn't it? [the question being why she is committed to nursing as an occupation] It has to be the fact that you get a reward from doing it. And what reward do I get is just the satisfaction of being able to help other people. It can't be anything else.”

Anthea, 53, NHS Staff Nurse.

This nurse’s hospital was under threat of closure and she was actively engaged in a (subsequently successful) campaign to save it because of her passion for her patients, not simply because her job was under threat. She was one of two NHS nurses who worked part-time but not for financial reward. Her husband was over 10 years older than her, had taken early retirement with good pension provision and she wanted to maintain a professional role outside the domestic sphere, as discussed by Higgins et al (2000), Brannen et al (1994) and Lister (1992). She explained her rationale for entering and staying in nursing.

“It was just something I've always wanted to do and felt passionate about and felt very privileged that I do, or have done something that I've wanted to do. I suppose it's just my mad passion about nursing really. It certainly isn't the money. You heard the comment from my dear husband [she pays the cleaner more than she earns]. So it isn't the money. It's, I think it's being part of a team that I work with and if and when the hospital does close, it will be very interesting to see how I react to that because I think I'm going to find that quite difficult.”

Anthea, 53, NHS Staff Nurse.

For other nurses, the ideology of nursing (Graham 1983) and caring for patients was paramount. Desiring to see patients get better and that nurses’ actions can help ameliorate pain and suffering was a fundamental motivator to keep many of the nurses interviewed in nursing.

“Seeing them get better most of the time; they're in acute pain, post op pain. Most of the patients do, to some degree get better. Actually seeing a patient who - I'm a nurse prescriber as well so, a patient who you have actually changed their prescription, you've got them comfortable and seeing them
walking around the next day, that kind of thing. That's what motivates me to
go to work.”

Stella, 44, NHS Consultant Nurse.

For some nurses, the passion was perceived as something intangible, internal to their
personality. Nurses discussed the fundamental issue that although they needed to
work to pay the mortgage, it was mostly not the financial imperative that motivated

“Obviously I have a good life and I’m able to pay my mortgage and things but
that wouldn't be what motivates me, it would be more the fact that it's
something – it sounds really cheesy, but something in here [thumps chest] that
brings me to work, because I don’t think you - I think to be in nursing you
have to be a certain type of person. And I won't say a people person, per se,
but I do think you need to be a certain type of person who wants to interact
with others.”

Stella, 44, Consultant Nurse.

The following quote demonstrates that making a difference satisfied a fundamental
need for nurses in this study. It illustrated that their work was endorsed by those who
received nursing care and consequently, they received a boost to their morale and self­
estee, through the acknowledgement by their patients, that their professional nursing
and interpersonal skills were making a difference.

“I suppose you have a need to be needed in nursing. I think it's a two way
thing, although people need you, it's quite nice that people think you're ok and
that's quite a nice buzz to think you can help them.”

Camilla, 50, NHS Specialist Nurse.

For these NHS nurses, one of the primary motivations for occupational commitment
is the philosophy and ideology of caring. They wanted to make a difference to their
patients’ lives, not simply because it was part of their job role but because they had a
fundamental belief in the art of caring and the ideology of nursing – caring for people.
Medicine’s role can save lives, alleviate illness and pain (a curative role), but it is the
nurses’ (curative) role, the essence of care that is practiced at the bedside, the often
intangible, unquantifiable aspects of care that give job satisfaction to nurses.
7.2.2 Making a Difference in Care Homes

For nurses working in care homes this fundamental aspect of nursing was also important. Although client turnover is relatively low in care homes compared to the NHS, and they may not see great changes in their clients’ lives, the nurses interviewed felt they had an important role to play in making their clients’ lives as comfortable and happy as possible.

“Yes, you are making a difference, to their lives. It will be different in a way like - if they were at their own home, it wouldn't be the same. I'm able to do more for them here than if they were at home, yeah. Though I still encourage their family life. They can come here, spend time with them, join them for meals, take them out for meals. I still encourage that but, at the same time, I fulfil my duties to make sure they're happy. This is their home and I should make them happy.”

Molly, 53, Care Home Staff Nurse.

This was echoed by a manager of a nursing home, who also discussed the impact of being able to make a difference to her clients’ lives and the importance of trying to change the perception of care homes, to construct a more optimistic view of care homes as places for positive ageing lifestyles rather than being viewed as the end of a terminal decline in life.

“Positive aspects? Um, making a difference to the residents’ lives. Trying to give them um, choices, and they may be small choices but they're choices. And um... developing, developing life and not just ‘Oh, it's God’s waiting room’ attitude. Trying to make a difference in that.”

Julia, 47, Care Home Manager.

Influencing the care that clients receive was an important agenda for nurses working in care homes, especially for home managers who have the autonomy to make changes. This autonomy appeared to enhance their job satisfaction and motivated them in their occupational role.

“I can influence the care for up to thirty one people really. Um, you know, in my position, hopefully I'm having an effect on the care, a positive effect on the care out there. And if I'm, you know, a nurse in a bigger organisation or something, I can do my best when I'm there but kind of like [pause] that's my reason for being here really.”

Candice, 48, Care Home Manager.
Even though the responsibility for their clients’ wellbeing is intrinsic in the nurse’s role, the public portrayal of the standards of care within care homes, by the media, is often very negative. This is the opposite to the perceptions and opinions of nurses working in care homes visited during the research study. Undoubtedly there are care homes where standards are not maintained and this is evidenced by the star ratings of the Care Quality Commission and the reporting of high profile scandals in the media. However, during the process of the research, the overwhelming perception I gained, of nurses and managers I encountered, was of a personal conviction to maintain the highest standards of care.

“I think the fact that people’s lives depend on you has got to be high up on the list [of reasons for staying in nursing]. And whilst I know that if I have a fortnight’s holiday, it’s not going to make a difference to their lives but when you’re dealing with people’s lives, which you are as a nurse, whatever stage you’re in within that [pause] even from a care assistant, you are actually dealing with people’s lives and it does make a difference to you getting up and going to work in the morning.”

Janice, 44, Care Home Manager.

For nurses working in care homes, the idea of commitment was about a strong belief in the nursing profession, its ideology and the end product they were offering.

“I think it’s got to be a passion for what you believe in, you know. It’s like anything. At my home, a lot of the emphasis is on marketing as well you know, you have to have that passion there. If you’ve got that passion, you actually will be motivated. I feel in nursing, it’s not the salary that motivates you, it’s actually the people that you’re looking after, and with that together with the passion I have for training, link the two together, yeah?”

Sam, 52, Care Home Specialist Nurse.

For one manager, her passion has been directed at making her care home a place that her residents felt comfortable in. She cared deeply about this, a passion that was conveyed during her interview.

“And I just sometimes, at the end of the day, I just sometimes stand out in the garden and look up and think, ‘I’m really lucky to be here’, so I still feel I’m lucky to do what I’m actually doing. Put all the difficulties aside, ‘cos every job’s got some difficulties, but then not every job will give you what the residents give us back.”

Penny, 55, Care Home Manager.
Even when the situation appeared intolerable, and for some nurses there were plenty of days when shelf-stacking in a supermarket or any other work than nursing may have seemed appealing, there remained the belief that nursing is a worthwhile occupation.

“There’s so much need to have commitment and passion and, to run a home and continue the role. And on the bad times you just think ‘oh, I’d just do anything, gardening would be superb or even Tesco looks attractive’ on a daily basis but, and then you think ‘oh come on, get over it.’ It’s the positive reasons that are making the difference, that make you work in the role.”

Julia, 43, Care Home Manager.

One care home manager, had previously worked part-time in the NHS and part-time in her care home. This manager had left the NHS because she felt angry and frustrated that she could not give the high standards of care she wanted to, often due to staff shortages and highly dependent patients. She explained these were her reasons for leaving the NHS, her decision to move to the care home sector full-time and why she was happier working in the care home sector, where she had the autonomy to affect change and improve practice, something she felt she could not do in the NHS.

“I felt at least I could actually make a difference here. I could select the staff I wanted here. I could select the standards that I wanted people to work to. I could perhaps influence the number of people working on a shift and that I could make some difference. […] Because I was already working here part-time, I knew that I could make a difference.”

Sophie, 53, Care Home Manager.

From this data, it can be seen that it was important for care home nurses to feel that they were making a difference to their clients’ lives through their professionalism and this contributed to their overall job satisfaction and subsequent commitment to nursing. The perception of making a difference also appeared to validate the nurses’ role, giving them the personal satisfaction that they were ‘doing a good job’, to the best of their ability and that they took pride in their work role and had pride in being nurses. This concept of professionalism was evident throughout the study. Both nurses working in the NHS and those working in care homes demonstrated that the ‘caring’ aspect of their role was an important element of job satisfaction, a motivator to ensure occupational commitment. Nurses in this study could be said to demonstrate
‘affective’ commitment in relation to this facet of professionalism (Meyer and Allen 1991). Their occupational commitment occurred because obtaining a sense of job satisfaction, from making a difference to patients’ lives makes them want to stay.

White’s (2002) concept of vocation – giving the best care possible and putting the patients’ interests first was important to the nurses interviewed. The nurses in this study represented a shift from the ideology that vocation is an all consuming, devotional, almost “quasi-religious” concept (Hallam 2002: 36). However the vocational paradigm has not disappeared but appears to have changed into a paradigm more suitable for twenty-first century ideals. Nurses are still as passionate about nursing and their work with patients. It is this passion rather than the notion that nurses devote their entire life to nursing (part of the original concept of vocation) which is key to a re-conceptualisation of the idea of vocation in nursing.

7.3. Teamwork

Research has demonstrated that teamwork and relationships, both professional and social, between nurses has an impact on job satisfaction (Aiken et al 1998, Adams and 2000, Budge et al 2003). Teamwork was an important factor in the working lives of NHS and care home nurses interviewed in this study and was evident in contributing to their job satisfaction. Nurses need to be able to work in teams, communicate with colleagues and have positive interpersonal relationships to provide effective patient care. Nurses in this study worked in a variety of team formats, ranging from large teams such as intensive care units to much smaller teams at the other end of the spectrum, just a nurse and her line manager comprising the team members.

7.3.1 Teamwork in the NHS

Nursing teams may be quite large in numbers, as for example in the intensive care unit of one Trust, so communication and trust are imperative for effective working teams. For one nurse, working in an intensive care unit in a large district general hospital, teamwork was essential, not only for the efficient functioning of the team but for a sense of personal job satisfaction and commitment. Here, the importance of having a stable, positive collegial environment is illustrated and how it influences nurses’ commitment.
"The team I work with, because we've all been there quite along time - with junior staff even the turnover isn't very high. They come, they do their course and they tend to stay. And we, we just got, I think we've got 50 of us working down there but they are just such a lovely team. That would be one of the main reasons if I ever thought of leaving that would stop me, would be because of the people I work with 'cos they're fantastic."

Felicity, 40, NHS Sister.

The nurses in this study discussed the importance of relationships and teamwork to their job satisfaction and commitment. Nurses on wards have to work as a team to provide 24 hour patient care, they rely on each other and health care assistants to communicate about patients' health status, alert senior staff when there is a critical situation and provide accurate handover to the following shift of nurses.

"As far as the patients are concerned, I think for rehabilitation, you've got to have problem solving skills and also good teamwork. And the emphasis is on teamwork. At the moment, we've got a very good team and it's nice to see everybody working together."

Joan, 52, NHS Sister.

This contrasted with another of Joan's experiences of teamwork which supports the assertion that without good teamwork and feeling valued as a member of a team, a higher staff turnover is more likely to be the result (Sourdif 2004).

"The teamworking is great. I've worked at G where the teamworking wasn't great and the consultant actually left because of the physios making life unbearable for him. And you wouldn't think that one set of therapists could make life that intolerable. But obviously you know, he didn't need to be there. It was only one person. That person moved on. But it's lovely when everyone as a team works together, and I think that's so important."

Joan, 52, NHS Sister.

Although this nurse's comments related to medical staff, it could easily translate to members of the nursing team. If one person is effectively bullied, the result can be isolation, alienation and an incentive to consider alternative employment.

Teamwork was important to nurses even when they were part of a very small team. It gave them a sense of belonging and association with like-minded people, compensated for the feeling of isolation that some specialist nurses discussed and
acted as a conduit for relieving stress through opportunities to discuss professional issues and access advice. Specialist nurses may not share the same in-depth professional knowledge but they could empathise with the situational experiences.

“When I’m on shift, I’m either on my own if I’m on one of the sites, or there’s two of us on together. We work very closely with the other person, which I like. Maybe if they go and review a patient and they’re not sure, they’ll call me and I’ll go and review the patient as well, or if they’re disagreeing with a doctor or something, they might want a third party to come and push their point a bit, or see what they think and I do the same. So, we work very closely with that immediate team member. I guess you would just – it feels quite, when you’re on nights as well, it feels like a big team, I think. ’Cos you know there’s so few people to rely on. There’s not many people around. I think that makes a difference.’

Sheena, 45, NHS Specialist Nurse.

Even for those nurses who were part of a very small team (the nurse and her line manager), teamwork was important for them to feel part of a bigger service, to decrease the isolation that they may feel as a lone worker.

“I’m not part of a team although people around me that I work with make me feel part of that team which is nice. It’s nice to be part of something and not lone working, although I do lone work because that’s part of the job.”

Sarah, 38, NHS Specialist Nurse.

The positive aspects of teamwork in nursing were emphasised by Alex, a staff nurse working part-time nights in an acute NHS Trust. She discussed the importance of having a supportive team.

“We have a really good team on our ward, you know? Even in the downside [sic] we cheer each other up, definitely. I think that’s why I like my ward so much, because we do have a good team. I mean, we’re all supportive of each other, you know, in personal reasons and work reasons.”

Alex, 42, NHS Nurse.

Teamworking is not always a positive experience for staff. The effects of not working as a team within practice areas was discussed and this can lead to feelings of despondency, a lack of recognition, being undervalued and not supported as a professional.
"Um, we feel that as a team, we feel they [the GPs and managers] are, we're working against them in a kind of, you know [pause]. It feels like we're not working for the same cause really, and we are. It's not, you know, it's not working as a [pause] very well as a team altogether and being helpful to each other really. Um, things could work a lot better really."

Jade, 38, NHS Staff Nurse.

The formation of positive social bonds at work and the presence of teamwork is associated with affective commitment (Meyer and Allen 1991, Powell and Meyer 2004). For the NHS nurses in this study, teamwork was important to a positive working environment. Several specialist nurses who worked mainly alone expressed that teamwork was also important to them, not in the sense of working with a team every day but feeling part of a wider team and having that team support when they required it.

7.3.2 Teamwork in Care Homes

Teamwork was also important to nurses working in the care home sector. Few studies have examined the role of teamwork in care homes with the exception of Wicke et al (2004). Nurses working in care homes also discussed the importance of teamwork to the quality of their work. One nurse manager of a care home for people with learning disabilities and epilepsy indicated that multidisciplinary teamwork was important to the functioning of the department and felt that teamwork was one of their department's strengths.

"I think teamwork is one of our stronger points here actually and it's right across the board, you know, extending out of medical departments into education and the care staff, and the therapy staff. Um, you know, we all work as a member of a the team. Most people value each others' contribution."

Claudia, 47, Care Home Manager.

For nurses in this study, working in a care home was often a more positive experience than working in the NHS. As there is a paucity of research into the working lives of registered nurses working in UK care homes, little is known about the experiences of these nurses or why they have left the NHS. Nurse working in care homes, often found that the care home environment was more supportive than the NHS.
"I think that there’s more positives here on the whole than there were in the NHS. On whole, I feel much more in a team and supported here compared with my last job in the NHS, I’m just sort of comparing with that, not previous jobs. So yes, feeling more supported, it is a less pressurised environment, there’s absolutely no doubt about it, here, so I think that’s a positive compared to the NHS’s job, um, I think here is good multidisciplinary teamworking and I think that is really helpful and really supportive and I think that’s much more so than in the NHS where people are tending to fight their corner a little bit more, not saying that that doesn’t happen here, but less so.”

Shelly, 43, Care Home Staff Nurse.

The concept of teamworking and having a good team was supported by Doreen, who worked in a care home that was the sole home owned by a proprietor.

“You know, as I say, it is a good team here, and everybody works as a team and I think S [her manager] is a very fair boss, so is the proprietor who owns it.”

Doreen, 52, Care Home Senior Staff Nurse.

This sentiment of teamwork being positive in the care home environment was also supported by Pauline’s experience.

“Um, I think the teamwork, the good teamwork and we have a good working team. And most of the girls have been with me long term. Um, and even to them the work that we’ve put into place in the home has improved the quality of their working, if you like, and the atmosphere that they’re working and the environment and everything, it’s all just kind of improved really.”

Pauline, 47, Care Home Manager.

Managers working in care homes, highlighted the importance of having the support of staff, and the importance of teamwork as a two way process. The support of a manager towards staff and staff support of management was considered essential to promote effective teamworking.

“But not for, it’s for all of us because I can’t do it without the team. I’ve got great backup. If I didn’t have the backup, without the backup, I think this is a very hard job. It’s not an easy job, it can be a thankless job when you get a horrible day but I suppose most jobs can be. But because I’ve got the backup and I know if the chips were down, then they’re there, they’re there for you. And they all help out and everybody tries to do this, tries to sort things out.”

Penny 56, Care Home Manager.
Overwhelmingly, care home nurses reported positive working relationships with their colleagues, staff and managers. However, respondents reported that colleagues had not always been supportive in the workplace.

"Ok, this is the only place I've worked in where you've got men and women working together and all ages, and it works. Women together are poisonous. We are so bitchy."

Coral, 43, Care Home Staff Nurse.

This section has demonstrated the importance of teamwork for both NHS and care home nurses. Nurses in both sectors reported that they thought teamwork was essential for good working relationships and contributed to their sense of job satisfaction. Interestingly, some nurses in the care home sector reported higher levels of satisfaction with teamwork than when they were working in the NHS. This may be as a consequence of smaller working teams, closer working relationships with managers and better overall job satisfaction.

7.4. Skills, Knowledge and Experience: the familiarity of the nursing role

The concept of 'familiarity' with the role of being a nurse was one of the reasons given for occupational commitment and organisational commitment. This varied in its definition; nurses defined familiarity as being comfortable with the job role they were currently in, being able to cope with what was expected of them, feeling confident and competent in their nursing roles and not feeling that they did not have the skills to do anything else. Nurses' skills in the NHS and in care homes are quite different. However, because they are differently skilled (NHS more technical, care home more generalist) this does not necessarily mean that care home nurses are less skilled than their NHS colleagues. The care home nurses in this study emphasised their specialist skills within their speciality (care of the older person, dementia care, care of people with physical and learning disabilities) and end of life care.

7.4.1 Skills, Knowledge and Experience: the familiarity of the nursing role in the NHS

Nurses working in the NHS discussed how they felt about their role and why they had chosen to stay. Nurses' reasons for staying in their nursing role were often linked to
the belief that nurses had learnt to perform a job or role, had acquired the necessary skills and did not want to be challenged by having to learn a new role.

"Um, it's familiar [the nursing role she has], I suppose. It's familiar and I feel confident. I feel, not just confident but I feel very competent in what I do and that makes things natural doesn't it? when I come here I don't think, oh, I hope nobody asks me about that. [...] I can handle whatever comes along I suppose, and that's a good thing. And that's come out of years of experience isn't it?"

Chloe, 42, NHS Sister.

These nurses had gained considerable knowledge, skills and experience throughout their career and indeed within their current role so that they were working within their 'comfort zone'; they were being comfortably challenged in their role but did not feel 'out of their depth'. However, this adaptation to their current role has led to 'continuance commitment' (Meyer and Powell 1991) because the effort involved in learning a new role is regarded as too much of a challenge.

"It's just very hard to go from being in your comfort zone, very confident in what you're doing, [to being] totally out of your comfort zone. So yeah, I think a lot of it is just because it's better the devil you know, really. So that's probably why."

Felicity, 40, NHS Sister.

Some nurses did not want to be challenged by considering an alternative career, even if they could afford financially to retrain, they felt that they did not want to waste this considerable library of skills that they had accumulated. For one nurse, the rationale was much more straightforward in that she wanted to ensure that she maintained her nursing registration. In order to remain on the Nursing and Midwifery Council (NMC) register, nurses must work a minimum of 450 hours over three years (NMC 2005) otherwise registration and the ability to practise as a registered nurse is lost. The consequence of this would be that nurses have to complete a six-month return to practice course, with assessment, if they do not fulfil the NMC criteria for re-registration each year. When asked why she stayed in nursing, Teresa replied:

"The money really. And also I have to go to work so many hours to register. So then, that would be why I go. And I'm in nursing because I can do nursing. And I'm, um.. I don't know really. Maybe if I went away I wouldn't be able to do it. Um, no you see, because I know I can do it and I can do it really well, so
it’s not that I go there to be congratulated, it’s just that I know I can do it.”

Teresa, 42, NHS Staff Nurse.

For the majority of the nurses interviewed, most had been nurses their whole working lives and had commenced their nurse training straight from school. However, in addition to this being the only profession that they had experienced, 49 of the nurses interviewed still enjoyed their nursing work.

“I think that it would be just – I don’t know what else I would do. You know, I just can’t think of anything else I would want to do, really, that would be different. And then if you did retrain, it would be ‘how long would it take to do that?’ would you have a salary cut whilst you were retraining, going to a different job? I think ‘what else would you like to do?’ and I think, ‘I don’t know.’”

Sheila, 43, NHS Specialist Nurse.

There was little motivation to leave their relatively well paid jobs - specialist nurses and sisters are paid on Bands 6 to 8, a salary that provides £24,831 at the bottom of Band 6 up to £45,596 at the top of Band 8A (RCN 2009). Despite this, it is the enjoyment of the job role and the fact that it is so familial that helped keep nurses committed.

“Why am I committed? Yeah, because I do like the job. I’m committed because I like what I do and it’s second nature and I can’t imagine doing anything else really, I just do this so – I just go and do my work and it’s just so second nature.”

Kyra, 47, NHS Specialist Nurse.

So, for these nurses, there was still a desire to continue nursing. Many had ascended the nursing hierarchy, achieved positions of status e.g. Sister, Specialist Nurse, as would be expected of nurses with 20 plus years of experience, become comfortable with their job role and its responsibilities, know what is expected of them and what to expect from the job and, to some extent, the organisation for which they work. This adaptation to their current role has led to ‘continuance commitment’ (Meyer and Allen 1991) as changing occupation/organisation becomes less attractive because of the effort involved in learning a new role or the policies and procedures of a new organisation.
7.4.2. Skills, Knowledge and Experience: the familiarity of the nursing role in care homes

The utilisation of skills, knowledge and experience arose in the interviews of nurses working in care homes. However, their narratives did not dwell on not being trained to do anything else or the feeling of entrapment, with the exception of one nurse, who had left nursing to train to be a teacher but had returned because she preferred nursing to teaching.

"...because really apart from the very short experience I had teaching, it's all I know. And I've – apart from that two and a half years that I was out of it, I haven't really wanted to do anything else."

Janice, 42, Care Home Manager.

For one nurse who had left nursing and returned, she justified her return to nursing by stating that the skills she'd gained were important.

"And in that time, my marriage broke up, so my father looked after the children, I moved and then I was doing night duty and I was doing agency as well, the two together, to sort of get everything going with three children. Um... and then I decided I'd had enough and I wanted to go back to what I'd trained for."

Doreen, 52, Care Home Senior Staff Nurse.

Care home nurses discussed the knowledge, skills and experience they possessed however, they did not discuss them in terms of the familiarity of the nursing role or that they were content to stay in their nursing role because they felt confident and competent. There was no evidence in the narratives of care home nurses that they were staying in their roles because they were afraid to move on, or of new challenges.

"Why I chose to work here? They were so friendly when I came for the interview as well and I thought I'd got a lot to offer them, with the training side of it and with the nursing and to pass on my experiences so that there was good care here for the residents. [pause] I enjoy the training and getting feedback from staff as well because they're so enthusiastic here to learn, they really are motivated."

Paula, 51, Care Home Sister.

Nurses in care homes were eager to learn and extend their skills and knowledge and encouraged and embraced new learning opportunities. Care home nurses fulfilled similar roles to those of their NHS colleagues in that they are expected to teach and
mentor junior staff and student nurses. They embraced and enjoyed this role. Coral, who worked in a care home for people with profound physical disabilities, articulated how she felt that she was an expert in caring for people with multiple chronic conditions and that this was not recognised by the public, a sentiment echoed by other care home nurses in the study.

“We’ve got a lot of people with communication problems. So that’s quite hard in itself, I mean we’re very skilled. We have a lot of problems with a swallowing difficulty so that they take a long time to feed. You have to think about how you’re going to give them their medication.”

Coral, 50, Care Home Staff Nurse.

One care home manager highlighted one of the fundamental differences between the NHS care homes. Care homes have to market the specialist skills and experience that their staff can provide and it is important for care homes to be able to retain nurses with these skills in order to help generate business. This marketing of skills, knowledge and experience was not discussed by any of the NHS nurses in this study, which may be because NHS nurses do not have to ‘sell’ or advertise their skills and the NHS does not have to attract potential patients as care homes have to do to ensure bed occupancy.

“When you put the business to one side, I think we are selling what I do. And it’s that expertise, I believe that they’re [the clients] buying and that the company is saying that we’ve got. But that expertise is around guiding and promoting the welfare of elderly people.”

Karly, 55, Care Home Manager.

Conceptually, the use of accumulated skills knowledge and experience was important to nurses in both sectors, yet was more prevalent in the narratives of nurses in the NHS, potentially because they had acquired more skills as a result of their specialities. Nurses working in the NHS are considered to have the more ‘technical skills’ required to work in the acute sector yet nurses in care homes are expanding their roles to include more ‘technical’ skills for example, venepuncture (taking blood). Care home nurses are still perceived to have more general nursing skills associated with bodily care and functions (washing, feeding, changing). However, care home nurses are not less skilled and do not consider themselves less skilled, they are just differently
skilled and being able to use and develop these skills had resulted their wanting to stay in nursing and with their organisation.

Becker (1960) suggests that employees’ commitment can result from ‘individual adjustments to social positions’, as outlined in Chapter 2. This is evident in the case of nurses who have indicated that nursing is all they know. There is no attraction to other occupations because the nurse perceives that all her skills lie in nursing. This leads to ‘continuance commitment’ (Meyer and Allen 1991) because the perceived costs of leaving the occupation are outweighed by the benefits of staying. However, affective occupational commitment is also evident as nurses stay because they want to use the skills they have gained throughout their careers.

7.5. Remuneration: the need of nurses to earn a living wage

Goldthorpe et al (1968a) used the term ‘instrumental orientation’, or work as a means to an end, ‘the need for a living wage’, and whilst their research examined male workers, their concept is applicable to the women nurses in this study. Although nurses are often portrayed as not being financially motivated and would themselves often suggest that money is not the primary motivating factor in nursing, the respondents in this study discussed remuneration in detail and the majority admitted that they needed to work for financial reasons.

7.5.1 The Need of NHS Nurses to Earn a Living Wage

Financial necessity, or the desire for financial independence was cited by most respondents as a reason why they engage in nursing as paid employment. Only two nurses working in the NHS stated that they did not work for financial reasons but for the enjoyment of nursing and for the social interaction with patients and professional colleagues. The majority of NHS nurses (n=23) worked because they needed to, either as the sole wage earner (n=4) or as the provider of a second income (n=19). Many nurses were second wage earners in the household.

“To be perfectly honest mainly it’s money. (laughs again). I do have to earn an income, not a great deal but I do have to earn an income and that just adds to the quality of life and then, and then again, not working can be quite boring so, especially now.”

Lucy, 46, NHS Staff Nurse.
For two NHS nurses (Isobel and Anthea) the financial motivation was independence that earning their own wage gave. These nurses did not have to work to earn a wage. Both had husbands who had retired with good pension provision. These nurses worked for enjoyment and because nursing gave them an interest outside the home.

“I like the money that I have, you know it’s just that little bit of extra that’s mine. It’s, you know [pause] I enjoy the money because it’s the bit of extra money that’s mine rather than because we need it to pay the mortgage. Fortunately, you know, my husband had a good job and we’re still married!”

Isobel, 55, NHS Staff Nurse.

For other nurses, the motivation to engage in paid work was financial, as they were providing a second income for the family to supplement their husbands’ salaries as they were not sufficient to cover the families’ needs. One nurse expressed a desire to ensure that her children did not feel disadvantaged compared with their peers by living in the relative affluence of the South East of England. She wanted her three children not to feel left out and to have the opportunities that their peers also have, for example, driving lessons and holidays.

“I feel that I have to come here to get the money, so that my kids can do what they want to do, you know, they can have. They don’t have an extravagant life at all. I don’t want [them] to live in an affluent area feeling like they’re poor and that’s my motivation.”

Chloe age 40, NHS Junior Sister.

For other nurses, the financial necessity was tempered with the rewards of enjoyment of the social role that work played in ‘public’ (as opposed to domestic) life. This supports the work of Higgins et al (2000) discussed in Chapter 2 who argued that there are ‘career women’ who choose to work part-time do gain a sense of ‘personal and professional fulfilment’ (and identity) but, because of their domestic commitments do not have the time or resources to work full-time.

“Unfortunately, yes I have to go to work, I need to. There was a time when I really didn’t want to go to work, I wanted to be a housewife and look after the children, but financially it’s not worthwhile. I can’t afford to do that … so I have to go to work. And in a way I’m glad. I think I’d be bored out of my
brains if I didn’t go to work and it’s, it’s good stimulation. Something different to focus on. And again as I mentioned earlier, it’s social as well, I can talk to other people. Although the girls, most of the girls are quite young, that doesn’t matter. It’s nice to hear them talk about their boyfriends. It’s something different than children.”

Heather age 41, NHS Staff Nurse.

Some nurses in this study admitted that it would be difficult for them to change jobs and receive as generous pay as they were receiving at the time of interview, and as a consequence demonstrated continuance commitment because to move elsewhere, unless it was a sideways move or a promotion, would result in a reduction in salary.

“No, sometimes I wish I could do something different. Um, but no. To be quite honest, as a senior nurse, financially, um, I earn quite a lot of money.”

Lucy, 46, NHS (Senior) Staff Nurse.

NHS nurses in this study demonstrated that they had a financial orientation to work and although this alone cannot explain commitment, it remains a pivotal reason for nurses engaging in work. However, many nurses in this study, who have spent the majority of their working lives in nursing, had achieved a level of seniority and enjoyed a reasonably good financial reward commensurate with this. Even for nurses who have not achieved relatively senior roles, they had received incremental increases as a result of their longevity within their organisation.

7.5.2 The Need of Care Home Nurses to Earn a Living Wage

Care home nurses’ responses were similar to those of NHS nurses. Without exception, all the care home nurses (n=25) in this study stated that their primary motivating factor was the need for financial remuneration. Thirteen care home nurses were sole earners and 12 were second income providers.

“Um, I think most people, their main motivation is that they need to earn money, and then if you enjoy your job, that’s the second motivation. Um, I would put my main one – is to earn money.”

Sophie, 53, Care Home Manager.

Although money was often cited as a motivator, the reality for most nurses was more complex. Financial motivation was often paramount, however, most nurses do not work simply to earn a salary and a series of factors contributed to occupational and organisational commitment as indicated by Natale and Rothschild (1995).
“[the motivation to go to work is] Money, especially with taking on a bigger mortgage? Um, yeah, I don’t think you just come for the money, I think you come because you enjoy the job, you know, you enjoy being in this environment, and it's lovely to get feedback from relatives.”

Pauline, 47, Care Home Manager.

Another issue for nurses, especially older, more senior nurses, who were commanding reasonable salaries, was that they could not afford to consider other forms of occupation, even if they desired to change because this would probably mean a drop in salary. Some of the care home nurses interviewed denied that money was the primary motivating factor. Grace, although the sole wage earner in her family as she was widowed, stated that for her, altruistic actions of being a nurse outweighed the monetary aspect.

“It's not about the money, it never has been. Um, it was more about [pause] just assisting people.”

Grace, 46, Care Home Manager.

This sentiment resonated with another nurse, who had remained enthusiastic about nursing for 37 years since becoming a cadet nurse in the 1960s, and was one of the nurses who had spent the longest time in nursing of all the nurses interviewed.

“It wasn’t about money. It's never been about money because I would do the job whatever anybody paid me. No it didn't, the thought about that didn't even cross my mind.”

Celia, 54, Care Home Manager.

However, the relatively poor level of care home nurses' salaries has had an impact on recruitment and retention in the care home sector with managers acknowledging that it is an issue when recruiting qualified and non qualified staff. When asked about issues of recruitment, about why it was a problem attracting UK trained nurses into the sector and retaining staff, responses indicated that salaries (and conditions of service) were not as attractive as in the NHS. For example, unsocial hours payments and annual leave entitlements are not as generous, and sick pay is often limited to Statutory Sick Pay (SSP) rather than full pay for a limited period of time. In addition to this, the cost of living in the South East is high leading most nurses to search for the best paid jobs to compensate for this.
"In this environment I would definitely say it was salary in nursing homes and care homes. Whichever care home I've worked in it's always been a very poor salary for trained nurses and care workers alike."

Candice, 48, Care Home manager.

And this situation did not occur just in the smaller care homes. Even in large national providential (not for profit) care homes, the financial conditions were not as appealing as perhaps would be expected.

"Well, certainly pay will have to come into it because pay is, certainly with X [company name] not as good as in some areas. And I also think the pay structure’s got to be, nationally. I don’t care whether it’s X or somebody else, there are one or two places that we know that pay a reasonable wage but God, do they work for that. And they’re probably cooking and cleaning and all sorts for it. It’s not right. It’s a hard job they do, hard job and very responsible job, caring for people. I still don’t think it’s recognised properly. There you go! I’m still pleased I did it."

Penny, 55, Care Home manager.

The financial rewards of extended tenure were also apparent in the data from nurses working in the care home sector, as exemplified in the extract below. However, for most nurses working in this sector, the additional benefits that NHS nurses enjoy, such as final salary pension scheme (with the exception of one BUPA employee), and generous holiday entitlement did not apply.

"Financially, I would be hard pushed to retrain and start again on the money that I earn now. You actually live up to your wages, don’t you, your standard of life reflects what you earn. And, you know, my commitments do as well. So financially I’d find it very hard, and I don’t know what I’d do, I’ve only ever done nursing."

Sian, 55, Care Home Manager.

Despite research suggesting that remuneration is not of primary importance to nurses, previous studies have indicated that pay does have an impact on nurses’ commitment (Callaghan 2003, Reeves et al 2005). The interviews with the nurses in this study suggest that whilst remuneration may not be the only reason for their work commitment, it is an important factor and supports Becker’s (1960) side bet theory that the costs of leaving the profession are too great for many nurses. The data presented also provided support for Powell and Meyer’s (2003) additional side bet category of ‘lack of alternatives’ where nurses perceive that they do not have the
appropriate skills to transfer to another occupation and therefore demonstrate continuance commitment.

7.6. Work as an end in itself: job satisfaction

In addition to the ‘instrumental orientation’ to work, Goldthorpe et al (1968a) identified the ‘bureaucratic orientation’ to work, which they defined as work as an end in itself, giving high levels of satisfaction and enjoyment to workers. For many of the nurses interviewed, job satisfaction and enjoyment played an enormous role in why the nurses in this study demonstrated occupational commitment.

“Well partly 'cos of the money side of it 'cos I need to work, pay the mortgage. If I didn't do nursing, there is nothing that springs to mind that I'd want to do instead. I also feel that if I'm doing a job where I have to do up to 30 hours a week, which is a huge proportion of the week. I want to do something I'm gonna enjoy and get something out of. [...] I could probably go and do something else but I wouldn't get the sort of enjoyment factor out of it what I do. Um, and I think, I did think it sounds really ridiculous, but I've worked, I have worked quite hard to get what. I mean I haven't [pause] done a lot of the academic things but I’ve done quite a few courses, and I have sort of, I have worked hard to get to where I am and I just think there's an awful lot of pressure on you to stay because if you leave, you have to downgrade if you come back.”

Felicity age 40, NHS Sister.

Job satisfaction and its intrinsic function in nursing has been debated at length by researchers (Tovey and Adams, 1999, Lundgren et al 2005). Other researchers have attempted to determine a causal relationship with intention to stay or leave (Larrabee 2003, Sourdif, 2004). This study is not a direct comparison with these other studies as it is not quantitative in approach. However, the majority of nurses in this study recounted high levels of job satisfaction, perhaps explaining their long tenure in nursing.

“Why am I still in nursing? Because as I said, it's something I'm trained to do and it's something as the years have gone on, I've actually grown to love my job more. I get great satisfaction. Um, something that I've obviously trained for. I enjoy it and although we all have our bad days you know, there are times when I've thought, gosh, you know, do I really want to do this? But it's something I can come home - I have great admiration, you know, I've done a good day's work, to see people get better. I think if you're prepared to work
hard, cope with the pressure and at the end of the day it's rewarding.”

Alex, 42, NHS Staff Nurse.

The nurses in this study were still very positive about their work, despite the pressures and challenges that nurses faced on a daily basis, they still found the work rewarding and satisfying.

“Yeah, I look forward to going to work. I never sort of dread going to work. Sometimes we’re very quiet which I don’t really enjoy. I find I don’t work as well. If we’re busy or something happens, I find that a real buzz. I don’t think I could find another job which encompasses everything I love doing really.”

Selina, 43, NHS Staff Nurse.

Surprisingly few of the nurses interviewed were disillusioned with their current role. Only four of the 50 nurses interviewed were actively seeking new jobs and only one of these was considering leaving nursing to help set up her husband’s business (see Chapter 6). For Simone, her rationale for considering alternative employment (in nursing) resulted from changes to the nursing management structure within her NHS Trust which had left her with limited options in terms of redeployment. Effectively she had been forced into a role which she did not enjoy and for which she had a pay cut due to the introduction of Agenda for Change pay bandings which had decreased her banding.

“But job satisfaction, yeah. Sometimes I think if I hadn’t changed jobs [pause] sometimes I regret moving. I’d love to work in the health centre I did. So this suited me until the sort of job changes last year. And as I said straight away, ‘this is not a job I want, I don’t want to be a manager’. I could manage because I have all those organisational skills and what have you but I don’t want to. It’s not my forte. My forte is still working with people.”

Simone, 45, NHS Specialist Nurse.

This illustrates Larrabee et al.’s (2003) assertion that if nurses do not feel empowered they are at risk of attrition. However, Simone’s situation contrasted with that of Hannah who was subject to a similar experience of management restructuring within an NHS Trust and, although she did question her effectiveness in her current role, was not considering leaving.
"I suppose I do enjoy it. I enjoy – there are people, there is somebody I share an office with and I enjoy that bit of it. I enjoy meeting up with people and interacting with them and seeing them you know. We've got so many little bits of projects going on and you think 'yes, this bit is really going to make a difference.' But sometimes you go back a year later and you think, 'did it really make a difference?' but there are those things going on so I guess that is what motivates me.”

Hannah, 41, NHS Specialist Nurse.

Care home nurses also derived high levels of job satisfaction from the nursing work that they performed. The extract below supports the element of 'individual adjustments to social positions' in Becker's (1960) side-bet theory. In the following extract, this care home nurse felt satisfied in her job because she felt that the job role she was expected to perform fell within her capabilities and she perceives that she was able to cope with what is expected of her by her clients and organisation.

“I feel quite satisfied in my job. I think, you know I'm at a level that I'm comfortable with and that I can cope with and the residents appreciate that. And they know, you know, that they can trust you and it takes a while to build that with somebody new. I'm working in a role I enjoy and I think, I hope I do it well, and I hope that I gain the trust and the respect of my colleagues and the residents while I'm here. I think I do, I hope I do, yeah.”

Darcey, 42, Care Home Staff Nurse.

Job satisfaction is gained from the different responsibilities inherent in a job role. Not only did the satisfaction evolve from direct contact with clients, but also from other responsibilities such as teaching. Job satisfaction is also derived from the positive recognition received by organisations from the care home inspectorate which nurses feel reflects their hard work and dedication to nursing, their client and the organisation. (CSCI)

"I mean on the nursing side when I was on the floor it was somebody who was comfortable and settled and the family happy, that. That used to make me [sic] a huge job satisfaction and especially caring for the dying. I enjoyed that. On the teaching side, it is somebody actually saying 'oh yes' and goes off and does something and progresses onto something else and you hear that they're doing well. […] And obviously when CSCI come round and give you a 4 [star rating], that was marvellous, I was very excited!"

Delia, 42, Care Home Sister.

A sense of job satisfaction and reward for work was echoed by Pauline.
"'Cos I enjoy the job. Um, I get a lot of satisfaction out of it. um, and I think it's a very fulfilling and I think the progress I've made over the years and the respect the proprietors have for me, you know, in my position, I just find it very rewarding."

Pauline, 48, Care Home Manager.

Other nurses made a distinction between occupational and organisational commitment. Janice indicated that she felt more committed to her occupation than to her organisation. She indicated that the organisation she worked for had less influence on her sense of job satisfaction than nursing did.

[I am committed] "definitely to nursing and I think because the organisation that you work for is only your employer and so long as you are doing what the employer wants you to do, they're quite happy and you're getting your salary every month. But it doesn't really make a difference to me as a person, but nursing does. So I could work for any organisation and get the same job satisfaction out of it but it's the actually nursing bit that gives me the job satisfaction."

Janice, 44, Care Home Manager.

Finally, Penny who has stayed in nursing for her entire career, without a break for childcare as she had no children, still enjoyed a sense of job satisfaction.

"There's certainly job satisfaction, I think so still, after how many years is it? I don't know, thirty eight, thirty eight years, to say the job is still giving you something I feel is quite fortunate."

Penny, 56, Care Home Manager.

Whilst job satisfaction appears to be high and a motivator for these nurses, they did elaborate on experiences and situations that caused them dissatisfaction and were demotivating them. The majority of these were organisational constraints such as lack of time, lack of staff, isolation, lack of support, the threat of hospital closures, not feeling recognized for the work they perform and feeling undervalued by management. These factors will be analysed in the Chapter 9.

7.7. Conclusion

This chapter has considered the concept of commitment in nursing through the themes of making a difference, passion and altruism, teamwork, skills, knowledge and experience, remuneration, using the concepts of professionalism and caring with which to analyse the data. The concept of commitment represents a complex interplay
of many of these factors and cannot be defined by just one alone. Other elements of occupational and organisational commitment will be analysed in Chapters 8 and 9. Most nurses in this study (n=48) were motivated to work by financial needs, for example, paying the mortgage, financing children’s activities, improving their quality of life through a second income or financial independence through having an income of their own. In addition to this is the reasonable level of remuneration for senior nurses and the perception that they would incur a cut in pay if they pursued an alternative career, is a powerful motivator to stay leading to ‘continuance commitment’ (Meyer and Allen 1991).

One of the main contrasts in this chapter is that although both NHS and care home nurses declare that remuneration is important, as they needed to satisfy financial commitments, nurses in the care home sector appeared to be less concerned about the level of pay than those nurses in the NHS. Only a minority (n=2) of NHS nurses were fortunate to be able to work solely for the enjoyment of nursing and the job satisfaction it affords them. All of the nurses (n=25) in the care home sector stated that working for a living wage was a primary motivator.

There are many comparisons that can be made between the two groups of nurses. The concept of professionalism and the ideology of caring were common to both NHS and care home nurses in terms of defining their occupational commitment. These nurses remained occupationally committed because they were passionate about providing the best possible care for their patients/clients and although their skills are different, they articulated that they are skilled at what they do.

Teamworking and relationships with colleagues was an important element of job satisfaction but is not, in isolation, the primary motivating factor for these nurses in terms of commitment. However, without it, their nursing role would be much more difficult and a less pleasurable experience, potentially causing increased turnover of staff as indicated by Sourdif (2004).

Their familiarity with the nursing role, the skills, knowledge and experience that leads to this familiarity is also an important factor for nurses in terms of why these nurses have stayed in nursing. They enjoyed the advantages that familiarity with their role
offers them, such as confidence, competence and seniority. This adaptation to their current role has led to 'continuance commitment' (Meyer and Allen 1991) as changing occupation/organisation becomes less attractive because of the effort involved in learning a new role.

The concept of 'making a difference' was important to the majority of these nurses, however, this is actually a reciprocal relationship. The patients benefit from the nursing care given but the nurses also benefit in that they derive job satisfaction from the utilisation of their professional and interpersonal skills in producing a positive patient outcome. This, coupled with the sentiment of needing to be needed, and the perception of a job well done, suggests that nurses derive a lot of satisfaction from patient interaction and care. The nurses in this study remained passionate about their work and they still show elements of vocationalism which need to be considered in the professionalisation debate. The data support the affective commitment thesis that the nurses in this study stay because they enjoy their work and want to stay. The study also supports elements of Becker's (1960) side-bet theory and Meyer and Allen's (1991) continuance commitment theory, the job satisfaction and the rewards that are reaped outweigh alternatives. It can be concluded that commitment to nursing is a combination of affective and continuance commitment. Nurses have invested time and effort in their careers, have achieved seniority and are reliant on earning an income, and perceived there was no alternative at this current stage in their careers.
CHAPTER 8

Nurses' Working Lives, Work-Life Balance and the Importance of Flexible Working

8.1. Introduction

The concept of flexible working is prevalent in the discourses on work and family life, as discussed in Chapter 3. The aim of this chapter is to analyse the working lives of nurses in this study in terms of their work roles, and in relation to how they combine paid work and family life. The theme of flexible working is analysed in the context of nursing work and it is established that the efforts of NHS employers to improve nurses' working lives through flexible working initiatives ('Improving Working Lives' (IWL) DOH 2000a) does not afford parity to all NHS employees. This contrasts with the situation in the care home sector where initiatives are local rather than national and have far fewer negative repercussions. In this study, achieving work hours that fit in with family life has emerged as an important factor in nurses' organisational commitment, particularly, but not exclusively, for women with children of school age and under. Nearly a quarter of nurses in the study worked shifts and the impact that shiftwork has on their family lives is analysed. Finally, nurses' career pathways are examined. Nursing can and has given women a flexible career that enables them to combine paid work and family life, however this can be to the detriment of career development (Whittock et al 2002). This final section examines nurses' career pathways and suggests that despite previous research indicating that flexible working policies can damage career progression, (Whittock et al 2002, Grant et al 2003, Tomlinson 2006) most of the nurses in this study have had and continue to have a flexible approach to career progression with no definitive career plan and remain unconcerned about aggressive career advancement.

Abbreviations will be used in this chapter to denote whether the nurse is full-time (FT), part-time (PT) or has dependent children (dep ch).
8.2. Flexible Working Practices

Chapter 7 has established that 48 of the 50 nurses interviewed demonstrated an instrumental orientation to paid work; they were motivated to engage in paid work because they had to earn a living wage. One of the most important factors and the reason many nurses have demonstrated organisational and occupational commitment is the availability or negotiation of flexible working hours. Seventy eight percent (39 out of 50) of the nurses interviewed had had children and sixty percent (n=30) had children/dependant adults living at home at the time of interview. For working mothers and those with adult dependents, flexible hours, term-time contracts and the ability to work shifts including nights, was a key dynamic and played important role in maintaining occupational and organisational commitment.

As stated above, the Improving Working Lives (IWL) initiative, part of the NHS Plan introduced in 2000 aimed to assist employees to achieve a healthy work-life (in reality a work-family) balance through flexible working opportunities (DOH 2000a). However, as the data in this section will indicate, not all nurses feel that this initiative has improved their working lives and some feel that the policy does not apply equally.

8.2.1 Flexible Working in the NHS

The data revealed that a variety of options were available to nurses working in the NHS. These included part-time hours, working school hours only (9/9.30am to 2.30/3pm), early shifts (7/7.30 to 2.30/3pm), late shifts (2.30/3pm to 9/9.30pm) nights, weekend only working, term-time contracts, condensed hours (e.g. working longer days but 4 instead of 5 days), annualised hours (a fixed number of hours to be worked in a year). However, the data from the interviews showed that not all organisations offered options to all staff.

Amanda, a sister working part-time in the NHS felt that she had achieved a reasonable work-life balance as the negotiated hours she worked suited her family life. This was an incentive to stay in her role and with her organisation. By changing work role or organisation, she may not have been able to achieve the satisfactory work-life balance she stated she had at the time of interview.
“And also the other thing is I've got the hours to suit me, fitting in with my home life as well. It's not part of my role working weekends, not working Sundays and I've actually got it to benefit me now as well. I work half eight 'til six one day and half eight 'til four fifteen the other two days. I've got one [child] twelve years old and one fifteen year old still at school so I need that flexibility for peace of mind really.”

Amanda, 46, NHS Sister (PT, married, 2 dep. ch.)

Trying to achieve a work-life balance is not a binary transaction between employee and employer. Nurses often negotiate work and family in conjunction with their partners and other family members in order to combine paid work and domestic responsibilities. This not only requires flexibility in the workplace but flexibility from husbands, partners and other family members (such as grandparents) involved in childcare. Felicity, a full-time sister in an NHS Intensive Care Unit, discussed the negotiated responsibilities of childcare that she shared with her husband that her work-life circumstances forced upon them.

“I do sort of two or three weekends a month, quite often does, obviously, impact on your family life - you're not there. I don't think it's necessarily a negative thing in the fact that my husband's probably bonded a lot better with the children than a lot of husbands have because he spends so much time doing stuff with them, we're definitely equal, as in childcare. He does just as much as me, maybe more. I think we've almost got the balance right but it's very, very difficult. But you have to be, have a very flexible partner. You couldn't do it if you had somebody, that wasn't really flexible, I think.”

Felicity, 40, NHS Sister (PT, internal rotation, married, 3 dep. ch.)

The importance of flexible working for nurses with school age children was exemplified by another nurse, whose husband also worked shifts. She discussed what this involved on the day that she was interviewed and how she combined this with her work role and the flexibility of being able to leave early, the outcome of which was having to take work home, although this suited her because it gave her the flexibility to meet her work and family commitments.

“But I suppose I've got flexibility in my job, that's the only way I can work to then meet the needs of my family. So, for instance, because my husband's going on nights at half past four, he will drop off both children to the orthodontist at half past four and I'll meet him there, so it's literally a drop off. He goes to the orthodontists and I take them home, do their teas, do their
homework, do this, sort their lunches, finally get them to bed and do some work if I need to, which I have the flexibility to do that ‘cos this laptop, or rather, the USB stick comes home and I can access my e-mails.”

Sarah, 39, NHS Specialist Nurse (FT, 9-5, married, 2 dep.ch.)

Nurses who had negotiated day-time work hours to suit their domestic needs were generally satisfied with work-family balance. However, this led to the potential conflict that working part-time hours to accommodate domestic and family life created in that it compromised career prospects and promotion. This was a result of the restrictions that having children of school age placed on the hours available to work. This therefore limits any chances of career advancement, supporting the arguments of Tomlinson (2006) and Grant et al (2003) discussed in Chapter 3. Jade had managed to obtain working hours to suit her childcare needs and was not prepared to sacrifice these for promotion opportunities.

“I think as far as my family’s concerned it’s pretty perfect really. But as far as work’s concerned, I feel I’m limited in what I can do. I’m sort of – I mean I’m stuck at the end of my band (grade), so I feel kind of, a bit trapped really. I can’t go anywhere else. And I can’t – if I want to do anything different, if I want to progress up, I feel like even if I want to change to another job then my benefits I’ve got at the moment, I’ll lose. So I sort of, kind of feel trapped, you know, because of my term-time contract.”

Jade, 38, NHS Staff Nurse (PT, married, 2 dep.ch.)

In addition to the benefits that flexible working offered nurses, they also identified that there was an exchange mechanism in operation and that both parties, the nurse and the organisation, benefited from reciprocal flexible working practices (Emerson 1976, Nelson 2000).

“And I don’t work the same days each week so you know, it means I can be around if my children have got things at school. And it benefits the service because it means that if things happen on the days which I not usually going to work it means I can rejig them. I think it’s not all one way, I think they get a good deal out of it as well. And I would have left – I mean if I hadn’t have got a term time contract, I would have just stayed on the bank [the organisation’s internal nursing agency where nurses are employed to work solely for that organisation rather than many organisations] because that’s what I was doing when I came back.”

Camilla, 50, NHS Specialist Nurse (PT, married, 2 dep, ch).
This reciprocal working practice was also evident in the data from other nurses. Isobel, who worked annualised hours described how she was much more valuable to the organisation because of her flexibility. She could be called in at short notice to cover shifts when the unit she worked on was busy.

“I don’t think it would work if everybody was on flexible hours! But, it works very much for me and for the unit. Because of the way I work, they can just split – and because of living so close, they can just phone me up, you know?”

Isobel, 55, NHS Staff Nurse (PT, married, 0 dep ch).

The importance of flexibility in the workplace was evident for NHS nurses who worked conventional 9 to 5 hours. Within this fairly rigid working day they had managed to build in small pockets of flexibility into their working lives to accommodate childcare needs such as taking children to the dentist or going to the school play. This was done either by condensing lunch breaks, starting earlier in the day or negotiating for time off to be repaid later with their managers’ approval.

“So I have to sometimes do little jobs like go to dentist but my boss knows. She's very flexible. Um [pause] or I might have to pop in and pick up something that my daughter needs for school. That’s my own way of managing really.”

Kyra, 47, NHS Specialist Nurse (FT, married, 1 dep ch).

Flexible working practices were important to nurses working in the NHS. The data shows evidence of a variety of working practices. Flexible working is not only important to women nurses engaging in paid work who have children or dependant adults. It is becoming an increasingly important part of the discourse about work-life balance as shown in Chapter 3, section 3.7. However, for many nurses the only way of achieving flexibility to engage in paid work and combine this with family life is to work part-time.

8.2.2 Flexible Working in Care Homes

Nine of the care home nurses interviewed stated that they had left the NHS because of its inflexibility (n=5) or because of family needs (n=4). The desire to improve work-
life and family-life balance was a factor in some of these decisions. For example, Astrid moved to the care home sector to improve her work-life balance 8 years ago, having worked as a theatre sister in the NHS. She reported that she was finding working hospital shifts, which involved being on-call at night within the hospital, and being away from home for days at a time (as she had to sleep at the hospital when on-call) was increasingly difficult when trying to raise and care for two children. She (usually) worked Monday to Friday, 9 to 5, at the time of interview and confirmed that the move to a care home had a positive impact on her work-family balance. She also reported that achieving a good work-life balance is something that took practice and required conscious decision-making.

"Now my day has a natural end to it. So, I leave work and my home life takes over and I come to work in the morning. It impacts very little on the family because I don’t do on calls anymore. I’m not away three days a week. So I come home every night, which is not something I used to do. And you know, the children can get to school and I can be home for them if I need to be, which again, I couldn't do before. So this job has very little impact or very little crossover with my home life."

Astrid, 49, Care Home Specialist Nurse (FT, married, 2 dep. ch)

The opportunity to achieve flexible working in care homes appeared to be fairer, with nurses negotiating locally with line managers to obtain the hours that suited their work-family needs. There was no discussion of preferential treatment or resentment by care home nurses. Shelly, who moved from the NHS to a care home discussed how she had achieved flexibility in both environments to achieve an optimum working pattern. However she insisted that a lack of job satisfaction would not compensate for flexible hours, and that job satisfaction was her primary consideration.

"I mean that really has been a huge bonus the hours that I work here [the care home] which are Wednesdays and Fridays, sort of 8 'til 2, 9 'til 3 sort of shifts and every other Thursday, so no weekends, no nights anymore and of course, term time only is a huge bonus when you’ve got school children. Yes, well, I suppose so but I think that is secondary. If I was doing something where I didn’t have any satisfaction in the job, that’s not enough to compensate really. It's been incredibly flexible with having children. I was lucky that A&E was my speciality and they needed twilight shifts which worked out fantastically, so I’ve never had to get into childcare issues."

Shelly, 43, Care Home Staff Nurse (PT, married 2 dep. ch.)
Kirsty, who had two children, explained the importance of having flexible working hours to accommodate work and childcare and how she had managed to negotiate flexible working hours to fit into her lifestyle.

“It's quite important to me because I do fit it [work] around my children and things as well, which is the good part about working from home. I know it has negatives - you can never get away, you've always got a pile in the office so flexibility is important and I think I've always done that in interviews [negotiated flexible working], made sure I've kept my flexibility.”

Kirsty, 43, Care Home Manager (PT, married, 3 dep. ch.)

Celia, a care home manager, acknowledged that her work-life balance had not always been good, especially when she worked in the NHS. However, as the manager of a care home, through local flexible working arrangements, she was able to adjust her hours to suit her health needs and felt fully supported by her employer.

“I'm a lot better at taking time off now. I mean, when I was in the NHS, I took hardly any time off at all. Mostly because, you know, they didn't have enough people and I carried on doing it. Now, I'm in the position that I'm in, I come to work and leave sort of when I want to. Now I can do that. In the mornings, I have to make sure I have a lot of time to myself because I've got arthritis and I like to have a bit of space in the morning.”

Celia, 54, Care Home Manager (FT, divorced, 0 dep.)

Some of the nurses found that working in the care home sector gave them greater flexibility in terms of working arrangements. The care homes, although smaller in size than many NHS departments, offered greater flexibility for part-time working women with children and they had a less rigid, more accommodating approach than the NHS. This was because the managers had greater autonomy and control over their systems and workers were able to negotiate more informally with their managers. Some nurses had left the NHS because they found greater flexibility within the care home system such as Astrid.

“Well I think it's a sort of, series of events really that led up to it and they were looking for somebody to support the health care co-ordinator, at the time. It fitted in with the reasons I left the NHS, which is that I needed more flexibility.”

Astrid, 49, Care Home, Specialist Nurse (FT, married, 2 dep.ch.)
It was not only women with children of school age who benefited from flexible working practices. Two care home nurses in the study were carers for adult dependants (husband and parents) Celia (above) had arthritis which meant she needed more time in the morning at home to get organised, and benefited from a degree of flexibility within her role. One care home nurse, who cared for her dependant husband, talked about the importance of flexibility for her.

“For me, with my circumstances, that is important. And as employers here, S [her line manager] is pretty good and the home manager, I can come in, if I want to, a bit later in the morning or what have you, I can. And they’re pretty good. So I suppose why this sort of environment and the training side suits me better at the moment. Yeah? And the flexibility.”

Paula, 51, Care Home Sister (FT, married, 1 dep. adult)

The issue of flexible working for women without children was also illustrated by Pauline, who discussed the importance of flexible working for her as she disliked early starts and had to travel 40 miles to work, via the M25.

“We do flexi hours, as a manager, I do flexi. Um, I mean I could be here at 9, I could be here at ten, half ten, but I do generally 38 hours. I was originally [pause] I was only up to last year contracted for 42, but because of my travelling and everything, I just couldn’t get the hours in, you know, so at that time of day, you just think ‘I want to go home now’, so I discussed it with the proprietors and they just took my hours down. If I do over, fine but at least the minimum I have to do is 38 hours [pause] Because I don’t like getting up in the mornings! That’s essential [flexi-time]. I’m terrible. I’ve always been for years.

Pauline, 47, Care Home Manager (FT, widowed, 0 dep.)

Flexible working appeared to be less of a contentious issue for nurses working in care homes. Those who needed flexibility had achieved it through local negotiations or had chosen to work nights. Unlike in the NHS, a discussed below, there was no evidence of resentment expressed towards co-workers because of perceived injustice as illustrated by the narratives of NHS nurses. I argue this is due to the high proportion of care home managers in this study compared with NHS managers (13:2), who have the autonomy and authority to permit flexible working, and the local negotiation of flexible hours if required.
Whilst resentment of flexible working was an issue discussed by nurses in the NHS, it appears to be a phenomenon that is particular to the NHS as nurses in the care home sector did not highlight this issue during the interviews. As can be seen from the extracts from the interviews in this section the care home sector appeared to be more amenable to flexible working than the NHS and some of the nurses had moved to the care home sector because it offered greater flexibility or the ability to adjust their working hours to suit their work-life balance.

8.2.3 Resentment of Flexible Working Practices in the NHS: I have a life too.

The major contrast between the NHS and care homes is that flexible working caused conflict within the workplace between some nurses because of the perception that nurses with children get preferential treatment over nurses who have no children. This is not entirely as a consequence of the IWL initiative. Nurses who had not had children often saw maternity leave as a 'perk', a break from nursing that was not afforded to childfree nurses. This is illustrated by the following extract from Hilary’s interview.

“I mean, you know, we have sort of flexible working hours and we have crèche facilities but like, having somebody who’s never left nursing, or had children, I mean, you can’t help thinking ‘well, what about the ones who haven’t done that?’ and you know, there should be like, I’ve never had maternity leave, how much does that cost? Why can’t I just have a month off, full pay? I don’t know, you know, because I think there must be something, the fact that [pause] ‘cos there’s more of us out there than you know, the fact that we haven’t had the break of service, given sort of the best years of our lives, there must be something that, you know, you get for doing that. Even if it’s - a month off work does sound appealing”

Hilary, 42, NHS Specialist Nurse (FT, single, no dep.)

A similar issue was introduced by Felicity, another NHS Sister who worked part-time with three young children, who suggested that integrating into the team was more difficult with nurses who only work on term time contracts.

“I think the flexibility side of it – I mean, they’re getting better, I think. I mean, on some of the wards they do term time contracts now. But I don’t think that – it’s difficult ‘cos that’s pressure. If you do a term time contract, it’s great for you but then you do hear everyone else moaning about the term time
contract people. So there’s a vicious circle for them. Although they’re getting to work, the flexibility they need they’re then not [pause] I don’t think they’re incorporated as part of a team when they get to work and people moan about them because they go home at half past two to pick the kids up, or they’re not there in the summer or whatever. So although that’s providing the flexibility, people aren’t going to work in that atmosphere.”

Felicity, 40, NHS Sister (PT, married, 3 dep. ch.)

There were also suggestions that the system is being ‘played’ by some nurses who are perceived to be exploiting the system.

“Yeah, I think one of the problems is – I think possibly some of the system has been abused. ‘Cos I think there are people working certain flexible hours, ‘cos their children were small, they have children who are 18 and they are still saying ‘I can’t work Christmas because of…’ whatever.”

Hannah, 41, NHS Specialist Nurse (FT, married, 2 dep. ch.)

NHS nurses perceived that organisational justice and fairness was not afforded to all nurses who wanted to work flexible hours. This was apparent in the interviews of nurses with and without children of school age or under who felt that their needs had not been taken into account as a result of the implementation of the IWL (DOH 2000a) initiative.

Lucy had asked her manager if she could work the same nights, every week, because of her husband’s work and her children’s activities. However, because her request had been denied she said she felt that she had no option but to reduce her nights and therefore her weekly hours. She discussed how she felt that the Trust had not demonstrated organisational justice as she was not afforded the same opportunities as another member of staff on her ward.

“I was told I couldn’t do the same nights every week. That was a little bit discriminatory, actually, because somebody else on the shift was getting the same, were allowed to do set nights but suddenly I was told I couldn’t do that. Erm, as a result of that, I had to reduce my hours so it meant I was out fewer evenings, so the boys could actually do their activities.”

Lucy, 46, NHS Staff Nurse (PT, nights, married 2 dep. ch.)
The data suggested that some NHS employers have made an effort to accommodate some flexible working practices, but these have been met with a mixed response. Nurses who have the flexible working hours they wanted were very satisfied with the outcome. However, there was a perception that nurses with school age children were given preferential treatment over those who did not and other nurses were left to pick up the pieces when the part-timers and the term-time contract nurses had gone home. This led to a sense of inequality within the scheme.

Stella, a single, childless nurse, discussed this at length, about how she felt discriminated against simply because she did not have children or dependant relatives to care for. Having worked for 27 years in the NHS she would have expected to have the same allowances made. She discussed a desire to be able to work compressed hours, whereby she could work more than seven and a half hours a day and work a nine, rather than ten, day fortnight, but that this option was not available to her.

"I think having - like for so in my position, an acceptance or an understanding that there does come a time - we laugh about this, my colleagues and I, the ones that haven't had children, have worked full-time for 20 odd years and although it seems they talk about flexible working, if you look at the policy, it's about having children and relatives to care for. It's not actually about those of us who haven't got those things."

Stella, 44, NHS Consultant Nurse (FT, single, no dep).

She also discussed how she felt taken advantage of because her colleague could take a year off for maternity leave and she was left to pick up the pieces and the extra work involved as maternity cover was not being allocated. She also discussed the notion that women without children are expected to cover the 'family occasions' such as school holidays, Easter and Christmas.

"If I was to ask for 6 months [off] for - or the different hours, there's a thing called compressed hours, that you can do more hours in one day and then you can have like a nine day fortnight. I thought 'that looks really good' 'cos I thought that would be a good compromise for me and yet you look at it and it's actually for people who've got children or commitments and I think that's very unfair. I don't think they're appreciating the [pause] role that we have and what we put into the job. Because with the best will in the world, it will be us that's expected to work Christmas, or this and that because we haven't got
children and I do feel very strongly about that because it's assuming you haven't got a life.”

Stella, 44 NHS Consultant Nurse (FT, single, no dep.)

However, it was not only the nurses without children that had strong opinions about the issue of flexible working. Alex, a married mother of two, working nights, talked about the impact of term-time contracts on staffing levels.

“They can be quite negative as some of the staff, they don’t feel it's fair, especially obviously in the holiday season, Christmas time, you know. It's always the same ones that are working the shifts. But saying that, it does work—we have staff coming in when you need them. Yeah, we have two or three staff on term-time contracts.”

Alex, 42, NHS Staff Nurse (PT, nights, married, 2 dep. ch.)

This was emphasised by Chloe, another married mother of three, who discussed the unfairness of term-time contracts, which were not available to all staff in her department.

“Like these girls in the department on term time [contracts] and I would have loved a term-time contract. And I brought up my children with me having to go out to work and yeah, generally, you know, I would take some time off in the holidays but I could have had the whole summer holidays with them and things like that. So you know, there isn’t a good feeling about the term-time girls ‘cos they’re never here when it’s busy. They come in late, they wouldn’t know how to set up [the clinic]. They come in late, they go home early, it's very nice innit? We’d all like that for everybody else who’s here from 8 o'clock, setting up, ‘til 6, tidying away, it doesn’t make for a good feeling”

Chloe, 40, NHS Sister (PT, married, 3 dep. ch.)

Whilst undoubtedly flexible working practices are essential for some nurses with children of school age, as outlined in the sections which discussed flexibility and work-family balance, there is some antipathy towards the system which, in the opinion of some respondents, appears to discriminate in favour of women with children over women without. This created dissatisfaction, disharmony and took some of the enjoyment out of working for the nurses who felt they experienced discrimination. It might not be a sole factor in prompting nurses to leave; however, it may be a contributing factor. Although the Improving Working Lives initiative affords some nurses the flexibility they require in order to work, it fails to address the
issues of women without children. The IWL initiative is misleading in that it suggests, by using the word ‘Lives’ in the title, that it is aimed at all employees, when in reality, only those with child or adult dependants appear eligible for flexible working arrangements.

8.3. Shiftwork

For most nurses, shiftwork is an unavoidable consequence of nursing. For the cohort of nurses in this study, those who trained in the late 1960s, the 1970s and 1980s, the recognised pathway for nurses entering the nursing profession as newly qualified was to gain experience working on various wards within a hospital. This usually entailed working on a medical ward and a surgical ward, before deciding on a particular speciality on which to concentrate with a view to becoming a ward sister and, during the 1990s with the introduction of this new role, a specialist nurse. Shiftwork was an inevitable consequence of this but, for some nurses, shiftwork played an important role in allowing them to combine paid work and family life.

How shifts are organised is determined by the structure of a particular organisation and within the NHS. This is established at departmental level and is determined by job role and function. Nurses working within an NHS ward environment usually work either a rotating two or three shift system; a two shift system consisting of approximately 12 hour shifts or a three shift system comprising a morning shift commencing at approximately 7 to 8am lasting seven and a half hours, an afternoon shift starting at 1 to 2pm and lasting seven and a half hours, and a night shift starting at 8 to 9pm and lasting 11 to 12 hours.

This type of shift pattern occurs on a system of rotation, so that nurses work a mixture of morning and afternoon shifts to fulfil the 37½ full-time hours required by the NHS or a mixture of shifts to fulfil their contractual part-time hours. For nurses who work full-time, the contractual obligation mostly requires that they work a series of night shifts every six weeks to two months. This is dependent on job role, and in some areas NHS Sisters are required to work nights as the department requires the presence of senior nurses at night, for example, ITU and A&E, whereas in other non-specialist areas, nursing sisters are usually not required to work nights.
In care homes, the shift system is similar, either a 7½ hour morning or afternoon shift and a night shift, or two twelve hour shifts. However, there are significant differences in the way nurses are financially rewarded for the work they perform. In the NHS, nurses are entitled to unsocial hours payments which are typically at a rate of one third added to their contractual rate of pay for shifts worked on Saturdays and between 8pm and 8am, and at a rate of time and two thirds on Sundays and Bank Holidays. In the care home sector, these unsocial hours payments are not always provided because of budgetary restrictions. It was only in care homes run by providential organisations and charitable trusts that evidence of unsocial hours payments was found.

For mid-life nurses working shifts, there is little doubt that this impacts significantly on their lives outside work. However, for the most part, the nurses interviewed were resigned to the fact that shift work was part of their job role and they tried to work this to their advantage; for example, for some nurses who worked nights it meant that not having to pay for childcare was a significant motivator and reason for staying in nursing and with their organisations.

“And I, [pause] cos I do nights as well – J [partner] used to do nights but he doesn’t now, so it used to be very difficult with 2 people doing nights, and children. So I try and fit it in around when he’s off and it’s less impact on the children, when I can be in bed and they can go, get up and you know, do other, normal things. So I just try and fit it around them really. And the minimal amount of [pause] that’s why I don’t do days, because I wouldn’t be able, because if J was at work, I wouldn’t be able to have someone to look after them for that early in the morning. You can’t do it. And you can’t expect anyone to do that. And also, with my nursing, we decided not to pay anyone for childcare, so that’s why we try to fit it around each other.”

Teresa, 42, NHS Staff Nurse (PT, nights, co-habiting, 2 dep. ch.)

One of the nurses interviewed explained how she had found the transition from ward based nursing to a specialist nursing role difficult because she had worked shifts for an extensive period of her nursing career. This had led to a period of re-adjustment and re-negotiation of roles with her husband as they both acclimatised to her having a more traditional working pattern.
"I found it really different and the difficult thing was that [...] is that I'd normally work weekends so my husband had had the house to himself a lot of the weekend and I'd have the days to myself during the week and suddenly we had weekends together. Which sounds stupid but we weren't used to spending every weekend together. And actually we still do very much our own thing but it was getting used to actually -- and we'd have every evening together where I'd done lates so there were evenings where I wouldn't get home 'til 9 o'clock at night so he's had an evening, so he'd have chance to wind down. And we always seemed to be there together at one point and it was too much. So that was quite difficult adjusting to that."

Sheila, 43, NHS Specialist Nurse (FT, married, no children)

In the care home sector, the shift pattern for nurses is comparable with the NHS, with early starts to the day shift. But some nurses also had to contend with a long working hours culture (12 hour shifts during the day), which is not helpful in arranging childcare, leaving women with no option but to rely on partners or family members to care for their children at weekends or at night whilst they go to work. This is illustrated by the narratives of Darcey and Kim (below), who discussed the impact of shiftwork on their families in the section on negotiated work-life balance.

In this study, nurses did not explicitly discuss the costs and benefits of shiftwork per se. Shiftwork afforded opportunities for some women in this study to continue working and maintain their child-care responsibilities. However, the nurses interviewed discussed the physical and emotional toll that nursing had taken on their lives, from exhaustion as a result of working nights.

"It can be stressful. It can be hard work. You know, under a lot of pressure. I get tired, you know, I've got a family to look after, I actually do work nights at the moment and I, I get extremely tired, deprivation of sleep. I actually had a car crash back in February because I was so exhausted, I fell asleep at the wheel."

Alex, 42, NHS Staff Nurse (PT nights, married, 2 dep. ch.)

They also referred to the psychological issues that dealing with emotive situations, for example death, diagnoses of terminal conditions such as cancer, in the context of caring for patients, that contributed to the feelings of stress and burnout.
The impact of shiftwork on husbands was discussed by some nurses. Heather, who worked part-time on an assessment unit was reconsidering her job location because her husband had just changed jobs which was having an impact on the respective roles they played in terms of childcare. Heather was separated but negotiated childcare with her estranged husband so that she could fit her shiftwork in, however, this was causing difficulties for him.

"I need to start looking for something more local, it's just because of my husband's job really. I mean, at the moment, it's working for me, him taking our youngest to school. It's not working for him as he has to travel to Middlesex and I sometimes feel a bit guilty. Cos when I'm on an early shift, he has to take him to school."

Heather, 43, NHS Staff Nurse (PT, shiftwork, separated, 2 dep ch.)

Flexible working was also important to nurses who did not have children. Some nurses became accustomed to the flexibility that shiftwork afforded them. Hilary, a specialist nurse who had spent much of her nursing career working shifts, spoke of the adjustment needed and improvement to her life as she made the transition from ward sister to specialist nurse. This meant working 9 to 5 rather than the shift system.

"I enjoyed for years working shifts, I didn't mind at all. Now my life is much more Monday to Friday, 9 'til 5. I thought, 'I don't think I can cope with this. I like having Wednesdays off, I like working at the weekends at times.' But I've actually fallen into that [9 to 5] quite quickly [pause] but it's quite nice now and I wouldn't want to go back."

Hilary, 42, NHS Specialist Nurse (FT, single, 0 dep.)

When analysing the data from nurses in the care home sector, the subject of shiftwork was not overtly discussed by the nurses. Of the 25 care home nurses interviewed, only 4 did not work day shifts or a 9 to 5 shift pattern, primarily because the majority interviewed were more senior nurses and matrons/managers. Of the three nurses who worked night shifts, all had chosen this option to fit in with their domestic commitments.

Care home nurses also discussed having to negotiate childcare and work roles with family members. Darcey, who worked part-time nights in a care home, discussed the
these negotiated roles and the issue of not wanting to, or being able to spend her income solely on childcare if she worked days. She also discussed the impact of night work and the resentment of missing out on family activities due to night work, such as weekend days out as a family unit, a common theme amongst nurses who worked nights and weekends.

"Um... well, that's why I do nights because I think it would be impossible to work the days because [of] the long days. I mean, they start at 7.15am to 7.15pm and if you've got children, young children then that's just out of the question. So obviously when I first had the children, I had a toddler and a baby, working Friday and Saturday night was my only option because my husband looked after the children while I came to work because there's no way, you're just spending your money on childcare otherwise."

Darcey, 42, Care Home Staff Nurse (PT, nights, married, 2 dep.ch.)

Doreen, a divorced care home nurse with grown children discussed negotiating childcare with her parents when her children were young and she worked nights. She needed the flexibility that nursing offered, compared to other jobs, in terms of shiftwork.

"And in that time [talking about her career history] my marriage broke up, so my father looked after the children. I moved and then I was doing night duty and I was doing agency as well, the two together, to sort of get everything going with three children. [...] But you see, because I was on my own, with three children to bring up on my own, I carried on with the nursing because of the night duty and my dad used to look after my kids."

Doreen, 52, Care Home Staff Nurse (FT, divorced, now 0 dep.ch)

The theme of 'missing out' was also evident in the narratives and not only from the perspective of the nurse. Kim, discussed the issues of working shifts, their impact on family life and the impact they had on her children, who felt they were missing out on family life too because of her work.

"I think when I do my long shifts, the three long days, it just impacts on the evenings, but we do 8am to 8pm so it would impact on about 5 hours, so it's about 15 hours per week. But I do do weekends as well, but we balance it – my husband's off or I'm off, so how much impact it has on them, I don't know how to measure that. They certainly say to me like any mum, they'll say to me 'oh, I wish you weren't going to work.' They have me all the holidays as well"
so it's a pretty good balance actually. I'm entitled to some time too, so I think they have quite a good balance.”

Kim, 53, Care Home Staff Nurse (FT, married 1 dep. ch, 2 non-dep ch.)

The issue for nurses that worked as care home matrons/managers was the hours they had to work because of their job role. Whilst they were contracted to work a 38 to 40 hour week (depending on the care home), they routinely worked far in excess of this particularly because they were ‘on-call’ when they were not at work. This was discussed by matrons/managers who worked for both small, independently owned homes and a large providential group.

"Yeah, 'cos it's long hours and not much you know, financial reward for the responsibility and the hours and the erm [pause]. Yeah. The hours, I mean, it's continuously on-call so three hundred and sixty five days a year, so. Well unless you go abroad then you've got to get somebody else to answer the phone. Um, yeah, I think it's the hours and the responsibility. Although you could restrict the hours, but then it's job satisfaction as well, you know?"

Candice, 48, Care Home Matron (FT, divorced, 0 dep. ch.)

Overall, the majority of nurses in this study (n=38) did not work shifts (nights, internal rotation) usually as a consequence of their seniority within the organisational and occupational hierarchy. Of those that did (n=12), some of the nurses (n=7) deliberately chose to work night shifts, in order to combine work with family life, to avoid paying childcare costs, as their partner or other family members assisted in caring for the children. These nurses appeared to accept shiftwork because it fitted in with their family and home life at that time. For other NHS nurses, it appeared to be an accepted part of the structural requirements of the occupation. Nurses accept that nursing is a 24 hour role and although there may be some resentment directed at the system which they judge to be unfair because not every nurse is afforded family friendly working practices, there is a fundamental appreciation and understanding that shiftwork is unavoidable, especially in areas such as the general wards, theatres, ITU and care homes.

To conclude, shiftwork was not considered to be an organisational constraint by the nurses in this study, nor was it deemed to be a cause of job dissatisfaction. None of the
nurses interviewed complained about shiftwork, however the number of nurses working shifts was small (n=12). For nurses who have chosen to work shifts to accommodate child-care needs there are costs as exemplified by the nurses who felt guilty about missing out on family life. However, these are often negated by the advantages that shiftwork offers nurses with children such as combining paid work with little or no childcare costs contributing to ‘continuance commitment’.

8.4. Career Pathways
This section will analyse the career pathways of nurses and aims to examine nurses’ rationales for entering nursing as a career, the career pathways they have taken and to find out whether they intended to remain in nursing. The career pathways of the nurses participating in this study were long and varied, as would be expected from nurses at this stage in their career. However, there was evidence of a flexible approach to their nursing careers. During the interviews, they discussed their career histories including any breaks in service for child rearing or gap years, caring for dependant adults, to their present role. Nurses in this study have used the flexibility that a nursing career offers to leave and then return to nursing. Three nurses had ‘gap years’ and returned, two travelled as a result their husbands’ work and three nurses took more than 5 years out of nursing to care for children. Many of the nurses interviewed reduced their hours to part-time when caring for children and returned to full-time work as their children became independent. Finally, they discussed how they viewed their career progressing, whether they anticipated remaining in the nursing profession and what their career intentions and aspirations were.

In terms of the initial rationale for wanting to be a nurse, the key aspects identified were – always wanted to be a nurse from a young age, influences from family members or acquaintances who were nurses or who were health care professionals, the media, caring for family members with acute or chronic illnesses, careers advice at school, not knowing what else to do, wanting to contribute altruistically to society, lack of opportunities for girls during the 1960s, 70s and even 80s, and the expectation that non-academic young women would become teachers, secretaries or nurses (see Figure 8.1).
This was supported by other nurses in the sample, both those working in the NHS and the care home sector, most of whom trained in the 1970s and the 1980s. There was only one nurse who trained in the 1990s in the sample, so it cannot be ascertained whether this perception and experience still existed.

"I think I always had it in the back of my mind to do it since I was little. Well I wasn’t encouraged to do it by my family, they wanted me to be a secretary."

Amanda, 46, NHS Sister.

"I suppose in those days that’s what, unless you went to university, that’s what most young girls did, so you know, it was secretarial or nursing or you went to university."

Astrid, 49, Care Home Specialist Nurse.

Most of the nurses in this study indicated that they had no definite career plan and that their nursing career was characterised by opportunistic career moves rather than career planning. Ring (2002) stated that organisational structures can influence career
progression, either positively or negatively, and that there was a "culture of consolidation" (p203) that existed in the 1970s and 1980s resulting in nurses' career progression being artificially impeded by having to work a specified amount of time in general surgery, general medicine and then choose to specialise in one of these or other areas. However, some nurses in this study used the opportunity that a more relaxed and flexible approach to career progression afforded them to withdraw temporarily from the profession to pursue other options. They were then able to return to nursing without the structural constraints of job scarcity or having to complete a 'return to practice' course. The organisational culture in the NHS at that time also allowed greater flexibility in choosing a career pathway as it was relatively easy to change direction within nursing without the feeling of being penalised for doing so.

"I started training in 1982 at St. Thomas's in London, and I finished that, well 3 years later. And at St. Thomas's at that time, as part of your training, you then did two 4 month staff nurse allocations. So my first 4 months was on a care of the elderly ward and my second 4 months on a cardio thoracic ward. I then had a break and went off and did a ski season and then I went travelling for a year and I came back from that and I went to work at the Brompton on the cardio thoracic ward there for a year. And then I had a complete change around because it was easy enough to do that in those days."

Shelly, 43, Care Home Staff Nurse.

For the nurses in this study, their perceptions and experience suggested that, contrary to Ring's (2002) assertion that organisational structures can impede careers (although Ring's sample involved only graduate nurses with degrees), a progressive career in nursing was not always considered paramount and job satisfaction was often seen as more important than climbing the career ladder.

"I think it has taken a long time to move up the career ladder though. But I think that's because I enjoyed what I did at the time. I stayed on a ward with patients for a long time. 'Cos I enjoyed what I did."

Sheila, 42, NHS Specialist Nurse.

Many of the nurses interviewed were or had been responsible for child rearing and had reduced their working hours to part-time to fit in with their family commitments. A nursing career offered them the flexibility to reduce their hours in order to combine
paid work and child rearing, and the opportunity to increase their hours should they wish to once their children had become more independent.

When expressing ideas about their future careers, none of the nurses had definite, structured career plans despite most planning to remain in nursing until retirement. Heather, who worked part-time, had two children of school age and had been a staff nurse for 18 years.

“At the moment I try not to look too far in the future, but I’m [pause] I just take each shift as it comes really and if an opportunity arises for a senior post then I will be there applying for it. I can see myself nursing until I retire.”

Heather, 46, NHS Staff Nurse.

For nurses working in care homes, the career pathway can be much more restrictive, as there is a more limited organisational structure and, consequently, opportunities for career enhancement, unless the home is part of a large company where opportunities exist for regional managers. For nurses who wish to remain in clinical nursing, options are limited. Homes are usually staffed by nursing assistants or auxiliaries with few registered nurses, plus a matron or home manager in a mainly administrative role with little ‘hands on’ involvement in care. If the home is independently owned and not part of a group or there are just a small number of homes within the organisation, there is little for nurses to aspire to in terms of career advancement. Celia acknowledged this, but also emphasised that there are opportunities and flexibility to move within the private sector (although these can often be sideways moves rather than promotion).

“And, and also in the private sector you can move about a bit. It's not so easy if you're with an independent provider, you know, but with big private providers [pause] well, there's three hundred odd care homes. You know, there's always something new going on. Um, so you can sort of move about a bit.”

Celia, 54, Care Home Manager.

This lack of career structure in care homes was emphasised by another nurse who also discussed additional organisational constraints within her home and the lack of clinical supervision that restricted staff development within the organisation.
“It [clinical supervision] would help to move people along as well I think in their careers. There’s a little bit of a tendency here to – there’s no real career structure so it tends to be everybody floating along at staff nurse level. That’s all right, and that’s been fine in the past but I can see as the big wide world of nursing’s changing dramatically out there, things are going to have to change here. It’s difficult to know how to do that or get people to do that.”

Shelly, 43, Care Home Staff Nurse.

Finally, Hannah illustrated the experience of all the nurses in this study. None of the nurses interviewed had a definitive career plan when they started their training, throughout their careers or in the future.

“Oh, God. I’ve never known what I want to be doing in 5 years time! I’ve had a snowball career really.”

Hannah, 41, NHS Specialist Nurse.

Nurses have used the flexibility that a nursing career offers to take gap years, significant time out for child rearing, move with their husbands’ work, reduce working hours to accommodate childcare and increase hours if they wanted to. My conclusions from interpretation of the data suggest that the degree of flexibility a nursing career offered these nurses (with and without children) also had some influence on the nurses’ occupational and organisational commitment.

Flexible career structures are important to keeping nurses in nursing. The Department of Health and the Nursing and Midwifery Council have recognised the need for initiatives to find and channel nurses’ expertise to ensure that the labour force meets the needs of employers, primarily the NHS (DOH 2008). Research suggests that older nurses are committed to their organisation and promoting career opportunities within their particular organisations helps to retain older employees (Ingersoll et al 2002). This ultimately benefits the organisation through the transmission of ‘cultural ideology’ to newer employees and, as a result of career progression, older employees benefit from the recognition of their value and the commitment of the organisation (Ingersoll et al 2002).
8.5. Conclusion

Nurses' working lives are often negotiated and mediated within the context of family needs and work-life balance considerations. Flexible approaches to working have been promoted by policy makers as an opportunity for employees to negotiate a healthier work-life (and family) balance as outlined in Chapter 3. However, the reality is somewhat different for the nurses in this study. For many working in the NHS, including those with children, the policy of Improving Working Lives (DH 2000) is little more than rhetoric as they cannot access flexible working arrangements. The promotion of work-life balance initiatives leads to confusion by policy makers, employers and employees. Flexible working practices aimed at improving work-life balance are actually promoting a work-family balance. However, the parameters of what constitutes a family are often very narrow, certainly in the context of IWL, with NHS Trusts offering flexible working only to employees with adult or child dependants. What policy makers have failed to address is employees' expectations of organisational justice - that every employee will be treated equally. Analysis of the data in this study has established that some NHS nurses do not feel that they have equal opportunity to improve their working lives. This is due to a combination of attempting to reconcile organisational labour requirements with employee wishes. Consequently, nurses rely on established methods of accommodating childcare needs such as local negotiation with individual line managers, weekend working, nightshifts and relying on family/partners to assist with childcare. The data indicates that NHS nurses without children (married or single) experience the greatest difficulty in accessing flexible working practices.

In contrast, care home nurses have not had their expectations raised by national policy. They negotiate their working hours locally with their managers and often use traditional shiftwork patterns (nights, weekends) to accommodate their childcare needs. The data indicate that there is no resentment of colleagues because all have equal access to negotiated patterns of working, regardless of the presence or absence of child or adult dependants.

In terms of nursing careers, the striking pattern is that the nurses in this study have never had a definitive career plan, with all nurses having what can be described as 'snowball' careers demonstrating a flexible approach to career progression. Nurses
made an initial choice to train in acute, mental health, child or learning disabilities nursing. They then had fallen into/discovered a niche or specialty that they enjoyed, some became trapped in this (due to seniority and pay) or have been redeployed into a role not of their choosing due to restructuring of the organisation. They have then continued along this pathway without any careers guidance. Some nurses have chosen to use the flexibility that a nursing career offers to reduce hours and have utilised flexible working when needed for childcare. Or, they have withdrawn and re-entered nursing after taking time out for various reasons.

For nurses in the NHS who have reached the pinnacle of their specialty and do not want to enter management, there are few opportunities for career development because they have made the decision that they want to remain in clinical practice. In the care home sector, there are fewer opportunities for career advancement and care home nursing is rarely promoted as an option for registered nurses. Some of these issues are being addressed by national initiatives including, ‘Towards a Framework for Post-Registration Nursing Careers’ (DOH 2008) as outlined in Chapter 3, and although one of the pathways is aimed at nurses to enter long-term care, the focus is on NHS nurses. As yet, there is no definitive policy on careers for registered care home nurses, only the ‘Care First Careers’ initiative focusing on getting young people (18 to 24 years) into the care sector (DOH 2010). It has been reported that employers are experiencing difficulties attracting UK trained nurses into nursing homes. It is therefore essential that policy makers promote caring for older people in care homes as a positive career option and ensure the sector can attract sufficient registered nurses into care homes.
CHAPTER 9

Organisational Structure, Culture and Context

9.1. Introduction
This analysis chapter will examine the organisational structure, culture and context within which the nurses in this study are expected to perform their work. The first section will analyse the reasons care home nurses gave for leaving the NHS. Following this the concepts of bureaucracy, management and managerialism and themes which emerged from the data, such as the target driven culture, autonomy and nurses’ experiences and perceptions of leadership will be analysed. These salient constructs affect nurses’ working lives and have a role in affecting their commitment to the organisation. The concepts of respect, recognition and being valued, will be analysed to elucidate the complex interplay of the organisational context and how this can affect the commitment of nurses. The potential threats to, or opportunities to, enhance that commitment will be analysed. Also considered is the concept of nurses’ professional identity and how this is affected by the type of organisation and sector worked in.

Organisational structure, culture and context affect the way nurses’ work life is experienced. The nurses interviewed worked within two distinctly different organisational structures and cultures. These were NHS Trusts, which are part of the NHS structure, and care homes, an umbrella term for nursing and residential care homes, which fall under the auspices of the social care sector and were regulated by the Commission for Social Care Inspection (CSCI) until 2009 which has now become the Care Quality Commission (CQC).

Within the two structures, the NHS and care homes, many types of organisations exist. In this study, these ranged from small nursing homes with fewer than 30 clients, to large district general hospitals with over 500 beds. Organisations encompassed nursing homes, residential homes with nursing care, hospitals and community services. Of the care homes that were accessed in this study, some were privately owned stand alone homes with the owner owning only one home, to companies with a
portfolio of homes (six homes in the organisation), charitable organisations and providential companies such as BUPA.

9.2. The Reasons for Care Home Nurses Leaving the NHS

The question of why nurses had left the NHS but continued to work in nursing was of interest because it demonstrates that nurses are occupationally committed as they have chosen to remain in nursing. However, their organisational commitment is of particular interest because they have chosen to leave the NHS for employment in the care home sector, a sector that is not as well perceived in terms of respect or kudos and often has poorer working conditions and working environment. To date, little is known of the reasons for qualified nurses leaving the NHS to work in the care home sector.

The stated reasons that nurses gave for leaving the NHS were varied. Some reported that working in the NHS led to frustration, anger and stress. Organisational politics and the way the NHS was run were cited as reasons nurses decided to leave. Denise only spent a year working in the NHS before moving to the care home sector, as she felt that NHS nurses were not listened to by their employer.

"Post qualification it was only a year [that she stayed in the NHS]. As I say, they had completely changed it [the NHS], and I don’t know if I was more militant then, but they sent round a from asking for our opinions on A, B or C options, and having done a straw poll myself, most [staff] had gone for A or B, knowing full well we were going to get C, and when we got C I thought, ‘no, I’m sorry, this isn’t how I want to be treated’. So, I used my feet and marched.”

Denise, 53, Care Home Manager.

The political organisation of the NHS was also a reason, cited by Grace, for leaving the NHS.

“I’d found in my last few years, I found the NHS frustrating. Um.. not only in the political sense of the continual re-organization but in some of the [pause] in some of my colleagues’ attitudes towards public service as well. Um, how do I explain that? Um, there was a lot of [pause] people call it a loss of morale but I always found that people sometimes were just as bad as the system, the people working in the system were just as bad as the system.”

Grace, 46, Care Home Manager.
Not being able to deliver nursing care in accordance with nursing ideology was a common reason cited for leaving the NHS, as indicated by Sophie in Chapter 7 and Amy:

“I wasn’t being able to do my basic nursing care, that I absolutely loved […] It’s very sad and that’s not what I went into nursing for. You hardly have chance to have a chat with your patients […] I just felt thank goodness this job at [her care home] had come up because I would have left anyway. I wasn’t enjoying it. Probably not, ‘cos I was so disillusioned with the NHS. Really, really.”

Amy, 46, Care Home Specialist Nurse.

The work in the NHS was physically and emotionally draining and sometimes induced burnout. The pressure and stress inherent in acute nursing was the reason given by Delia for leaving the NHS. She was considering leaving nursing to be a secretary but saw a job advert for a post in a care home, applied and has worked in the same care home for 19 years.

“I think stress and pressure, things like that do invariably take their toll. But I mean I was seriously going to be a secretary but I went to the nursing home and one thing led to another and I stayed.”

Delia, 48, Care Home Sister.

Further reasons for leaving the NHS were family trauma and not getting flexible hours or family friendly working hours. Other reasons included leaving to rear children, to accompany husbands who were working abroad and then returning to the UK, not feeling like they fitted in. One nurse had a negative experience in her first six months as a newly qualified staff nurse and did not want to work in the NHS but wanted to stay in nursing. For other nurses, they stated that they simply wanted a change from the NHS.
“Um, I was living in the nurses’ home, I was living in Epsom, and I thought—I just want a change. I don’t want to be here anymore.”

Doreen, 52, Care Home Staff Nurse.

It must be highlighted that the nurses who worked as mental health or learning disability nurses in the NHS experienced significant changes to the way their patients were cared for in the 1980s and early 1990s with the mass closure of psychiatric hospitals in the 1980s (Stewart 2008). The government’s (DOH 2001a) white paper ‘Valuing People’ set targets for the closure of all long stay psychiatric hospitals for people with mental health and learning disability problems by April 2004, (extended to 2006 when the target was not met, and is still unmet). As hospitals closed, nurses opted to move into the care home sector as their clients were relocated to community settings.

The majority of care home nurses said that they would not consider returning to the NHS at the time of interview. Again the reasons for this were varied. The minority that might have considered returning to the NHS felt they had lost skills or considered trying to re-enter would be too difficult. Many nurses were frustrated with the standard of care they could (or could not) give in the NHS and cited this as a reason for leaving. Others felt they had greater support, less pressure, and better multi-disciplinary teamwork in care homes than in the NHS. Management in care homes was much more accessible as there were not as many layers to the hierarchy and often the managers in care homes were more autonomous, resulting in decisions being made without protracted negotiations, bureaucracy and with a sense of being involved. Figure 9.1 below illustrates the main reasons care home nurses gave for leaving the NHS.
These disparate reasons show that nurses’ working needs were not being met by the NHS. Nurses who had left the NHS to work in the care home sector felt that their professionalism was being compromised as they could not provide nursing care that was consistent with the professional standards and values of nursing ideology. Nurses felt that they had no ‘voice’ within the organisation and that their opinions were not respected, recognised or valued.

Seven nurses currently working in the NHS had worked in care homes, one as an auxiliary at the age of 16 and this had partly influenced her decision to enter the occupation. One nurse currently working in the NHS had for six years simultaneously worked in both care home and the NHS, but had left the care home due to change of ownership and a perception of declining standards. One nurse had moved into the care home sector for six months for more flexible working hours, but had returned to the
NHS as she had found the job role did not meet her needs for interesting and dynamic work and her skills knowledge and experience were not being used.

"The nursing home, I did not enjoy. I did not enjoy nursing home work at all ‘cos I found the work very un-stimulating. Um, I don’t think it was very happy experience."

Lucy, 46. NHS Staff Nurse.

One nurse had moved back to the NHS as care of the older person did not appeal as a specialty. One NHS nurse had worked as a matron in a care home but had lost belief in the ‘product’ she was ‘selling’ – the product being the care home and the skills of the staff employed. Another nurse had been made redundant as funding for her specialist post in the nursing home had ceased.

As with nurses that had worked in the NHS and moved into care home work, the nurses who had moved from the NHS into care homes and back to the NHS found that their work needs were not being met. There were conflicts with nursing ideology and standards; nurses could not work in organisations that they perceived did not meet the (high) standards that they expected to give so these nurses moved back to the NHS.

9.3. Bureaucracy, Management and Managerialism

The concepts of organisational structure and culture are important as they are relevant to all aspects of work life; work occurs for the nurses in this study within differing organisational structures and contexts. The employing organisations of the nurses exhibited differing organisational structures and working cultures, and respondents discussed at length the various organisational constraints that they faced during their working lives. These included both structural and cultural issues including the allocation of resources such as time, budgets, staffing, recruitment of staff, bureaucracy and red tape, achieving targets, quality outcomes and the effect of all these on patient care and staff morale which led to conflicts in the workplace. Whilst these issues tended to have a negative impact on nurses’ working lives, they did not have an impact on their stated commitment to being a nurse. However the managerial
approach of nurse managers and leaders to these issues had a sustained impact on nurses and did affect their commitment.

In terms of organisational structure, Watson (2003) suggested that there is a duality of purpose for managers and their subordinates as managers seek to impose authority through the construction of hierarchies in order to control work activities. This, he suggested, differs from employees who attempt to understand and define their own work routine, form associations and their own order within the workplace. If nurses in this study perceived their concerns were recognised and action taken to minimise their impact or if they were able to voice their concerns to their managers, they were less likely to become disaffected, experience conflict and be alienated from their work.

Watson (2003) differentiated between conflict of interests whereby different workers within the organisation have different expectations regarding outcomes, and conflict of behaviour which he defined as disagreements over the differing expectations with regard to outcomes.

The main concepts to emerge from the data are the target driven culture, autonomy and nurses’ experiences and perceptions of leadership. These elements, as stated by the nurses, impacted on and affected their performance within their organisations. The following sections will consider the most important concepts that impact on nurses within their organisations which emerged from the data.

9.3.1 The Target Driven Culture

A phenomenon in the NHS that has changed the way nurses work and has had a direct impact on patient care is the introduction of targets. The current Labour government introduced performance ratings in 2001 as a way of monitoring how well, based on set criteria (targets), NHS organisations function and ultimately serve patients (Bevan and Hood 2004). These included targets for maximum waiting times for certain elective operations and maximum waiting times for people with cancer to be seen by a specialist. Also included were maximum waiting times in Accident and Emergency Departments, targets for reducing health inequalities, mortality targets for people with cancer, circulatory diseases, intentional self harm, accidents and injury of undetermined intent and access to genito-urinary medicine within 48 hours. Clinical areas were not the only areas to be affected as targets for estates management and
targets for management costs were included (DOH 2008). On the Department of Health website, there are more than 500 results displayed for the search term ‘NHS Targets’. This target culture has pervaded all aspects of the NHS during the last 9 years.

This target setting has not been limited to the NHS, targets have also been introduced into the social care sector. A search of the DOH website using the term ‘social care targets’ again delivered over 500 results, including changes to the Commission on Social Care Inspection’s (CSCI, now CQC) remit on how and when it inspects care homes. However, the fundamental difference in my study between NHS nurses and those working in care homes is that none of the nurses in the care home sector discussed performance indicators and targets during their interviews. Constraints such as time and budgets were reported but not the constant government-initiated monitoring that NHS nurses frequently reported. Whilst care home nurses appear to experience similar constraints in terms of bureaucracy, administration, budgets, staffing and lack of time, none of the nurses expressed concerns about government targets such as the National Service Framework for Older People (DOH 2001b).

The NHS nurses in this study discussed at length the issues pertinent to their practice. They reported a great deal of frustration with the target culture; the bureaucracy that is associated with the targets - additional paperwork and administration which accompanies it - and the budget restrictions enforced upon departments. The nurses declared that they wanted to get on with the job of being a nurse, providing care for their patients, making a difference to their patients’ health without the constraints that government targets imposed.

Felicity, an ITU sister explained the frustrations of waiting list targets and the impact for her department.

"The main thing I’ve noticed recently, and it’s getting more and more noticeable is the politics side of things, I think. It’s that we’re constantly meeting targets and you never know from one day to the next you know? One day you’ll be getting people out to empty beds and the next lot of people in, and the next day there’ll be people ready to go, but were not allowed to move them out, because we have to keep our bed occupancy up, to look as if we’ve got people in, and it's all just - that side of things is a bit of a nightmare really.
And um, probably just the hassle of the staffing, quite a hassle from the seniors’ point of view.”

Felicity, 40, NHS Sister.

Felicity’s concern was that meeting these targets was ostensibly to improve the patient experience, in reality it was a measure exercised by the government to tighten control over the NHS. Patients, she argued, were suffering as a result and it was frustrating for nurses because they want to get on with their role of caring for people.

“...The constraints they put on us and the targets like A&E waiting times, all that business, it’s just absolutely insane and that’s [pause] that side of things. That’s what I’m trying to say is we don’t care as much about the patients now. In the fact that they sat in A&E regardless of what’s the matter with them. They get shipped out to wherever there happens to be a bed for them, even if it’s totally inappropriate and it means they’ll [pause] it’ll be detrimental to them, because there is so much pressure from above. You have to fit all these things in now whereas you didn’t use to have to do that. And I’m sure that that’s not a good thing.”

Felicity, 40, NHS Sister.

Other nurses working in different departments within the NHS discussed this sense of patients losing out to the target driven culture. Hannah, a specialist nurse, discussed the issue of targets when explaining how she felt her employer could encourage nurses to stay in nursing, and suggested that there needs to be a refocusing of priorities. James (1992) highlighted the issue of organisational constraints, caring and emotion work and argued that the medical ‘curative’ model took precedence over the ‘carative’ (nursing) ideology of giving one-to-one care. This, she stated, leads to a tension for nurses’ autonomy in organising individual, holistic care and meeting the priorities of the organisation.

“And perhaps if people celebrated more about caring for people, rather than this constant, you know, you’ve got to meet this budget, that budget, the other budget. But I don’t quite know how the employers are going to do it because everybody’s on a pressure, from one person to another really.”

Hannah, 40, NHS Specialist Nurse.

Nurses who were not working in the hospital setting who autonomously ran their own services, such as specialist epilepsy or diabetes nurses, considered their professional evaluation was being called into question. Camilla, a specialist nurse working in the
community, discussed her organisational commitment and how she wanted to do a
good job for her own self-fulfilment and sense of professionalism. She reported issues
which led her to feel less committed to her NHS Trust. Again this element of the
patients’ needs coming bottom of the agenda (wanting to cut clinics), which was not
satisfactory to nurses, is borne-out.

“I think that’s where a lot of conflict arises now because previously you were
probably just allowed to get on and do the job that you thought was ok and
you thought was important. Now outside influences are trying to tell you that
you can’t do that anymore [pause] But everything’s monitored much more
closely. How many visits you’ve done to different sorts of people. They’re
looking at clinics at the moment because they think why would well people
come to clinic and that they shouldn’t do that and you try and explain they
need the emotional support and come to clinic, or they wouldn’t get that
somewhere else. And that there are other factors and you can’t just look at the
bare facts in that – you know the numbers game other than looking at the
reasons why people come. That’s just one example.”

Camilla, 50, NHS Specialist Nurse.

Amanda, a sister working in an ophthalmology clinic, indicated one of the problems
her department faced was ensuring that the waiting list target for cataract surgery was
met. At the time of interview, the government was introducing overseas surgeons with
the express intention of reducing the cataract waiting list using ‘one-stop’ services
outside the NHS ophthalmology service. Her frustration was not limited to the targets
themselves but also to the lack of continuity of care and quality of service she felt the
patients received, in addition to having to ‘pick up the pieces’ if the operation did not
have a successful outcome. What the government did not factor into the plan for
reducing the cataract waiting times by using these stand alone ‘one-stop’ services was
the complication rates and who would care for the patients should they experience a
complication, especially as the department would not have any clinical notes or
information about the patient. This meant more work for the department as patients
with complications needed frequent follow up appointments, which were not covered
by her department’s budget.

“All they’re interested in is getting their targets met, not looking at other
issues along side it, ie. get our cataracts done by South Africans so we can get
the waiting lists down to six weeks. They go back and we’re left with the
Mueller and Neads (2005) proposed that the motivation behind health care changes are social, financial and political and that structural changes are driven by environmental demands and the ever increasing need for health care provision. This often leads to the restructuring of organisations and the attempts to manage clinical services to improve service outcomes with the intended goal of meeting the needs of patients. My data suggests that this has led to the disenchantment and disenfranchisement of nurses working in the NHS and has led to a sense of alienation at work.

9.3.2 Autonomy
Autonomy can be defined as how much control employees have over their job (Kovner et al 2006). Marshall (1998) suggested that to be autonomous is to be a self-determining actor who is able to express his or her own goals and is not subjected to determinism.

The concept of autonomy, and its importance in the context of their working lives, was discussed frequently by the nurses in this study. Autonomy was important not only for nurses who had attained positions of power and leadership in nursing, the sisters, specialist nurses and managers interviewed for this study, but was relevant for staff nurses working at grass roots level too. Autonomy and its presence or absence is important conceptually as it has been linked to nurses’ job satisfaction and is predictive of their intent to stay (Laschinger et al 2001, Larrabee et al 2003).

The level of autonomy is not only influenced by a nurse’s position in the hierarchy of the organisation she is employed by but other variables such as:

- Level of competence associated with tenure – the longer a nurse has held a position, usually the more competent she becomes in her role (Benner 2001);
- Nurse leadership and their ability and desire to delegate responsibilities in order to develop junior nurses’ professional practice;
- The willingness of nurses to assume greater responsibility and autonomy;
The individual learning environment and whether it facilitates nurses to learn autonomous decision-making and the culture of the organisation - whether it encourages risk taking (allowing junior nurses greater autonomy is certainly a calculated risk).

The capacity for learning and assumption of greater responsibility by nurses is specific to the individual. Some nurses learn a lot quicker than others and accept autonomous decision making earlier than others. Some nurses are more willing to accept greater responsibility and therefore greater autonomy, others are not. Nurse leaders vary in their leadership capacity to devolve responsibility to more junior nurses. However, there are often fewer opportunities to learn and teach these skills in a busy, pressurised environment.

What is apparent from this study is that nurses enjoy having autonomous working practices. It is evident from the data that nurses place great importance on exercising control over their workload, their ability to interact with and care for their patients. Here, Coral explained her enjoyment of the autonomy that she did have working at an independent hospice, how this has been reversed in the role that she is working in now in her care home. It is perceptible from this extract that she missed the autonomy that she once had.

“One of the things I enjoyed doing in the hospice, that I can’t do here and it was quite a big learning curve was we had far greater access to how we managed our patients. With the drugs that we used but that was partly because of the unit we were in. It’s very restrictive in a situation where everything you need for somebody, apart from the homely remedies you can use, you’re allowed to give something for a cough, you’re allowed to give paracetamols for pain but you can’t really do more than that.”

Coral, 50, Care Home Staff Nurse.

Another facet of autonomy is that, like flexibility, it affords nurses options for managing their workloads. They have control over the pace at which they do their work, they are not subject to the direct influence of their line managers, have freedom to organise and structure their working week and freedom from the interference of line managers. They can negotiate some of their workload to suit their circumstances,
for example, for some nurses, paperwork can be done at home (often outside contractual hours) for example, when the children have gone to bed, which allows them to leave work in time for when the children arrive home from school.

“You know, because I'm the manager here so, I get piles and piles of paperwork to do. So I can choose to do those here or I can choose to do them elsewhere [...] And again, because I have got so much autonomy, I mean, I've always said I couldn't work in an environment where I wasn't the manager and if I had lots of people above me that would drive me mad.”

Colleen, 47, NHS Specialist Nurse.

Autonomous working practices also mean that sometimes nurses have the opportunity to do nursing work that offers them job satisfaction, they are not solely restricted to their job descriptions. As seen in chapter 7, nurses derived job satisfaction from being able to make a difference to patients' lives and often this take the form of small, non-nursing tasks and emotion work, which give pleasure to the patients and to the nurses themselves. For managers, it also afforded them the opportunity to 'walk the floor' and assess what was occurring within their home without being too conspicuous.

“I think because I can do everything. Like today at lunchtime, making pancakes and um, not just because it's pancake day and everything and sort of cheer the residents up and no-one ever, I mean, maybe they do think I'm a bit mental you know. You feel you can do anything like that. Whereas, you know, as a nurse in the NHS, you're sort of pigeonholed into doing different things all the time and um, I like being sort of hands on, with so many different things. But I like being, just having a small home where, you know, I can hear and see.”

Julia, 47, Care Home Manager.

However, not all nurses felt that they had autonomy within their working environments. This often occurred because of the government targets that NHS Trusts are required to achieve, impacting on autonomous working practices, and left nurses with the impression that they were not self-determining within the workplace.

“We don't seem to have a lot of autonomy sometimes, we are dictated to quite a lot really.”

Simone, 45, NHS Specialist Nurse.
Whilst some nurses working in the NHS had autonomy and lamented the restrictions that constraints such as targets have on this, for nurses in care homes, autonomous working practices were often not an option but a consequence of the organisational structure. Registered nurses working in nursing homes had less support in terms of other colleagues, particularly at weekends and at night when they were the only registered nurse on duty. This can lead to additional stress and pressure on nurses and the lack of professional support could be a contributing factor to nurses not wanting to enter this sector. This research study establishes that NHS nurses desire autonomy but this is restricted by managerial and government intervention. In contrast, care home nurses can feel vulnerable because of the added responsibility they experience.

“A nurse on a ward wouldn’t really know about nursing in a care home unless they’ve actually done it and how you have to be autonomous in that role because you haven’t got the doctor at the end of the phone, you haven’t got, you know, somebody across the way on another ward if something goes wrong. You haven’t got all that support, you’ve got to be that person making those judgements, professional judgements on that client.”

Kirsty, 43, Care Home Manager.

Whilst research has been conducted into the effects of job satisfaction and its positive relationship with autonomy (Rafferty et al 2001, O’Brien-Pallas et al 2006), there is a lack of research and literature which focuses on registered nurses working in nursing homes and their autonomy. Previous research (Rafferty et al 2001, O’Brien-Pallas et al 2006) indicated that autonomous working practices are a positive element of nursing work. However, in this study, nurses working in care homes who discussed autonomous practice, suggested that they have no choice but to accept responsibility, whether they wanted to or not due to organisational structure. Nurses working in care homes indicated they were often the only qualified member of staff on duty so had to accept responsibility. The negative issues associated with autonomy and responsibility in care homes may have implications on recruitment and retention strategies for these organisations.
9.3.3 Nurses Experiences and Perceptions of Leadership

Leadership, in the form of nurse leadership and non-nursing management, has a significant impact on nurses' working lives. What is perceived as good leadership can promote job satisfaction and establish a positive working environment (Mrayyan 2004, Tourangeau and Cranley 2006), which leads to improved staff performance and nurse retention.

Important to nurses is the perception that they are well supported in their work and that they receive recognition for their skills from their immediate line managers, not only as a nurse within a professional context but as a representative of the organisational structure. From the comments below, it is apparent that nurses do not always receive this and that the perception of the quality of nurse leadership is contextual and situational. The quote below indicates that Sarah had a manager that supported and recognised her work; however, she stated she had worked in organisations that have not afforded her the recognition and support she felt she deserved.

"I have a fantastic boss. I call her fantastic because she’s very supportive and she really recognises my skills which is really nice, you know, to be praised and recognised for a change."

Sarah, 39, NHS Specialist Nurse.

This sentiment was echoed by Colleen, again indicating that being valued for the role that she performed was significant to her job satisfaction and suggesting that the relationship between nurses and their managers is vital to this.

"I’m very lucky because, um, my manager, I’ve told her if she thinks about not being my manager anymore, forget it. So, and she’s actually taken me at my word actually ‘cos she’s re-jigged her management structure so actually she’s kept me in the management structure. Because I know who I couldn’t be managed by. I am actually very lucky. She is very supportive but she also values what I do. You know, she’ll talk about, you know, the stuff that I’ll do. [pause]. And I have said to my manager, if she stops being my manager and I get somebody else that I cannot abide, that there’s potential for that person to be a manager, then I’ve said I’d have to leave. Because I have to be comfortable with the people I’m working with."

Colleen, 47, NHS Specialist Nurse.
However, in contrast to the comments above, Heather, a staff nurse on an NHS in-patient ward, did not feel that the matron of her unit was supportive towards nurses or patients.

"... the one that we have, I don’t find her very compassionate at all [pause] she’s more focused on the bed state or how many beds we’ve got or have we got enough staff or - it’s not ‘how’re you doing, how’s things down here’, blah-di-blah it’s not of that caring aspect with her particularly. She’s more interested in who’s on the computer, and that’s not why - I just think that’s, that’s awful.”

Heather, 41, NHS Staff Nurse.

Within the context of the care home environment there were comparative issues in terms of leadership. Nurses appreciated the day to day support of their immediate line managers and perceived them as being ‘in touch’ with what was occurring at the nurse-client interface, whereas managers who are further up the management hierarchy were perceived as being more remote and less interested in the issues and challenges facing their nurses on a daily basis.

"We have our head of home and we have the head of nursing care, and I think the head of nursing care is probably closer to the ground in a sense. [...] Yes, and my head of home, she’s [pause] well, she’s a different kettle of fish really. She has a much harder attitude towards staff. I think her attitude is well, you know, you’re here to do a job and if you don’t like it, you know, J [head of home nurse manager] is not as approachable.”

Coral, 50, Care Home Nurse.

The concept of immediate line managers being more in touch with nurses working at ‘shop-floor’ level was echoed by Delia who worked in a different care home. Delia, who discussed her team and interaction with her line manager, illustrated the importance for her of having her individual needs acknowledged and met by her nurse manager.

"I think what is nice is that we’re all very different, all three of us and she [line manager] allows us all to develop within our own structure and I think that’s quite nice. She doesn’t sort of dominate us ‘you do it this way or that’, it’s very much who you are, what strengths and weaknesses you’ve got and she’ll help you with your weaknesses and she’ll develop your strengths. I think that’s really good. I like that very much.”

Delia, 48, Care Home Nurse.
This section has illustrated the importance of nurse leadership to nurses and how this is linked to recognition, support and being valued. It also demonstrates that if nurses do not feel supported, this can lead to problems associated with retention of staff. The concept of respect, recognition and being valued occurred frequently within the interviews with nurses and was one of the key concepts to emerge from the data. It is not only linked to nurse leadership but to the wider organisational structure and context. In this respect, it deserves a more in-depth analysis in terms of the wider organisational work context which section 9.5. will provide.

9.4. The Effects of Working in the NHS or Care Homes on Perceptions of Nurses’ Professional Identity: ‘public eye’ and ‘private ear’

The nurses’ professional identity appeared to be shaped and constructed through the organisation that employed them. The nurses in these two different organisations and organisational structures are perceived differently by the public and the media. Organisational context shapes the public image of NHS nurses and constructs a different public image for care home nurses based on these perceptions, experiences and media constructions/portrayals. The organisation confers an image which can be positive or negative. In terms of the nurses in this study, there is a marked difference between the two types of organisations in how the nurses feel they are perceived and how their role is constructed within society.

Nurses working in the NHS, felt that they were generally well perceived by the public and that there was still a high status attached to being an NHS nurse (in contrast to care home nurses). These nurses generally felt there was public support for the NHS and for nurses working in the NHS organisational structure.

“Generally I think the public think that nurses work hard, and do a good job.”

Stella, 44, NHS Consultant Nurse.

Some nurses felt that they were still respected by the general public and the media as
exemplified by Alex.

“I think people have admiration for the nurses, definitely. I think they can see that we work hard and in supporting our wages, I think people are behind us. I don’t think there’s been a lot of bad press against us.”

Alex, 42, NHS Staff Nurse.

These were the comments of nurses that had exclusively worked in the NHS as nurses. For those nurses who had experience of working in a care home and had returned to working in the NHS, the experiences and perceptions were very different. In the following extract, Monica, who had worked simultaneously in the NHS and in a care home (for financial reasons) gave an account of how she felt she had to justify her role working in a care home by emphasising that it was a second job, acknowledging and reinforcing the negative perceptions about nurses who work in care homes.

“I think nurses in the NHS and the hospitals are probably looked upon that they have more knowledge um, and are more up to date and are a better care giver [...] when I said oh, where I worked, I always said I worked at the [name of the NHS Trust] in my job and second I worked in a nursing home and I think if you say you work in a nursing home, it's the lowest of the lowest.”

Monica, 42, NHS Sister.

The notion of a nursing hierarchy whereby nurses working in acute care have more status than those working in long-term social care was outlined by Colleen, whose role involved working with older people within the NHS and involved coming into contact with care home nurses as part of her role as a trainer. She suggested that there is an historical inbuilt hierarchy as an explanation for the way that care home nurses are perceived within our society.

“I think it is literally, a historical thing because I mean, we’ve got the hierarchy in nursing haven’t we? We’ve got the acute and all the rest of it, then we go down to older people, and then we come down to whatever, and then we go into nursing homes.”

Colleen, 47, NHS Specialist Nurse.

Even within the care home sector there exists an intra-professional hierarchy and organisational competition between what were traditionally called nursing homes and
residential homes. The extract below indicates that registered nurses in nursing homes feel that they were harmed professionally when the decision was made to remove the differentiation between nursing homes and residential homes. This is also exemplified by Amy’s comment later in this section. As a registered nurse working in a residential home, she always felt the necessity to inform others that she was a qualified nurse.

“I think, when care homes were all lumped together, when nursing homes and residential homes were all put in the same pot, I think that was quite bad for nursing homes and nurses within those nursing homes. ‘Cos now I think people perceive care homes as all being the same, as being the lowest denominator, as in residential homes.”

Kirsty, 43, Care Home Manager.

Denise offered an alternative yet complementary view of the position of care home nurses.

“I think for the nurses they are generally thought of better, there’s a certain - stigma is the wrong word, but certainly the idea of being a care worker we are viewed as being sort of, as I say, little more than bum wipers, certainly not a responsible job that it is and a career for that matter, and I do feel quite strongly. Whether again it’s the title, whether the fact that there isn’t a recognised academic qualification, I really don’t know what the answer to it is but I know, it’s almost like we’re equated with the auxiliaries and we’re little more that worker ants really in the public’s perception of us.”

Denise, 53, Care Home Manager.

The comment by Heather, below, exemplifies the central problem for nurses working in care homes.

“With regard to nursing homes, I’m not sure what goes on behind closed doors.”

Heather, 41, NHS Staff Nurse.

The majority of people in society have had some form of contact with the NHS, as a patient, a relative or friend of someone who has received health care. The NHS, on the whole, is an ‘open’ organisational structure, in terms of acute care, in that the public generally perceive that they know what occurs or what to expect in a hospital or primary care setting. The media helps to sustain this image with UK documentary series celebrating the work of health care professionals and clientele such as ‘The Hospital’ (Channel 4, 2009), ‘Bizarre ER’ (BBC Three, 2008; 2009), ‘The People’s
Hospital’ (BBC 1, 2009) and ‘Wounded’ (BBC 1, 2009). This is supplemented by long running drama series such as ‘Casualty’, ‘Holby City’, ‘Doctors’ and ‘Crash’, along with satire such as ‘No Angels’ and ‘The Green Wing’ and the famous ‘Carry On’ films. In conceptual terms, this is the ‘public eye’ that is engendered by the NHS.

In contrast, the care home sector is portrayed as a very private, almost secretive sector. Television documentaries such as ‘Inside Out: care home investigation’ broadcast by the BBC (2008), ‘MacIntryre: UK Undercover. Who Cares for Granny?’ (Channel 5, 2003) and radio programmes such as ‘You and Yours’ on Radio 4 concentrate on the negative aspects of care provision such as abuse in care homes. These documentaries are conducted in a very covert, secretive manner and are promoted as sensationalist exposés of abuse of position and care. Positive representations of social care tend to concentrate on clients rather than the staff providing the care for example, ‘Care House’ broadcast by the BBC in 2004.

In contrast to the ‘public eye’ of the NHS, the care home sector can be conceptualised as the ‘private ear’ as the public tend to only hear about what allegedly occurs in care homes rather than having any direct experience.

“Yes, and lack of knowledge of what exactly happens in the nursing home. ‘Cos it’s not always them who pass through the nursing homes, most of them they haven’t. They just know it’s nursing homes, but what exactly happens in nursing homes they do not know. Or, nursing homes, they just look at it like they’re for the elderly, that’s all. Maybe wiping the poos and giving the feeds, that is it.”

Molly, 53, Care Home Staff Nurse.

As illustrated by the extract above, the care home sector, is a much more private, closed domain. As Heather indicated, it is not known what goes on behind closed doors by the public and by nurses who have not worked in the care home sector. The subtext of this comment can be construed as being negatively charged. This comment could mean she does not know what the work organisation and routine is in care homes, or that what occurs in care homes is poor nursing practice, which is what is actually stated in the remainder of the quote. This is especially surprising given that Heather worked in a care home, as an auxilliary prior to commencing her training.
"You do hear people, we have heard people in the past say that [pause] well I don’t know, I’m just making assumptions that patients aren’t well looked after in nursing homes or if they’re admitted to hospital, they may have a bruise on their arm but it could just be the fact that they are elderly. They do bruise easily but I don’t know. [...] I don’t know what goes on in nursing homes.”

Heather, 41, NHS Staff Nurse.

The problem that nurses working in care homes have to deal with constantly is the suspicion that they are abusing their clients, that the care they are providing is substandard and that they are not as professional as NHS nurses. This is exacerbated by the media’s negative portrayal of care homes in the UK.

Amy, like Monica quoted earlier in this section, reinforced the negative perception of nurses working in care homes, promoting the suggestion of a nursing hierarchy between NHS nurses who are higher up and care home nurses lower down. Rather than emphasising the positive aspects of working in a care home, she chose to identify with society’s perception of her, and stressed her qualified (my emphasis) status, giving herself some kudos she felt would not be awarded otherwise.

“Well like I said before, I feel I have to explain myself and then I walk away and think why, you know my daughter was saying in the car she was saying ‘I’m so proud of you mummy and I told my teacher that yes, my mummy works in a residential home’ and I, inside — I didn’t say it to R [her daughter], I wanted to say ‘but did you tell her I was an RGN? Did you tell her that, you know, I’m a fully trained nurse?’”

Amy, 46, Care Home Specialist Nurse.

Care home nurses were acutely aware of the negative perception of care homes and nurses who work in them. There was a tacit acknowledgement that in order for this situation to change, nurses themselves and their organisations have to change the perception of care homes. However, in the following chapter, I will suggest and explore that it is primarily society’s perception of the clientele - the older person - that impacts on care nurses’ professional identity.

“I think we have to take that on ourselves really, don’t we, get our names out there, show the good work that we are doing, the good stuff that happens in Care Homes really um, I think that that’s the only way you can change it.”

Shelly, 43 Care Home Nurse.
Although some care home nurses, in their interviews, have stated that they are not overly concerned that the public has a negative perception of them, I suggest this is a defence mechanism that shelters them from the lack of value that they are afforded.

“Oh, it doesn’t worry me one bit. You know, ‘cos this is the job I like doing and if I didn’t want to do it, I wouldn’t do it really, I don’t – it’s never been about you know, oh it’s lovely to be a nurse, it’s never been about that, you know just a job you know, that I like doing. I think it’s important, and if you don’t like it, don’t do it really.”

Darcey, 42, Care Home Nurse.

The following extract indicates that this care home nurse was also unconcerned about the public’s perception of her.

“It doesn’t bother me. The reason why I say it doesn’t bother me is I just come here, do my work and go. I don’t mind about what other people think about me, I just want my work, my residents – are they alright, do I make them feel like this is their home? They’ve nowhere else to go, this is home. I have to make sure I’m there for them, whenever they want me. That’s why I was talking about taking even taking extra duties, ‘cos I tend to be sort of protective, so we don’t get agency nurses, so you tend to be protective and I’m there for them, whether day or night, I’m there for them. So what other people think about me doesn’t bother me.”

Molly, 53, Care Home Nurse.

However, there was an alternative view that the stigma of working in a care home is receding, but remained pervasive.

“I think there used to be sort of working in the NHS, some of your colleagues, there was a bit of a kudos there. You know, that it was nursing – I don’t know how one would put it, but to work in a care home you know, you were sort of degraded sort of thing weren’t you, you know? But I think that’s changed a bit now. Well, I would hope it’s changed now ‘cos I’m working here! But no, I think it’s changed more now hopefully, yeah? And you can still play a good part in nursing homes whatever setting you’re in really. I think that stigma’s gone, hopefully a bit.”

Paula, 51, Care Home Sister.

It is not only stigmatisation by the public and society that occurs. Care home nurses still felt they were regarded as less professional, less committed, less knowledgeable and less capable by nurses working in acute care.
"Oh, yes, the stigma is still there. In fact you notice that on study days and conferences, whereby sort of, it used to be a very much them and us situation. Where those in the NHS, on the more acute side – it's traditional, came through our training as well, the care of the elderly was second best, where somebody went to end their retirement or went to retire."

Sam, 52, Care Home Specialist Nurse.

Yet Sarah, who worked in a care home prior to her current NHS position stated that she did not feel that nurses who worked in the care home sector are perceived differently to nurses working in the NHS. However, she did detail how they were indeed stereotyped as subordinate to NHS nurses as they are regarded as ‘downgrading’ and not being concerned about their career by working in the care home sector, which, for the nurses in this study was patently not the case although there are fewer promotion opportunities in care homes.

“I don’t think the nurses in the care home are perceived any differently. I mean what I will say [pause] there’s comments from other people that if you work in a care home um, it's more like part-time nurses and because it's local to them it's something they've just taken on board [pause] I think the perception of going into a care home is, is cutting down, being part-time, and no career development when you’re in a care home. A, because the organisation may not have the funds to develop your career, it depends on the care home, um, or B, the person who’s decided, well, I’ll cut my hours, they can't cut my hours at the NHS, therefore I’ll take something less and local by going to a care home.”

Sarah, 39, NHS Specialist Nurse.

There was evidence from the nurses in this study that this stigma of being a care home nurse was being gradually eroded. Nevertheless care home nurses did not experience the same public status that NHS nurses are afforded. Yet because of their professionalism and desire to make a difference, they remained committed to the nursing profession and to their organisation. The next section considers the issue of respect, recognition and being valued by their employers and may offer some explanation as to why nurses working in care homes are committed, not only to their profession but to their organisation.

9.5. Respect, Recognition, and Being Valued

Recent literature has addressed the issue of respect, recognition, empowerment and valuing of nurses, or the lack of, and its impact on nurse retention and recruitment.
(Faulkner and Laschinger 2008, Milton 2005, Laschinger 2004). Faulkner and Laschinger’s (2008) research in Canada demonstrated that nurses in acute hospital settings within the study did not feel that they were afforded the respect they felt they deserved. This sentiment of disrespect in nursing is supported by Buerhaus et al’s (2005) research with American nursing students. Although the issue of leadership was discussed earlier in section 9.2.3., there is a difference between the (micro-level) nurse/immediate manager relationship and the more (meso-level) ‘organisational’ attitude to nurses.

The themes of respect and being recognised for their contribution to the organisation and the profession were articulated by the nurses in my study. This was manifest in the manner in which nurses discussed how employers could improve the work environment and conditions for nurses, and encourage nurses to stay in the profession and within their current organisation.

NHS nurses did not feel undervalued by their colleagues or by their clinical line managers with whom they had immediate contact related to the day-to-day demands of nursing work. However, they felt undervalued by senior managers who were perceived as not having an understanding of their clinical role and who were remote from the clinical environment. In addition, the ‘system’ or overall organisational structure and context was blamed for a sense of dissatisfaction and lack of being valued, for example having to pay for car parking at work and difficulty of funding relating to study days were common themes in the data. Nurses resented that they had to pay to park at work and suggested free car parking as an incentive for the retention of employees. Access to study days was an additional issue that nurses felt needed addressing. In addition to making them feel valued within the organisation, continuing professional development was important to nurses as they saw it as essential to enhance their clinical skills, improve patient care and as a method of disseminating new practices to colleagues. Nurses reported training budgets were drastically cut and they had limited opportunity to attend courses that were discretionary and practice enhancing, rather than mandatory.

“I think I felt quite undervalued really at work. Not by my colleagues or my immediate manager, but by the system and by the Trust. As I said, there was
the issue about the parking, I'd applied for this study skills day – it was all sort of little things really. The study skills day I was told “no, I couldn't get time off for that” and yet it would benefit the Trust, me doing this course.”

Selina, 43, NHS Staff Nurse.

Valuing nurses' contributions and their dedication to their work was a recurrent theme in the data. Many of the nurses interviewed felt that they were not valued or recognised by their employers. Senior nurses in particular felt that their clinical judgement was undervalued by managers, who they viewed as placing targets and budgetary considerations before patient care.

“I think they [managers] need to make nurses feel that they're valued and I don’t think they always do make nurses feel that they're valued 'cos to have decisions made about care by someone else like a bed manager, who will say – ‘no, that patient doesn't need a side room’, and the nurse is saying – 'but the patient is dying'. I think that kind of thing does not give nurses the feeling that they are valued in terms of their decision making and their role.”

Stella, 44, NHS Consultant Nurse.

Experience of the restructuring process and the possibility of redundancy had a negative impact on nurses' commitment to their work organisation as nurses felt that they were simply part of the mechanistic process of health care rather than being valued for their individual contributions, as the following extract exemplifies.

“But on the other hand, the NHS, [pause] I don’t know [pause] my commitment to the NHS is very different. I don’t know that I am as committed to the NHS, and I think that – if you’d asked me when I qualified, “would I ever go and work in the private sector?” I would probably have said no. Whereas now I would say “yes”, because I do think the NHS is under such strain that to deliver the quality of care that I believe people should have, I think it's actually quite difficult. And I think my experience of the NHS having gone through the redundancy process is a bit jaded really.”

Hannah, 41, NHS Specialist Nurse.

Simone, had a similar experience of the restructuring of her organisation and this experience had left her with a sense of not being valued by the NHS for her work even though she had committed herself to the organisation and the profession.

“I think I've worked extremely hard for 26 years. I try and be loyal to the Trust, but actually I see too many things. […] And the NHS, that's just a title
isn’t it? It’s not a family. It’s just a business and they have no loyalty to staff, and I don’t have any loyalty to them either. Now’s the time for me. If I can do what I’m doing, because believe you and me, every day I’m here, I do my job really well, so it’s not like I’m not committed to my job when I’m here. I’ll do absolutely everything to the best of my ability and probably will have some positive influences out there, I just don’t see it all the time. But I’m just a little cog, which they might struggle without for a little while, but then they’d get by, ‘cos it would just be pushed under the table ‘oh, we won’t worry about that role anymore’.”

Simone, 45, NHS Manager.

Heather, in the following extract, exemplified the resentment that could be felt by NHS nurses because of the perceived lack of remuneration and lack of value that the government attaches to nurses, leading to a feeling of being exploited and reducing staff morale as a result.

“No. we’re just slaves. We’re slave labour. Working [pause] slave labour’s the word I’m looking for, yeah. You know, we work really hard, it’s a difficult job really. It’s physically and emotionally stressful, it can be, for peanuts [...] I don’t think the government really values nurses. All they talk about is cutting jobs or saving money. The NHS is always in the red. Well, I mean making staff redundant isn’t an answer. It will just cause a lot more animosity and low morale. You don’t want that, don’t need that ‘cos patients need to see a cheerful face. Not a nurse that keeps moaning.”

Heather, 41, NHS Staff Nurse.

This feeling of not being valued by the organisation was supported by another NHS nurse in a different NHS Trust, as can be seen in the following extract.

“I think just because they [pause] it becomes very apparent I think, maybe not the longer you work there but now, in this day and age, the way things are. That you’re just a very small cog in a big [pause] And I don’t think [pause] I mean, yeah, I don’t think [pause] they make you feel very important [...] the team does, the environment you’re in does, immediate environment but I don’t think the [name of the Trust] shows any appreciation of what staff do at all, to be honest. And a lot of that is just because everything revolves around budgets now and targets. So they’re just pushing all the time but they never [pause] you just never actually get any appreciation of what you do, I don’t think.”

Felicity, 40, NHS Sister.

The nurses working in the NHS spoke of their lack of recognition and the feeling of not being valued by their organisation or the government. Although they did feel
valued by their colleagues and line managers, what was evident from the data was that they felt they were expendable and that their efforts were rarely recognised above line manager level. Their perception was that more senior managers were primarily concerned with government policies, performance indicators and financial targets.

In contrast, the nurses in the care home sector discussed the ways in which their employers did value them and how this made a difference to their job satisfaction. Despite nurses’ salaries in the care home sector being lower than their colleagues in the NHS, this appeared not to be a significant issue for them, whereas feeling valued and appreciated appeared to be more important to them.

“You know, the majority of people are saying ‘give them [nurses] more money’ and give them this, give them that, but actually I don’t think they’d be stamping their feet and looking for money, if they were treated the way that BUPA treats me. If the NHS had treated me the way that BUPA treats me now, I would never have left the NHS. Why would you want to go anywhere else, if you are being treated like that? So that’s all they have to do. They’ve just got to, you know, make you feel wanted and cared for.”

Celia, 54, Care Home Manager.

This last extract illustrates the important contrast between NHS and care home nurses — there is less public status for care home nurses but more organisational support and status. The appreciation and recognition by care homes of the skills that nurses have developed has led to a sense of job satisfaction and pride for nurses as exemplified in the following case. Again, better pay was not mentioned by this nurse as a method of retaining or recruiting staff into the care home sector. Nurses need to feel that their knowledge, skills and experience are valued by their employers, an essential part of job satisfaction that encourages the retention of nurses.

“One of them’s asked me to do a report, which is quite nice. And I’ve had that a couple of times, not very often ’cos C [her manager] does them. She will do one as well, but she’s asked me to do a little report and that shows she recognises that maybe I’ve got some skills, that are advantageous to her as well. Because of being here 10 years, [that] time gives you respect as well.”

Kim, 53, Care Home Staff Nurse.
Whilst the nurses working in the NHS discussed how employers could improve their efforts at recognising, respecting and valuing their employees, and spoke quite negatively about their experiences, nurses working in the care home sector were more positive in their appraisal of their employers. As managers were more accessible to the nurses working in the care home sector and the home managers were empowered by their line managers to reward their employees in ways other than remuneratively, it was apparent from the data that care home nurses were more satisfied with their employers in terms of being valued, recognised and rewarded than nurses working in the NHS. This supports the work of Laschinger (2004) who demonstrated that in terms of recruitment and retention, respecting nurses’ professionalism has a greater impact than financial inducements to stay.

Conceptually, what the data highlight is that although NHS nurses appeared to have more public respect, recognition and value from the public than care home nurses (as discussed in section 9.4.) they did not feel their efforts were appreciated by managers within the organisation other than by their line-manager. This led to a feeling of lack of esteem, frustration and anger at their NHS employers leading to dissatisfaction with the organisation but not necessarily with their job. Despite the lack of recognition, nurses in the NHS still retained a sense of job satisfaction derived from their nursing role, working with their colleagues and the recognition they received from the public. Nurses in the NHS suggested that one way of retaining staff was for their work to be more recognised by their clinical and non-clinical managers rather than having increased salaries.

In contrast, nurses working in the care home sector clearly felt valued by their clients, their families and their line managers and if these nurses were at managerial level, by their area managers (in large organisations) or the owners of the home, yet they received little public support or recognition for their work. The support they received from the people they work with and for the organisations they worked for appeared to negate any sense of disappointment that their role was not more highly regarded within society. The nurses working in care homes indicated that being recognised and praised at organisational level contributed to their job satisfaction and was important in maintaining organisational commitment.
9.6. Conclusion
This chapter has analysed the organisational structure and context within which the study nurses worked, contrasting the organisational context of the NHS with that of care homes. It has highlighted that the concepts of bureaucracy, management and managerialism are elements which impact on nurses' organisational commitment in particular, the target driven culture, autonomy, and nurses' experiences and perceptions of leadership. Also analysed were the effects of working in the NHS versus care homes on perceptions of nurses' professional identity and its impact on nurse commitment, particularly nurses working in the care home sector whose professional identity is often negatively perceived by the media and the public.

The chapter has highlighted the importance of the critical concepts of respect, recognition and valuing employees. This appears to be the most important aspect that nurses value, but is one that is often overlooked by managers and leaders within organisations, particularly the NHS. The conclusion is that respect, recognition and valuing staff can help to secure nurses commitment to an organisation, as illustrated by nurses working in the care home sector.

Organisational commitment is individualistic, complex, contextual and situational. Nurses are often agentic in their approach to work, ensuring their individual, personal and professional needs are met. However, there are many commonalities to organisational commitment as demonstrated in this chapter, both intra-professional and inter-professional.

Although the concepts discussed in this chapter are important to nurses and relevant in explaining commitment, they cannot be taken in isolation. It is important to consider the combination of the concepts that have been analysed (in Chapters 7 to 9) in attempting to explain why these two groups of nurses have stayed in nursing or moved from the NHS to work in the care home sector. The following chapter, will offer a conceptual framework based on the concepts discussed in the previous chapters and will present an argument for the organisational and occupational commitment of the nurses in this study.
CHAPTER 10

Discussion

10.1. Introduction

The focus of this research study has been the comparison of mid-life nurses working in the NHS and the care home sector in the UK to analyse the factors that influence the organisational and occupational commitment of these two groups. The preceding four chapters have sought to provide an analysis of the data obtained from the interviews with the study respondents. This chapter will draw together the findings arising from the analysis into three conceptual themes: the main concepts derived from the data are professionalism; work-life/work-family balance; and the influence of organisational structure and context. These are compared and contrasted for the nurses working in the NHS and care homes to demonstrate the parallels and divergences between the two groups. This chapter will discuss the concepts in detail to indicate how these elements influence the organisational and occupational commitment of both groups of nurses in this study. Conceptual models are offered to demonstrate the interconnectivity of these themes and to explain the commitment of these nurses and the comparisons between them. The theoretical framework of social exchange will be used to frame this discussion chapter.

The conceptual model, Figure 10.1 below, suggests how the concepts of professionalism, organisational structure and context, work-life/work-family balance and side-bets can help explain NHS and care home nurses’ organisational and occupational commitment. Table 10.1 below, illustrates how the different sub-factors within each variable apply to NHS nurses and care home nurses.
Figure 10.1: A Conceptual Framework to explain NHS and Care Home Nurses 
Organisational and Occupational Commitment
Table 10.1: Convergences and Divergences Between the Variables used to explain NHS and Care Home Nurses’ Organisational and Occupational Commitment

<table>
<thead>
<tr>
<th>Professionalism:</th>
<th>NHS Nurses</th>
<th>Care Home Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Making a Difference</td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>• Using Skills, Knowledge and Experience</td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>• Remuneration</td>
<td>Higher in NHS</td>
<td>Lower in Care Homes</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Organisational Structure and Context:</th>
<th>NHS Nurses</th>
<th>Care Home Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respect, Recognition, Value</td>
<td>From society</td>
<td>From managers</td>
</tr>
<tr>
<td>• Autonomy</td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>• Nurse Leadership</td>
<td>Important</td>
<td>Important &amp; more evident</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work-Life-Family Context</th>
<th>NHS Nurses</th>
<th>Care Home Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work-life-family Balance</td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>• Flexibility</td>
<td>Formal mechanisms in place such as IWL</td>
<td>Nurses perceived greater flexibility than in NHS</td>
</tr>
<tr>
<td>• Career</td>
<td>Good &amp; varied</td>
<td>Poorer prospects than NHS and less varied</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Side Bets e.g:</th>
<th>NHS Nurses</th>
<th>Care Home Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social bonds with colleagues</td>
<td>Important</td>
<td>Important</td>
</tr>
<tr>
<td>• Pensions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual leave entitlement</td>
<td></td>
<td></td>
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<tr>
<td>• Flexible Working</td>
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Nurses in the NHS felt they were making a difference because they were using their accumulated skills, knowledge and experience. Some of the concepts that contributed to occupational and organisational commitment differed from those of care home nurses. These differences include that nurses in the NHS received higher remuneration than their care home colleagues. They also received recognition, respect and a sense of value from the public and their nurse leaders but not from middle and higher ranking managers within their organisation. They also had a high level of autonomous practice creating a sense of job satisfaction. Within the work-life-family context, some of these nurses had negotiated flexible working arrangements to meet their domestic requirements, especially if they had children, yet this has led to a feeling of inequity among nurses as not all employees are afforded equal opportunities. For NHS nurses there were often fewer career opportunities for
flexibility at senior levels which led to nurses being stuck in a role because they made a choice about promotion. They did not seek promotion because this meant leaving clinical practice for managerial posts which they did not want to do.

Nurses working in the care home sector still felt they were making a difference. They were using their accumulated skills, knowledge and experience, but had fewer financial rewards and lower public status. However, they felt they had a better working relationship with their nurse and line managers, autonomy and had less interference from central government in the form of performance indicators and targets. In terms of work-life-family context, they had flexibility, which was negotiated at a local level and less conflict because they have not had their expectations raised and not met by the Improving Working Lives policy (DOH 2000a), unlike some of their NHS colleagues. Nurses working in care homes did not have the career opportunities that are afforded to NHS nurses and the status that can accompany this, e.g. specialist nurse or matron. However, paradoxically they have greater freedom in their careers as they have a more generic role which gives them greater flexibility and opportunity to move to other care homes should they wish to.

The following sections will expand on these concepts and explicitly compare and contrast the NHS nurses’ experiences and perceptions of their work with that of care home nurses to explain how these concepts constitute commitment for both groups of nurses.

10.2. Organisational Structure and Context
The two organisational structures studied vary considerably. The NHS is a monolithic, bureaucratic organisation that is centrally controlled and managed (Thompson 1991), and the largest employer in the UK (Watson et al 2003). There are benefits to this type of organisational structure in terms of efficiency, yet the costs to nurses, as evidenced by this study, were that they felt they had no voice and relatively little power in the relationship they had with the organisation which was controlled in a managerialist way.

Care homes are much smaller enterprises with managers in individual homes usually having greater autonomy. Whilst care home nurses enjoyed a much closer relationship with their managers and felt they had more of a voice, they had less power in their
relationship with the public, in terms of public perception of their image. NHS nurses enjoyed a much more privileged position than their care home colleagues, as the general public hold them in higher esteem. The perception of and value of nurses working in care homes, is often based on the largely negative media attention that care homes receive. The work performed in care homes is in one respect mysterious to the public as care homes operate outside the public domain, unlike the NHS. Although the public may have the impression they know about the nature of care that occurs in care homes, they regard it as unskilled work, not requiring specialist nurses, as discussed in Chapter 9. The care home sector also falls under the auspices of social care, rather than health care, even though some clients have complex nursing and health care needs, which suggests to the public that clients only require 'social care'. This is compounded by the government-instigated name change from nursing and residential homes, to the umbrella term 'care home'.

The erosion of professional knowledge and trust is an issue that affected both nurses working in the NHS and those in the care home sector. However, I would argue that the public trust in care home nurses has been affected more than NHS nurses due to the constant negative portrayal of care homes within the media. Media attention repeatedly focuses on the quality of care provided by care homes (Donald et al 2008). Care home nurses in this study related how they perceived their professionalism was constantly questioned when these negative media reports emerged. This is in contrast to nurses working in the NHS who acknowledged that although the NHS receives some negative media attention, this is mediated by frequent positive reports of medical and nursing care and the perception by these nurses that the NHS is viewed favourably by the public. This, in turn, creates a more positive identity for NHS nurses than for care home nurses. Hence, the negative media attention creates an inferior image of care home nurses, and consequently the professionalism of care home nurses is questioned.

10.2.1. The Importance of Financial Motivation

The underlying motivating factor for both groups of nurses who participated in this study was that of financial reward. With the exception of two nurses working in the NHS, all admitted that they worked to earn a living wage. However, it cannot be concluded, as illustrated in Chapters 7 and 9, that nurses are exclusively working for
financial reward and this is not what promotes occupational or organisational commitment, supporting earlier literature (Fagin 2001, Natale and Rothschild 1995, Sverko and Vizel-Vidovic 1995). If nurses engaged in employment exclusively as a financial exchange, and the attainment of income was a paramount motivation, as suggested in economic exchange theory (Zafirowski 2003), it does not explain why nurses have left the NHS for less well paid work in the care home sector or do not enter management, choosing instead to remain in clinical roles. If care home nurses engaged in work purely for financial reasons they would choose to stay in the more financially rewarding sector, which in the case of these two groups of nurses is the NHS.

As nurses do not remain committed to their employers purely for financial motivations, an alternative explanation must be sought. This, I argue, is a combination of the organisational and professional factors analysed in Chapters 7, 8 and 9, especially in the case of nurses working in care homes, who have rejected more financially rewarding conditions of employment to work in an organisational structure and context that fulfilled other aspects of their work needs.

10.2.2 The Effect of Managerialism on Nurses’ Organisational Commitment
The effect of managerialist policies has been well documented and debated within health care and sociology (Harrison & Macdonald 2008). However, the debate has concentrated on the effect of managerialism within the NHS, where these policies have in particular sought to limit the power, dominance and influence of medical practitioners. The debate has paid little attention to the case of care homes in the UK. Lymbery (1998) discussed the effects of new managerialism within the context of the social work profession and its effects on social workers, but did not address nurses working in care of the older person. Chevannes (2002) indicated how health and social care professionals are affected by this ideology and the effects managerialism has on those older persons receiving care outside the NHS but within the health and social care environment.

Whilst nurses working in the care home sector have not been insulated from managerialist ideology, the NHS nurses participating in this study articulated to a much greater extent than nurses working in the care home sector that managerialist
policies are adversely affecting their working practices. Nurses working in care homes explicitly stated that the political climate and their lack of ‘voice’ within the NHS contributed to their reasons for leaving the NHS to work in care homes. They demonstrated that they had been prepared to sacrifice status, income and kudos to have their work needs met, for example, a less stressful working environment, having a voice within their organisation, being able to give the care they wished to give as a professional, and gaining work hours to suit their domestic needs, as discussed in Chapters 7, 8 and 9.

That is not to deny that the detrimental effects of managerialism do not exist within the social care environment, as the rhetoric of managerialism has infiltrated care home work. However, the care home nurses in this study recounted fewer adverse experiences of managerialism with less frequency than those working in the NHS. Indeed, the reason why some of the nurses had transferred from the NHS to the care home sector related to their dissatisfaction with the managerialist practices and political ideology of the government concerning the running of the NHS and so they elected to leave (see Chapter 9).

Previous research studies support the assertion that effective nurse leadership has a positive effect on nurse retention in the NHS (Mrayyan 2004, Kosinksa and Niebroj 2003, Watson et al 2003). However, the nurses working in the NHS, when discussing leadership and management, acknowledged support from nurse managers, but tended to focus on the negative aspects of the middle and higher management role — budget cuts, inability to access study days, time and resource constraints experienced. What also was apparent was the large distance that nurses, especially those at ward level, perceived between themselves and nurse and business managers who had no clinical interests. McGuire and Kennerly (2006) indicated that the nurse leader’s approach to their role can have a significant impact on organisational commitment — those who show an interest in their staff’s development (‘transformational’ leaders) can positively influence attitudes to their organisation as opposed to ‘transactional’ leaders, whose leadership style is based on goal setting and rewarding achievement of these goals.
Although nurses working in the NHS verbalised their dissatisfaction with the managerial processes that permeated the organisational context of the NHS, they were not sufficiently dissatisfied with it to leave. However, although nurses may have accepted these constraints on their practice and the constraints might not be a catalyst for nurses leaving the NHS, nurses were prepared to vocalise their discontent within their interviews.

One of the areas of discontent voiced related to the professional and organisational distance between managers and nurses working at the ward level or those having significant patient contact. Junior nurses working in the NHS perceived a hierarchy with much more distance between themselves and their line managers compared with those in middle management. Nurses who occupied the more senior levels of management within the organisation were perceived by some junior nurses as even more remote and as having little direct contact or concern with the day-to-day professional concerns of nurses at patient interface level. The more senior NHS nurses indicated that they had more opportunities to access middle and senior managers. For them, managers were less remote and more accessible, but they conceded that this access was because of their level of seniority as a nurse. McCartney et al’s (1993) research supported the notion that nurses resented the introduction of managerialism and regarded managers with suspicion, resulting from a lack of understanding of managers' purpose and function and regarding cost cutting as the main purpose of their role. Professional distancing by managers was also perceived to be occurring by the respondents in this study, which McCartney et al (1993: 52) suggested is because “managers are by definition, not directly involved in patient care”. McCartney et al (1993) indicated that this is symptomatic of health professionals’ lack of understanding of the role of managers within the NHS.

Nurses working in the care home sector, however, had a much closer professional working relationship with their managers. This was due to the hierarchical structure of the organisation having fewer levels and nurses having greater access to their immediate managers. The managers working in the care homes involved in this study were all qualified nurses working in a managerial role. The perception by nurses of the managers working in the care home sector is that they are more concerned with, and more involved in patient/client care than managers in the NHS. This was because
in addition to their managerial responsibilities, they were more likely to be involved with clinical decision-making or supporting nurses making clinical decisions.

I argue that, for the nurse respondents working in care homes in this study, there was less obvious managerialist practice within the care home sector, and the closer working relationship that exists between nurses and management created an environment that aligned itself with the nursing ideology rather than the managerialist one. This creates an environment where the professional concerns and ideals of nurses were supported.

Within the social exchange theoretical framework (Homans 1958, Blau 1964, Emerson 1972, 1976), nurses expect some form of reward in exchange for their labour and commitment. This took the form of "rational or emotional, instrumental or intrinsic, and has physical or symbolic value" (Nelson 2000: 40). When there is the perception that there is an imbalance in the relationship of reciprocity in favour of the organisation, what Nelson (2000) described as an 'asymmetrical relationship', this social exchange mechanism can disaggregate and can lead to employees making the decision to leave the organisation, as in the case of some of the care home nurses, who had left the NHS. This is what Berger (1994) termed the 'mobility principle' whereby if the weaker actor (in this case, the nurse) in the social exchange is not able to change the actions of the stronger actor (the organisation), the weaker actor can choose to terminate the relationship, what is known as 'fate control'. Six of the care home nurses in this study chose to enact 'fate control'. They had chosen to control their fate by leaving the NHS, as they were unable to accept the demands that the NHS as an organisation was placing upon them in the pursuit of fulfilling their professional role (see Figure 9.1).

10.2.3 Organisational Support for Flexible Working
The concept of improving work-life balance through flexible working practices has been debated widely (Ansari 2007, Hall and Atkinson 2006). The concept of work-life/work-family balance was explored in the narratives of the respondents, and deemed important to the nurses in this study. In recent years, NHS nurses have been offered improved opportunities to combine work with childcare (eg. term-time contacts, annualised hours). Prior to the advent of government initiatives such as
Improving Working Lives (IWL) (DOH 2000a), NHS nurses negotiated flexible working practices at a local level. This included arrangements such as working nights only, weekend, twilight shifts or obtaining employment which facilitated working ‘9 to 5’ hours such as community, clinic and practice nursing.

The introduction of IWL has served to increase expectations of nurses working in the NHS for flexible working practices to be made available to all. The initiative’s intent was to offer flexible working to all NHS employees, yet the data in Chapter 8 indicate that for some of the NHS nurses in this study, these expectations have not always been met, a finding that is consistent with Wray et al’s (2006) research. For some NHS nurses, there was a sense of inequity about the initiative, with the perception that IWL was afforded only to those with children or those caring for dependant adults, despite the assertion and perception that IWL offered flexible working to all. Hall and Atkinson’s (2006) research investigating NHS employees’ perceptions of flexible working, suggested that uptake of flexible working practices primarily occurred on a more informal rather than formal level and this supports the findings of my research. Flexible working is still negotiated at a local level in both the NHS and care home groups. Whilst the IWL initiative was not applicable to those working in the care home sector, informal flexible working practices were negotiated by the nurses who required flexibility in their work hours to meet their family needs, as discussed in Chapter 8.

The formal negotiation of flexible working patterns in the NHS created tension and conflict among nurses in this organisational context, as the values of fairness and equity have been perceived as not upheld by both those who were eligible to request flexible working and those who perceived they were not. This is in contrast to care home nurses among whom there was no evidence of tension as all nurses had to negotiate their working hours according to the same principles. Consequently, the unintended consequence of the IWL initiative in the NHS was the friction between nurses as expectations of fairness were not met. For nurses working in the NHS, the allocation of IWL flexible working was perceived to be on a first come, first served basis and a recognition that not all employees could work child-friendly hours at the expense of the needs of the organisation, patients and colleagues. This sense of organisational injustice or inequity experienced by the NHS nurses in this study is
what is known, in social exchange terms, as ‘blocked exchange’ (Nelson 2000) and can lead to intra-professional conflict when individuals perceive that their needs are not being met, yet others’ similar needs are. The other side to this is that nurses with children who have found IWL indicates that IWL has perhaps kept them in nursing.

As argued at the beginning of this chapter, the convergence between the two groups of nurses with regard to work motivation was that they were both instrumentally orientated. It is well known that care home work is less well remunerated financially than the NHS. I assert that nurses who wished to work part-time, opted to work in the NHS as the remuneration and conditions of service are more favourable than working in care homes. I argue that the organisational structure of the NHS is much larger than that of a care home and the opportunities for flexible and part-time working more abundant. I also contend that future career options may also be more flexible for part-time nurses who wish to increase their working hours as there may be better potential prospects for career advancement in the NHS.

10.2.4 Flexible (part-time) Working and Commitment

In terms of commitment to organisations and occupations, the data from this study supports the earlier findings that part-time workers are no less committed than full-time employees (Jacobsen 2000), that women working part-time demonstrate equal commitment to their organisation and occupation as those working full-time, refuting Hakim’s (2000, 1997) assertion that women working part-time are not as committed as their full-time colleagues. However, for those nurses working part-time who have children, there appears to be greater dual-role conflict than for nurses without children living at home. The nurses in this study affirmed that the traditional domestic division of labour still exists, even among those with partners who ‘assisted’ in the domestic sphere. When children became ill at school and needed parental intervention, the nurses admitted it was they that the school contacted in the first instance, even if they were unable to leave the workplace as requested, as in the case of the ITU sister who, when on duty was the only senior nurse rostered and could not leave. The nurse-mothers also acknowledged that they were the domestic organisers, the diary keepers and maintained the organisation of the domestic division of labour in the private sphere.
10.2.5 Respect, Recognition and Valuing Nurses

However, whilst the nature of organisational structure and context can explain why nurses demonstrate organisational commitment, it does not adequately explain why nurses display occupational commitment. This will be explored in this section.

As outlined above and in Chapter 9, the organisational structure and context can have a positive or a negative effect on nurses’ decisions to stay in nursing. Nurses are dependent on these organisational structures to provide employment. Yet there is the expectation by employees that their efforts are recognised in some form, not just in terms of financial reward. One of the main findings in this study is that recognition, respect and being valued was as important as financial remuneration. Social exchange theory (Blau 1964) and the norm of reciprocity (Gouldner 1960) have been used to explain employees’ motivations and behaviours. The theory of social exchange suggests that when actors engage in social exchanges, there is the expectation that reciprocity will ensue. These concepts have also been used to explain organisational commitment (Settoon, Bennett and Liden 1996). In the workplace, two types of social exchange relationships exist - global exchange relationships which exist between employees and the organisation, and dyadic relationships which occur between an employee and their line manager, the level of perceived support having an impact on employee performance, behaviour and commitment (Eisenberger et al 1997).

The issue of respect, recognition and valuing nurses’ contribution to the organisation at macro (the NHS or Company), meso (Trust or individual care home) and micro (ward/team) levels is an important element in nurses’ job satisfaction. It was an aspect that both nurses in the NHS and care homes raised as an important contributing factor that motivated them to stay within their organisations. Taylor (1994) stated that recognition is a basic human requirement rather than simply a consideration for others.

Nurses working in the NHS felt valued at the micro level yet felt their contribution was not necessarily recognised by middle management and at board level. However, this was more likely to be the case for more junior and ward based nurses. Nurses with a degree of seniority, for example, specialist nurses who had greater contact through departmental meetings and board meetings felt that their contribution was
recognised. They felt valued and respected as they had a forum to convey their views, had increased contact with greater numbers of managers and health care professionals and were more visible within their organisation. These senior nurses were also more empowered as their status had conferred a degree of authority and this had been sanctioned by those managing the organisation.

Research studies have corroborated the link between respect, recognition and valuing employees, empowerment, employee commitment (Faulkner and Laschinger, 2008, Laschinger et al 2001), and job satisfaction (McGuire et al 2003). Not only has respect been linked to greater job satisfaction and commitment but also to improved job performance and nurses’ work-life quality (Milton 2005, Laschinger 2004, Laschinger and Havens 1996).

The nurses in this study, both in the NHS and the care home sector, cited recognition for their efforts as one of the ways in which employers could improve retention of nurses. This appeared to be one of the key features that nurses wanted to see from employers and also to some extent from clients and patients. The issue of respect, recognition and value links to the issues of de-professionalisation and managerialism. As managerialism has increased in the health care sector, managers have sought to control health care professionals and therefore registered nurses through the routinisation of work, the increased use of health care assistants (especially in care homes), and increased surveillance. This can lead to feelings of alienation and disempowerment. The findings of Daykin and Clarke’s (2000) study into organisational change and skill mix concluded that nurses’ views were not taken into account when deciding to implement change. However, I would argue from the findings in this study that senior nurses can have an influence on management decisions.

In addition to recognition within the workplace, I would argue that recognition and perceived support from the public and society is important to nurses’ occupational commitment. Although recognition, according to Honneih (2003) is afforded in the ‘public sphere’ of work, I would also suggest that in the case of these two groups of nurses, there exists an alternative social construction of the ‘public’ and the ‘private’ spheres. In this context, ‘public’ relates to the NHS, and ‘private’ relates to the less
visible care home work. Nurses working in the NHS are visible to other actors; society has a tacit understanding of health care practice within the hospital as most people have usually had some form of contact with hospital services during their lifecourse. However, there is a tangible lack of understanding of nursing practice that occurs in the more 'semi-public' sphere of the care home environment.

I would argue that the (negatively) socially constructed norms and values that society holds of older, non-economically productive people within Western cultures contributes to the more negative value placed on nurses working with older people in care homes. Those who are older, retired, dependant/disabled are not valued in Western cultures (Heath and Schofield 1999), and consequently the work of nurses in care homes is devalued. Heath and Schofield (1999) suggested that the reasons for the older, dependant, non-economically productive sector of our society not being valued is rooted in the historical social construction of the older poor and their historical connection with the workhouse.

Nurses generally perceived the public’s perceptions of nurses in the care home sector as negative as shown in Chapter 9 whereas managerial support was perceived a positive. I would therefore argue that it is more important for care home nurses to feel they have a positive manager and colleague support network within the organisation to offset this lack of perceived support by society and this has occurred for the nurses in this study. In contrast, NHS nurses are given much more public support, yet perceive managerial support to be less visible and more remote.

10.3. Professionalism and the Role of Caring

"The professional is motivated by service to the community rather than by the anticipation of immediate material reward; altruistic values predominate over egoistic inclinations."

(Turner 1993:14)

The nurses in this study have demonstrated occupational commitment, through the years they have spent in nursing which ranged from 16 to 39. Nurses working in both organisational structures have exhibited a high level of occupational commitment and the themes of professionalism, the art of caring, using specialist skills, knowledge and
expertise and continuing professional development are elements that influence NHS and care home nurses to remain in nursing. Each of these themes will be discussed in this section.

10.3.1. Professionalism: wanting to make a difference
One of the most common themes to emerge from the data was the professional and often altruistic desire by nurses to make a difference to their patients’ lives. One of the central features of the definition of a profession is that it is altruistic in its practice and provides a public service (Haralambos and Holborn 1995). A major commonality that was exhibited by both groups of nurses was that their own perception of ‘making a difference’ contributed significantly to nurses’ job satisfaction. However, this satisfaction was mediated by the reciprocal social exchange that occurred between nurses and their patients. Patients received professional nursing care and nurses received an emotional reward from the exchange, this is ‘making a difference’, which is seen as a positive outcome from the exchange.

However, if there is a constant negative outcome from repeated social exchanges with patients that results in perceived negative outcomes for the nurse, as occurred in some narratives of care home nurses who opted to leave the NHS, the option of ‘fate control’ can be activated and nurses chose to leave the NHS. Three nurses exemplified this; they had left the NHS because they felt frustrated that that they were not able to fulfil their professional role effectively, and the care that they were giving to their patients did not meet the standards expected of the profession or their personal standards. This links to the concept of emotional labour in nursing. Emotional labour is an integral component of nursing care (James 1989, 1992). Deery and Fisher (2009) indicate that the emotional aspects of autonomous clinical practice within health and social care are important but little recognised, and suggest that developing a better understanding of the emotional labour involved in clinical practice is needed to maintain the commitment of employees. Fisher and Owen (2008: 2065) posited that there is a ‘creative tension’ between the managerialist demands of an organisation and the professional, personal and practice based interventions that are constructed when providing care, and that these tensions need to be reconciled for practitioners to be satisfied.
10.3.2 Economies of Performance and Ecologies of Practice and Emotion Work
Stronach et al’s (2002) perspective on how professionalism is negotiated within the organisational and occupational context - ‘economies of performance’ and ‘ecologies of practice’ is relevant to the data in this study. Stronach et al (2002) indicated that ‘economies of performance’ are the elements of an employees’ work that employers attempt to measure such as “quality, effectiveness and outcomes” (p132) whilst ‘ecologies of practice’ are the “individual and collective experiences, beliefs and practices that professionals accumulate in learning and performing their roles” (p132). ‘Ecologies of practice’ are also referred to as ‘craft knowledge’.

Parallels existed for both nurses in the NHS and in care homes as they tried to temper the ‘economies of performance’ – having to work within the framework of clinical governance, performance indicators, National Service Frameworks, and audit practices at the same time as the ‘ecologies of practice’ – their personal experiences within their working environment, nursing ideologies and policies (Stronach et al 2002). Stronach et al (2002) posited that the lived experience of this tension is what creates professionalism. These authors also postulated that it is the very fact that these ‘economies of performance’ exist that creates the necessity of ‘ecologies of practice’, that “the ‘economy’ has to be ‘ecologised’ for professional performances to be motivated and to take place” (p128). In this study, nurses spoke of the difficulties of managing the needs of the organisation and trying to reconcile them with their professional ideology which created tensions in their professional practice. However, despite having to operate within these ‘economies of performance’ this motivated their professionalism in that they did not want to compromise the emotion work they wanted to engage in with their patients.

Nurses in both sectors described the tensions and conflicts that occurred in their attempts to fulfil their role obligations – especially not having enough time, staff or resources to give ‘proper’ nursing care. Here, the tension between the ‘economies of performance’ – the temporal aspects, budgetary constraints and poor skill-mix are combined with the ‘ecologies of practice’ – the nurses’ repeated experiences of these conflicts with their ideology of what constitutes good nursing care and are in overlap. NHS nurses particularly spoke about the pressure that performance targets placed on them and how they felt it conflicted with their professional ideology of care. The
organisational constraints conflict with the nurses’ desire to give high quality nursing care and there was a constant struggle to reconcile the two, supporting the arguments of Deery and Fisher (2009). The nurses in this study acknowledged that organisational constraints were unavoidable and their interviews indicated that their professionalism was a method of rationalising the divergence between ideology and reality - a philosophy of ‘we do the best with what we have, but we could be doing it better.’

The conflicts that nurses experience in contemporary health and social care contexts are, as Corbin (2008) suggested, in discord with the art of caring. The pressure to achieve targets and the increased workloads were felt by nurses to be in conflict with their emotion work. NHS nurses wanted to engage in ‘deep’ acting (Hochschild 1983) when providing care but were constantly aware of the constraints placed upon them to achieve performance targets. This is consistent with James’ (1992) assertion that the organisational context in which care is delivered is important. James (1992) compared hospice work to care given in a patient’s home environment however, similar parallels can be drawn with the work of NHS nurses in this study and care home nurses. James (1992) argued that the home environment gave greater flexibility than the hospice environment to engage in emotion work. I would argue that the care home environment gave nurses greater flexibility than the NHS as there were fewer organisational constraints, such as excessive performance monitoring, placed upon care home nurses.

10.3.3 Nurses and De-professionalisation

When considering the de-professionalisation debate, I would argue that in the case of the nurses in this study, de-professionalisation has been somewhat limited. Storch and Stinson (1988) asserted that nurses have become de-professionalised in three ways, a gradual deskilling through routinisation of work and loss of expertise via the increased use of health care assistants, proletarianisation occurring through loss of power and autonomy, and the erosion of professional knowledge and trust.

In the case of NHS nurses, analysis of their narratives and career biographies indicates that they consider themselves to have become more skilled through continuing professional development and accrual of clinical expertise during their working life as
a nurse. There is little evidence that they consider their work to have become routinised and colonised by health care assistants.

Nurses in the NHS who have become clinical nurse specialists, managers or equivalent, have acquired a more autonomous role with the advent of consultant nurses and the expansion of the clinical nurse specialist role. This contradicts the argument that nurses, through the process of de-professionalisation, have become deskill ed (Storch and Stinson 1988). The conflict approach to sociology of the professions has been criticised for exaggerating the proletarianisation of professional groups with opponents of this argument suggesting that professional practice is becoming more rather than less skilled (Jones and Stewart 1998). The data from this study supports the argument that NHS nurses are becoming more rather than less skilled through continuing professional development.

In comparison, whilst nurses working in the care home sector have been included in the attempts to professionalise the occupation, nursing work in care homes has always been somewhat routinised for registered nurses. Care assistants have always been a feature of care homes and have been used to cut costs and increase efficiency (Perry et al 2003). This increased use of care assistants has been exacerbated by the shortage of qualified nurses wanting to work in the care home sector, according to some of the managers interviewed. Managers and matrons of care homes who took part in this study affirmed the difficulty of recruiting UK qualified nursing staff. Care homes have attempted to and continue to control and minimise costs, especially in the case of homes accepting local authority funded clients, due to capping of fees by local authorities and the desire to maximise profit by owners.

The work of care home nurses has always been regarded as less skilled than that of NHS nurses. Whilst it must be admitted that there is no comparison between a nurse who works/specialises in for example, ITU, ophthalmology or neurology, who has more advanced technical skills than a nurse working in a care home, this is not surprising. However, I would argue that less technical skill does not mean poorer nursing skills. The care of the older person outside of the NHS is not regarded by the media and the public as requiring specialist nursing skills, as discussed in Chapter 9 (care home nurses are seen as little more than ‘bottom wipers’). Yet there is a paucity
of empirical research which examines or elucidates the case of de-professionalisation within the care home sector. Evidence from this study demonstrates that nurses working in this sector are attempting to change this by engaging in continuous professional development, to gain further skills and expertise and are as committed to improving professional practice as nurses in the NHS.

10.3.4 Conflicting Social and Professional Identity

The concept of commitment and professional identity is under theorised according to Bennett et al (2007). Stronach et al (2002) attempted to address this and theorised that nurses struggle with several professional (and personal) identities and that the plurality of roles needs to be recognised. Certainly in my study, the narratives of nurses in both groups revealed competing professional identities - for example, that of colleague, team-worker, autonomous practitioner, administrator, line manager, subordinate, in addition to the personal identities of friend, mother, wife, and daughter.

However, in my analysis, the main divergence between nurses working in the NHS and those working in the care home sector is that of professional and social identity. Nurses working in the NHS have very strong professional and social identities whereas for nurses working in care homes, their inter-professional identity is strong (amongst colleagues and other nurses) but their social identity is much weaker representing what Stronach et al (2002: 118) term “non-identity”. Whilst both groups of nurses exhibit these plural identities, for nurses working in care homes their work is less recognised by society than the work of NHS nurses and this may be as a result of the value society places on the clients they care for and also their ‘invisibility’ as a professional group. However, as established in Chapter 7, care home nurses’ skills, knowledge and experience was cited as a reason for remaining in nursing. Just because they have different skills to NHS nurses does not mean they are any less skilled.

One of the most striking contrasts between the two groups of nurses in this study is the way that their professional identities are constructed according to the situational context of their organisational and occupational locations. Nurses working in the NHS felt that they were positively perceived, on the whole, by their colleagues, patients,
public and the media, creating a strong professional identity and a certain pride in being occupationally identified as a nurse. Nurses working in the care home sector did not relate a strong positive social identity, felt they were regarded negatively by the public and the media, but paradoxically this did not create tension or concern because they ‘knew’ that they were ‘doing a good job’ and fulfilling their role as professional care-givers. They also related that they received the recognition they needed from their colleagues, clients and their clients’ families. I would argue that although these nurses are receiving recognition in the form of reinforcement from colleagues, managers, clients, families and friends, the nurses working in the care home sector do desire recognition as professionals from society.

I argue that the lack of identity of care home nurses as professionals is reinforced by the confusion caused by the aggregation of residential homes and nursing homes into one umbrella term ‘care homes’, as stated by one care home manager. This ‘genericisation’ has damaged the professional and already fragile social identity of registered nurses working in nursing homes and residential homes. This has contributed to the de-professionalisation of nurses working in this sector in that their work is regarded as more social care than health care, despite the increasing dependency and more complex nursing needs of clients who require professional care. Their work has also become increasingly task orientated as they undertake the work that nursing auxiliaries/health care assistants are not qualified to perform. Nurses working in care homes have been somewhat excluded from the de-professionalisation debate, as all nurses have been treated as one homogenous group.

Some of the nurses working in the care home sector stated their need to validate their professional status and identity by alluding to how, when discussing their occupational and organisational role to those outside and within the profession, they tend to justify their statement by emphasising that they are qualified nurses (my emphasis) working in a care home, to ensure that their status is not in doubt. This contrasted distinctly with the nurses working in the NHS who did not demonstrate a need to justify their professional identity. This is because there is little ambiguity in the role of a nurse working in the NHS compared with that of a nurse working in the care home sector; the identity of professional is automatically conferred on NHS nurses by society as opposed to care home nurses.
Adams et al (2006) indicated that although people inhabit a variety of groups at any one time in their lives, the professional group can be the most important. They also posited that within the framework of social identity, professional identity is affected by exchanges within certain organisational groups and is associated with the perceptions of group members about the similarities and differences between themselves and other groups. Jenkins (1996:24) said that:

"It is possible for individuals to share the same nominal identity, and for that to mean very different things to them in practice, to have different consequences for their lives, for them to 'do' it differently"

This is evident in the case of NHS nurses and care home nurses. Both groups of nurses may nominally possess the same professional identity however, the data indicate that their experiences as professionals and their social identities as nurses were different.

When nurses in this study considered their own professional identity and that of the other group of nurses there was consensus; both groups recognised the other's professional strengths. NHS nurses acknowledge and recognise care home nurses as specialist professionals in the care of the older person and care home nurses recognised the expertise of NHS nurses as specialists in acute care. However, care home nurses’ perceptions of NHS nurses are that they had greater opportunities to access some of the tools of professionalism such as study days and opportunities for continuing professional development (as outlined in Chapter 9).

To conclude this section on social and professional identity, care home nurses are disadvantaged in many respects compared with their colleagues in the NHS. They have a much weaker social identity in terms of their role as a professional, which I argue is a result of a combination of the society’s lack of understanding of their role and professional qualifications, and the invisibility of their work relative to that of nurses working in the NHS. This, coupled with the aggregation of nursing homes and residential homes under the umbrella term 'care homes', which fell under the social care inspectorate, has further confused society’s perception of care home nurses as not as qualified or as able as NHS nurses.
10.4. Side-bet Theory and the Construction of Commitment

The concept of side-bets (Becker 1960) posited that individuals remain in jobs because the costs of leaving outweigh the benefits of staying in the job is evident in this study. However, a side-bet is a bet that is lost if the main bet is lost, so if the job is lost, the employee loses the pay, the prestige, pension, the sense of a job well-done, social bonds with colleagues etc. I have not sought to quantitively test Becker’s ‘side-bet’ model as previous authors have done or develop a model of commitment (Powell and Meyer 2004, Meyer and Allen 1984, Ritzer and Trice 1969). However, there is evidence that for nurses in this study, organisational and occupational commitment was not simply a result of the organisational structure and context. Professional factors discussed earlier in this chapter – financial motivation, leadership, reciprocity, using professional skills and expertise and achieving flexible working arrangements - were instrumental in ensuring commitment.

As discussed in Chapter 2, Powell and Meyer (2004; 174) expanded on Becker’s work and identified side-bets more comprehensively as:

- ‘expectations of others’ (managers, company-workers, community, family and an obligation to reciprocate towards the organisation);
- ‘self presentation concerns’ (prestige of working for the organisation, reputation, status, social image);
- ‘impersonal bureaucratic arrangements’ (level of pay, benefits accrued from seniority, opportunities for promotion, pension rights);
- ‘individual adjustments to social position’ (training and development, time involved in updating skills, learning the policies and procedures of the organisation);
- ‘Non-work concerns’ (issues affecting family, friends and community as a result of leaving the job);
- ‘Satisfying Conditions’ (enjoyment, social bonds with colleagues, positive treatment by managers, content with organisational ideology);
- ‘Lack of Alternatives’ (unavailability of comparable jobs, possibility of unemployment).
Powell and Meyer’s (2004) research into side-bets resonated with the nurses interviewed for this study - that for most nurses, the reasons for staying in nursing outweighed the option of leaving the profession. Although Powell and Meyer’s (2004) research measured organisational commitment, I argue that in the context of this study, side-bets can be seen to affect occupational commitment to nursing. For many of the nurses working in the NHS, this can be equated with ‘impersonal bureaucratic arrangements’. The salary gains which have been accrued through promotion - 34 of the 50 nurses interviewed were sisters, nurse specialists, managers or equivalent and on salaries of (approximately) £25,000 to over £40,000. Other aspects of impersonal bureaucratic arrangements for NHS nurses included pension entitlement and flexible working arrangements. However, also apparent from the NHS nurses’ narratives was the ‘lack of alternatives’ element of Powell and Meyer’s (2004) side-bet category. NHS nurses discussed the dearth of available jobs with a level of salary and seniority comparable to their current levels of pay and seniority (and/or benefits associated with their role) that they were receiving in the NHS. These nurses were not prepared to leave their jobs unless they could match their current conditions of service or improve them.

Remaining in nursing because of a competitive salary above the national average, especially for women, was construed by some nurses as being ‘trapped’. This and also other less positive reasons that the respondents gave for staying in nursing, suggested a concept of entrapment in nursing. Due to extended occupational tenure (16 to 39 years) there existed a feeling of ‘not being trained for anything else’, not having the confidence to do any other job, or the expressed perception that they did not have the skills to perform any other type of employment despite the transferable management, administrative, and interpersonal skills that nurses have gained throughout their training and careers. These themes were analysed in Chapter 7. These feelings of entrapment were expressed only by nurses working in the NHS. Feeling trapped was cited as a consequence of having negotiated flexible working arrangements – leaving the job may have meant that the nurses might not get the same concessions with another employer. This sensation of entrapment could also be as a result of the differing grading/banding systems existing within their organisational structure. The NHS has a more rigid, definitive structure, with many more layers to the hierarchy yet
more opportunities for promotion for junior nurses, but fewer opportunities as nurses move into more senior and specialised roles.

Powell and Meyer's (2004) side-bet category 'individual adjustments to social position' were also apparent from the data. Nurses wanted to utilise the skills and expertise they had accumulated for the benefit of the organisation and their patients/clients and this was apparent for both nurses working in the NHS and care homes (as discussed in Chapter 7). However, I would argue that the major influence on nurses' decisions to remain with their employer were the 'satisfying conditions', the enjoyment the nurses received from the work they do, the social bonds and friendships within the work environment, the way that they are recognised and valued by some managers and leaders and the perceived fulfilment that working for the organisation offers. These 'satisfying conditions' as described by Powell and Meyer (2004), were more applicable to care homes nurses. This is perhaps the main difference between the two groups in this study. Although NHS nurses derived satisfaction from their work, patients and colleagues, this was tempered by the politics of the NHS and the more impersonal managerial style of leadership, the lack of recognition and perceived lack of value that nurses received internally, as a result of the way their organisation was structured. In contrast, nurses in the care home sector had perhaps sacrificed the 'self-presentational' aspects of an NHS - prestige, reputation, status, positive social image - in favour of the 'satisfying conditions' and the more intangible rewards of having their contributions recognised, a closer working relationship with their manager and less political influence by government in the day-to-day running of the organisation. That is, nurses in the NHS had 'external' recognition and value compared with care home nurses who experience 'internal' recognition from managers and their organisation.

Finally, there was evidence of Powell and Meyer's (2004) constructs of 'expectations of others,' or 'self-presentation concerns' affecting NHS nurses in this study as they liked that her roles were understood and presented positively in the media. In the case of care home nurses, there was little evidence that these constructs affected them as the role is less publicly valued than it should be. However, although 'non-work concerns' such as the influence of family or domestic roles, and the effects of moving geographical location on the family were not stated as an issue in terms of
commitment, some nurses did indicate that work was geographically convenient for them, yet others travelled long distances to the workplace.

As indicated earlier in this section, this study has shown that that the costs of leaving an organisation or occupation may outweigh the benefits of staying for nurses in this study. The side-bet theory of commitment helps us to understand nurses' decisions to remain in nursing and why they choose to stay with their employers. Side-bets are an important contributing factor to nurses' organisational and occupational commitment, perhaps not in an entirely rational way as depicted from the literature. In some respects, fear of change, lack of confidence and an uncertain job market in addition to the cost-benefit application of side-bet theory appeared to play a part in nurses' decisions to remain occupationally and organisationally committed. In this study both groups of nurses demonstrated ‘affective’ commitment in that they stayed because they wanted to and ‘continuance’ commitment, they stay because they had to (Meyer and Allen 1991).

10.5. Cohort Effects

Finally, it is important to mention the possible cohort effects influencing the data and outcomes of this study as this is not considered in the literature on mid-life nurses' commitment to nursing. There have been few research studies that have examined different specific cohorts of nurses and their occupational and organisational commitment and of those which have, there has been limited comments on cohort effects. For example, Bennett et al's (2007) study of nurses working in mid-life in two London NHS Trusts does not make any reference to possible cohort effects for the nurses aged 45+ in their study.

The nurses in this study fit into the 'baby boomer' or 'cusper' taxonomy, training at a time with an emphasis on the medical model of patient care (mainly during the 1970s and 1980s), when nurse training was very different to the current nurse training (Bendall 2006). Nurses were based in Schools of Nursing at individual hospitals up until the 1980s, with the exception of those taking a four year academic degree course in nursing at selected UK universities. Nurse education was restructured in the 1980s and nurses made the transition to being fully educated at universities (McKenna et at 2006). The nurses in this study all, with the exception of one nurse working in a care
home who was Project 2000 educated, undertook the ‘traditional’ nurse training, gaining either SRN, RGN, RMN or SEN qualifications. The nurses indicated that their training was very strict and disciplined, there was a definitive hierarchy with student nurses firmly at the bottom, expected to learn from their superiors without questioning, unlike current nursing students who are expected to be questioning, knowledgeable doers (McKenna et al 2006).

Many of the nurses interviewed referred to themselves as ‘old style nurses’ or ‘dinosaurs’ and talked about the ‘old days’, and my analysis of the narratives of nurses in this study is that they are proud of the training they received and the nursing they performed, often considering today’s standards as inferior. McKenna et al (2006) stated that nurses during the 1970s and 1980s were little more than ‘doctors handmaidens’, lacking autonomy, carrying out orders from medical colleagues, and that those who remember nurse training and nursing during this period perhaps have a ‘rose-tinted’ view of nurse training (McKenna et al 2006), a point acknowledged by one nurse.

The nurses in this cohort may be the product of the era in which they were trained. Cordeniz (2002: 239) describes this cohort of adults, the ‘baby boomer’ generation and the ‘cuspers’, those born slightly after the end of the previous generation and who have adopted some of the characteristics of the generation before, as being:

“dedicated and driven... equate work with self-worth, contribution and fulfilment... desire to make the world a better place... aspire for higher monetary compensation and titles.”

The nurses working in both sectors in this study demonstrated these characteristics. They were dedicated, wanted to use their professionalism to contribute to making a difference to the lives of their patients and also to society. Yet they also desired a sense of personal fulfilment and a sense of self-worth that doing something worthwhile, such as nursing, delivers.

This cohort of nurses represents the small majority of nurses practising in the UK at present. As indicated in Chapter 1 two thirds of nurses are over the age of 30 and one third of these is over 50, with nearly 20 percent of nurses being over 55, nearly double
the figure of a decade ago (Buchan and Seccombe 2009). It is therefore essential to consider the next generation of nurses, those in their late 30s and in their 40s (who will be filling the gap of nurses over 55 and heading towards retirement) and what the characteristics of these nurses’ organisational and occupational commitment are. By listening to the views of nurses who have demonstrated commitment, it may be possible to harness some of their positive reasons for staying in nursing and build on them to encourage retention. It is also necessary to take steps to address nurses’ negative experiences such as the perceived failure of management and government and recognise their vital contribution to the organisation, in the case of the NHS nurses, and publicly valuing the work of care home nurses.

The situation may be very different for nurses currently under 30 who represent one third of the nursing workforce as outlined in Chapter 1 (Buchan and Seccombe 2009). Their experiences of training and education are very different for this mid-life cohort who undertook almost ‘apprentice’ style training. As evidenced from some of the narratives in Chapter 7, nurses can feel trapped because they do not feel trained to do anything else which contributes to continuance commitment (they stay because they feel they have to). Nurses undertaking contemporary diploma and degree nurse training may feel they have greater opportunities because of their higher level of education. Also, because Generation Y/Millennial generation women (Strauss and Howe 1991) have grown up in a post-feminist era which has afforded them a wider range of opportunities and the motivation to seek them out and therefore they may not feel tied to one career and may change the mix of people who choose to study nursing in the first place.

10.6. Conclusion

This chapter has discussed the concepts which determine why mid-life nurses working in the NHS and care homes stay in nursing, demonstrating the contrasts between the two groups. Managerialism, inherent within the NHS, can alienate nurses and has been a factor in causing nurses to leave the organisation, but not nursing as an occupation. Some nurses in the care home sector have implicated managerialism as part of their decision for leaving the NHS. Their experiences of working in the care home sector indicate that managerialism still exists; however, this does not impact on their practice as much as it did in the NHS. For some nurses in the NHS,
managerialism contributed to their experiences and perceptions of not feeling valued by those above their line manager and by the NHS as an organisation.

Flexible working practices have caused divisions and conflict within the NHS as a result of the IWL initiative. Employees expect organisational justice - to be treated fairly and equally - but this was not the always case for nurses working in the NHS. This may also reflect the age of the sample. Perhaps more younger women with small children may find IWL helpful and stay in NHS nursing rather than leaving or taking part-time employment. In contrast, nurses working in the care home sector, who have not been affected by government intervention, reported satisfaction at the opportunities for flexible working and have, in some cases, moved from the NHS to the care home sector to secure more flexible working arrangements. Some might have stayed in the NHS if IWL had been in effect. There were no reports of conflict in respect of flexible working practices by the care home nurses.

In terms of professionalism, nurses in this study were motivated to stay in nursing and demonstrated occupational commitment because they felt that they were making a difference to patients’/clients’ lives, reflecting the ideology of nursing. It was what they ‘were trained to do’ and allowed them to use their vast array of skills, knowledge and experience. This, in turn, contributed to their sense of job satisfaction which can be a powerful motivator to stay and is where both groups of nurses demonstrated consensus.

Regarding the issue of how nurses’ professional and social identity differs according to the organisational context of nurses, nurses in the NHS report a positive professional and social identity, which to some extent may make up for the lack of organisational and higher managerial recognition that was reported as missing. In contrast, nurses in care homes reported a negative professional and social identity, with media representation partly responsible for this.

This chapter suggests that side-bet theory of commitment (Becker 1960) can help understand organisational and occupational commitment. Whilst side-bets cannot, in isolation, be considered to contribute to organisational and occupational commitment, their influence has been demonstrated. Side-bets can be seen to influence nurses
decision making in relation to professionalism – remuneration (impersonal bureaucratic arrangements) and not feeling trained for other work (individual adjustments to social position). Side-bets also influence nurses’ organisational commitment when flexible working arrangements have been negotiated (impersonal bureaucratic arrangements). This can lead to a ‘nursing nexus’ whereby nurses are bound to their occupation because the costs of leaving the occupation (and organisation) are perceived to outweigh the benefits.

Finally the issue of cohort effects has been discussed as this may be a contributory factor in explaining the commitment of the two groups of nurses in this study. Nurses who trained in the 1970s and 1980s have different cultural experiences and expectations to later generations. According to Cordeniz (2002), ‘baby boomers’, ‘cuspers’ and ‘Generation X’ women demonstrate characteristics of dedication and commitment which are associated with their generations and may be absent from subsequent generations.

The concluding chapter will focus on the major findings from this research study. It will link this research to previous studies and demonstrate how this research has contributed to further epistemological knowledge of qualified, mid-life NHS and care home nurses’ organisational and occupational commitment and how it advances the professional debate.
11.1. Introduction

This chapter summarises the thesis and draws together the main findings of the research study, integrating them with the theoretical debates discussed in the literature review chapters. The chapter will conclude by offering reflections on the limitations of the research and how the research advances the professional debate on nurses’ occupational and organisational commitment.

The study has concentrated on a specific cohort, examining the working lives of qualified mid-life (age 40-55) women nurses working in the NHS and the care home industry. The aims of this study were to investigate mid-life women nurses’ working lives with a specific interest in why they demonstrate occupational and organisational commitment. The research study explored the social actions of, and social processes that affect, these two different groups. The study compared the experiences and perceptions of mid-life NHS and care home nurses in order to increase knowledge and understanding of their working lives. I was particularly interested in the work experiences of mid-life qualified nurses working in care homes, as little research is available concerning qualified nurses working in this sector and how this compares with, or differs from working in the NHS. The research used qualitative methodology to explore what motivated these mid-life women nurses to engage in nursing and why they remained occupationally and organisationally committed. Fifty qualified mid-life nurses, 25 who worked in the NHS and 25 employed in the care home sector were included in the sample.

Whilst there are studies that have considered the working lives of older nurses (Wray et al 2006, 2009; Watson et al 2004, Watson et al 2003; Letvak 2003a, 2003b) and mid-life nurses (Bennett et al 2007), an extensive literature search provided no evidence of studies comparing qualified mid-life nurses working in NHS and the care home sector.
The research questions asked at the beginning of this thesis were designed:

- to explore mid-life qualified women nurses' working lives, specifically why they demonstrate occupational and organisational commitment;
- to explore NHS and care home nurses future career plans and whether they intend to stay or leave nursing and/or their organisations;
- to compare and contrast the experiences and perceptions of NHS and care home nurses with regard to their working lives, organisational and occupational commitment.

11.2 Working for Money and Love

The reasons why nurses demonstrated occupational and organisational commitment are a complex interplay of more than one factor. The majority of NHS (n=23) and care home nurses (n=25) stated that their primary motivator was the need to earn a living wage which demonstrated an instrumental orientation to work (Goldthorpe et al 1968a). This supports the findings of Blegen and Mueller (1987), Callaghan (2003), Reeves et al (2005), Barron and West (2005), Natale and Rothschild (1995), Sverko and Vizek-Vidovic (1995) which indicated that income is important to nurses. However, whilst this motivated nurses in this study to engage in paid employment, it does not fully explain why they chose to stay in nursing. As the data in Chapter 7 indicate, there were many convergences in the main reasons given by NHS and care home nurses for occupational commitment. Both groups of nurses maintained a passion for their work. They wanted to utilise the skills, knowledge and experience they had accumulated during their extensive nursing careers to make a difference to their patients'/clients' care. This in turn led to a high degree of job satisfaction. Commentators have argued that altruism (McCramant 2006, Fahrenwald et al 2005, Lynaugh and Fagin 2000, Smith 1995) and philanthropy (Baer 2007, 2009) are the backbone of nursing ideology, and one of the most significant findings of my research is that the nurses in this study remain in nursing because they love their work, and this is common in both NHS and care home nurses.

Both NHS and care home nurses reported job satisfaction as a significant factor in their decision to stay. The nurses in both sectors enjoyed the social bonds and
teamwork that they experienced in the workplace and this contributed to a sense of job satisfaction. A high level of job satisfaction was a key factor in both care home and NHS nurses’ decisions to stay in nursing and within their organisations and supports earlier literature which indicates that job satisfaction correlates with nurses’ commitment and intent to stay (Wilson, 2006, Dunn et al 2005, Sourdif 2004, Larrabee et al 2003, Tovey and Adams 1999, Syptak et al 1999, Blegan 1993) and work commitment (Cohen 1999, Randall and Cote 1991). My findings support Fagin’s (2001) assertion that money is not the only motivating factor when work orientation is considered; the rewards of self-fulfilment and enjoyment create stronger employee commitment than purely working for financial remuneration.

The vast majority of NHS and care home nurses’ intended to remain in nursing. The 8 that were planning to leave nursing in the next 5 years were mainly considering retirement. However, some were not considering retiring completely from the labour market. Three nurses expressed an intention to continue working by engaging in ad hoc nursing (‘bank work’) or voluntary work. My study found that nurses in both sectors mainly demonstrated an ‘unstructured’ approach to their careers, with no definite prospective career plans and although the nurses were committed to their careers, their approach to progression throughout their working lives was more opportunistic than structured. NHS nurses were often ‘self-limiting’ in terms of career progression, imposing their own ‘ceiling’ by not wishing to pursue management roles that were away from the clinical practice.

11.3 The Importance of Flexibility in Nursing
There has been much debate about the work-life-family balance of women (Roberts 2007, Burgess et al 2007, Wise et al 2007, Whitlock et al 2002, Mennino and Brayfield 2002, Tausig and Fenwick 2001, Lewis 2001, Schor 1991). However, the debate encompassing nurses has largely been confined to nurses working in the NHS and has neglected nurses working in care homes.

My findings illustrate that flexible working is important to many nurses, especially those with dependants (adults and children). The majority of nurses in this study (n=39) had had children and 28 had dependant children (plus two nurses had adult dependants) at the time of interview. For the many nurses with children who work
part-time, shiftwork and negotiation of flexible working practices offered solutions to combining paid work with the demands of family life and childcare. This led to occupational and organisational commitment which supports the earlier research of Walshe (1999). Shiftwork played an important role in providing opportunities for nurses with children to engage in paid work. Seven of the eight nurses working nights had children of school age and shiftwork was favoured because it reduced the costs of their childcare, supporting previous research by Burgoyne et al (2006). The findings in this study show that nursing has offered flexible career options to nurses with and without children. However, part-time and flexible working led to feelings of ‘entrapment’ for a minority of nurses who expressed that there were limited opportunities for career progression, supporting the findings of Whitlock et al (2002) and Grant et al (2003).

What is evident from the data and analysed in Chapters 8 and 9 is that, for NHS staff, government policies can have adverse unintended consequences. In the case of the Improving Working Lives Initiative (IWL) (DOH 2000), its implementation within the NHS has created an expectation amongst staff of fairness and organisational justice which was not experienced by all nurses. As illustrated in Chapter 8, this led to frustration, jealousy and a sense of inequity for NHS nurses who did not qualify for the flexible working practices offered by the initiative. Nurses working in care homes were not subject to this government policy, and local informal negotiations took place with regard to obtaining working hours to suit individual needs. Analysis of the data indicates that the nurses in this sector appeared to be much more satisfied with the negotiation of their working hours arrangements because fairness and equity was experienced, in contrast to the NHS.

11.4. Acknowledgement by Employers of the Value of Nurses
The importance of respect, recognition and feeling valued by employers was a significant finding from the data and supports the findings of previous research (Faulkner and Laschinger 2008, Laschinger 2004, McGuire et al 2003) as well as being linked to the theory of organisational empowerment (Kanter 1977, 1993). Not only was the respect and value of nurses by employers an important factor for enhancing nurses’ commitment, the wider perceived respect for nurses by the public...
emerged as a significant factor in the working lives of the nurses in this study. However, there are important divergences between the two groups of nurses studied.

Nurses working in the NHS indicated in their interviews that, on the whole, they did not feel that their contribution and work was valued by managers. With the exception of their immediate line manager, NHS nurses considered their managers to be remote, distanced from the ‘shop floor’ and having little interest in their nursing contribution, instead focusing primarily on government targets and performance indicators. NHS nurses considered that the emphasis on achieving targets was sometimes at the expense of their patients’ health outcomes and ultimately their own professional judgement. Nevertheless, lack of managerial support and recognition was mediated by the respect, kudos and value that the public and society accorded NHS nurses. The NHS nurses derived a sense of satisfaction from this public recognition. The public’s respect and value of NHS nurses was recognised, by both NHS and care home nurses. This finding supports Faulkner and Laschinger’s (2008) theory that recognition and reward lead to feelings of being respected which, in turn, are linked to job satisfaction and retention. It also supports the theory of reciprocity (Emerson 1976, Nelson 2000) whereby nurses expect some form of reward for their commitment and in this study, recognition, value and respect for their work were the rewards expected, in addition to financial remuneration.

In contrast, nurses working in the care home sector considered that they had a much closer working relationship with their managers and because of this felt a greater degree of respect, recognition and value for their work contributions. Care home nurses felt they were able to conduct their work without the interference of middle managers and government, and they had autonomy and responsibility. This contributed to the job satisfaction of nurses in care homes, and also contributed to organisational commitment. However, despite the nurses in the NHS recognising the professionalism of care home nurses and expressing a ‘sisterhood’ with them (acknowledgment of their professional role, specialist knowledge and hard work) nurses working in care homes did not feel that they were respected by the general public. They still perceived that they had a negative public image, largely as a result of the media’s portrayal of the abuse of residents in care homes. This was partly
because of the ‘private’ rather than ‘public’ nature of care that these nurses were engaged in.

Consequently, a paradox exists for these nurses – the prestige of the ‘public eye’ of NHS nurses, (which was recognised by both groups of nurses), yet NHS nurses enjoyed little recognition and value from their employers. This contrasts with the ‘private ear’ of the care home nurses who felt appreciated by their managers and employers and derived great job satisfaction from this appreciation, despite their lack of public recognition and respect and the lower pay in this sector.

11.5. Side-Bet Theory of Commitment

Although this study did not seek to test empirically Becker’s (1960) side-bet theory of commitment, (which posits that the costs of leaving are outweighed by the benefits of staying in a job or organisation), on analysis of the data I concluded that nurses demonstrated many elements of Becker’s side-bet theory. For nurses in the NHS, side-bets were manifest in pay and other conditions of service such as annual leave entitlement, sick pay, pensions that had accrued (particularly for NHS nurses who experienced better pay and conditions than care home nurses). For the nurses in both sectors side-bets also took the form of flexible working conditions, and the nurses’ perception of entrapment because they were not trained to do anything else. Their occupational and organisational commitment supports Meyer and Allen’s (1991) theory of ‘continuance’ commitment whereby employees stay because they feel they have to.

However, data from my study also show that both groups of nurses demonstrated ‘affective’ commitment based on positive experiences within their organisation and occupation; they therefore stay because they want to. The nurses in my study wanted to stay in nursing and with their organisation because they derived high levels of job satisfaction, had continuing belief in the philosophy and ideology of nursing and enjoyed their work. Nurses in both sectors wanted to use their professional, specialist and generalist accumulated skills, knowledge and experience to benefit their patients/clients and the organisation. For the majority of nurses, their commitment was a combination of continuance (the need to earn a wage) and affective (job satisfaction) commitment.
11.6. Reflections on the Research Study

The aims of this study were addressed by recruiting 50 nurses to participate in the study and equal numbers of NHS (n=25) and care home (n=25) nurses were interviewed. The concepts of organisational and occupational commitment were explored using qualitative in-depth interviews and nurses’ future career plans were explored. However, all research presents challenges and has limitations.

The NHS and care home nurses were recruited through snowball sampling, gatekeepers and ‘cold calling’ (respondents contacted by telephone using freely available CSCI contact details and who fitted the inclusion criteria); all but one agreed to participate. Whilst the initial intention was to recruit nurses between the ages of 40 and 55 finding nurses aged over 40 but under 55 working in care homes proved difficult. I had limited success with written requests for participants in the care home sector with several non-responses to my letters. This may have been due to lack of interest or respondents not meeting the inclusion criteria. Nevertheless, in general the response was positive.

The intention of the study was also to recruit equal numbers of part-time and full-time nurses for each group and although this was achieved for nurses working in the NHS, this did not occur in the care home sector. Nurses who met the criteria (see section 5.6, Chapter 5) were more likely to be employed full-time, therefore identification of part-time nurses from this group was more difficult and only 6 were recruited.

The qualitative interviews with nurses provided rich data, far in excess of what could have been obtained from structured questionnaires. For example, the data on the differences between the two groups in terms of professional and social identity, how the type of organisation within which a nurse worked affected their identity, conflicts associated with introducing flexible working practices and the influence of occupational/organisational side-bets on commitment. The career biography approach allowed for a more comprehensive understanding of nurses’ rationales for initially entering nursing, career development and future plans. This enabled the nurses’ working lives to be interpreted contextually and situationally. It must be emphasised that the conclusions of this study are not generalisable due to the nature of the sampling methodology employed.
The issue of positionality was addressed in Chapter 5. The methodological limitations of representing oneself as, and being perceived as, an ‘insider’ during the interview process was reflected on (Hodkinson 2005). Whilst the position of insider with a shared identity granted me access to respondents with relative ease and access to more detailed information than a researcher from a non-nursing background, this may have been at the expense of neutrality during the data analysis due to the social and situational factors that help to shape and define the outcome of the research. If the research had been conducted and analysed by a researcher without nursing knowledge, the focus of this research may have been quite different.

When conducting reflexivity, it must be acknowledged that the nurses in this study demonstrated very positive responses. One must question whether this is an accurate reflection of their feelings or whether there is another explanation for their responses. There are several possibilities. The nurses could be emphasising the positive aspects of their working lives due to ‘self-work’, needed to overcome the negatives. However, these nurses could also be exhibiting ‘face-work’ (Goffman 1955) as the nurses perceived they needed to maintain a ‘face’, a positive image in terms of approved social attributes, as maintaining ‘face’ feels good to them. Their desire to maintain a positive public image of themselves and their work could have led them to give socially desirable answers to the interview questions. The positive responses could also be due to ‘survivor bias’ – nurses with such a positive attitude are more likely to exhibit longevity in nursing and within their organisation. Finally, many senior nurses (n=34) were interviewed, especially in care homes (n=18); their responses could be indicative of Goffman-esque ‘face-work’ in that they were giving socially acceptable responses to the research questions and also ‘marketing’ their organisation, as their role was to promote a service and exhibit their organisation in the most positive light. My reflection is that there is no one prevalent answer and it is a combination of these factors that account for the positiveness of the participants’ responses.

11.7. Advancing the Professional Debate
Debates focusing on nurse recruitment, retention and attrition in the UK tend to solely focus on NHS nurses (Buchan and Seccombe 2004, 2008; Buchan 2002, 2007). Nurses working in care homes are often homogenised into generic care workers
within the social care sector and this is particularly evident where strategies for recruitment and retention are concerned (DOH 2006).

My study advances the professional debate as a qualitative, empirical, comparative study of qualified NHS nurses and qualified care homes nurses which has not been previously undertaken. My study has also significantly increased our knowledge and understanding of the occupational and organisational commitment of mid-life NHS and particularly care home nurses (where a gap in knowledge exists as UK mid-life nurses working in care homes have not been previously studied in terms of organisational and occupational commitment). The use of a qualitative methodology shows that reasons nurses give for remaining occupationally and organisationally committed are complex.

This study also contributes to the debate on the side-bet theory of commitment (Becker 1960) which has received little attention using qualitative approaches to data collection and interpretation (Cohen 2007). My study demonstrates that side-bets are still relevant to the debate on commitment. The data in this study establishes that whilst side-bets cannot explain commitment in totality, Becker’s (1960) theory and subsequent developments (Meyer and Allen 1991, Powell and Meyer 2004) are partially supported and useful in helping to understand nurses’ organisational and occupational commitment. Nurses in both sectors stayed in nursing and with their organisations because of the need to earn a living wage demonstrating Becker’s 1960)’impersonal bureaucratic arrangements’ side-bet. NHS nurses also stayed with their organisation because of benefits associated with conditions of service such as flexible working hours and other entitlements (e.g. pension, sick pay) again demonstrating Becker’s ‘impersonal bureaucratic arrangements’ side-bet. Nurses in the NHS and care homes remained committed because they were ‘trained to nurse’ and were comfortable with the roles that they were in, exhibiting Becker’s ‘individual adjustments to social position’ side-bet. Nurses in both sectors discussed the importance of social bonds with colleagues and teamworking, although nurses in the care home sector reported more positive treatment by managers supporting Powell and Meyer’s (2004) ‘satisfying conditions’. Finally, nurses in both sectors reported the ‘lack of alternatives’ side-bet in terms of comparable jobs (Powell and Meyer 2004), as a reason for remaining in nursing and with their employers.
As emphasised in this thesis, the prevalence of research involving registered nurses working in UK care homes is scant. Whilst this research study has aimed to fill some of that gap, there is still further research that can be conducted using this current study as a starting point. This study has provided an insight into the reasons why nurses working in mid-life choose to work and stay in nursing in UK care homes however, there is an opportunity to extend the research and investigate other cohorts of nurses working in care homes and their reasons for doing so. This would add to some of the interesting findings of this research and lead to a further understanding of why nurses choose to stay in nursing and especially in care homes. For example, do younger nurses and nurses who are near retirement recount the same passion for nursing as the mid-life nurses in this study; does the side-bet theory of commitment apply to younger nurses as they may not have as many ‘investments’ in nursing or in their employment; would they demonstrate the same level of positivity as the nurses in this study? This would increase our understanding of why nurses under 40 and over 55 years of age have left the NHS, choose to stay in nursing and specifically in care homes. The extension of this research would further close the epistemological lacuna regarding nurses working in UK care homes.

My research therefore fills an empirical gap in research as it contributes to our understanding of the working lives of mid-life nurses, especially those working in care homes and to the theoretical understanding of organisational and occupational commitment. This study has concentrated on one particular cohort, with very specific criteria – mid-life, UK trained nurses with at least ten years experience. I would suggest that there is an opportunity to build upon my research to investigate working lives of all qualified nurses working in UK care homes, particularly those in younger cohorts, to examine whether they are as occupationally and organisationally committed as this cohort. Is the concept of commitment constructed differently for successive cohorts; will those who trained in the 1990s and 2000s choose to spend their entire careers in nursing? There is continued growth in demand for health and social care provision (CQC 2009) and perennial problems with recruitment and retention (Buchan and Seccombe 2004, 2008; Buchan 2002, 2007). It is therefore essential that employers and policy makers understand the reasons for nurses’ continued dedication and implement strategies to ensure the commitment of its workforce.


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APPENDICES
27 March 2006

Mrs Lesley Durant
34 St Christopher's Road
HASLEMERE
Surrey GU27 1DQ

Dear Mrs Durant

**Perceptions and experiences of older workers in the health and social care sector: A qualitative Study (EC/2006/14/Socio) – FAST TRACK**

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **13 February 2006**

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:

- **Document Type: Application**
  Dated: 03/02/06
  Received: 06/02/06

- **Document Type: Approval Letter from the South West Surrey LREC**
  Dated: 21/12/05
  Received: 06/02/06

- **Document Type: Research Proposal**
  Dated: 10/05
  Received: 06/02/06

- **Document Type: Participant Information Sheet**
  Dated: 01/12/05
  Received: 06/02/06

- **Document Type: Flyer**
  Dated: 10/05
  Received: 06/02/06
This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research,

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr K Davidson, Supervisor, Dept of Sociology
Dear Mrs Durant

Perceptions and experiences of older workers in the health and social care sector: a qualitative study

Thank you for your letter dated 7 December 2005 enclosing a revised Information Sheet in response to the Committee’s comments on the above study.

Confirmation of ethical opinion

Your letter and its enclosure have been considered on behalf of the Committee by the Chairman who has been able to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documents as revised.

Site-specific issues

The Committee has, as you know, designated the study as exempt from site-specific assessment (SSA). You should, however, pursue any research governance issues with the appropriate Research and Development Departments as suggested in our letter of 9 November 2005.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

i) NHS RBC Application Form, Version 5.0, dated 7 October 2005
ii) Your curriculum vitae, dated October 2005
iii) Dr Kate Davidson's curriculum vitae (version undated)
iv) Research Proposal, version 1, dated October 2005
v) Statement of Indemnity Arrangements from the University of Surrey, dated August 2005
vi) Flyer, version 1, dated October 2005
vii) Recruitment Letter (to staff managers), version 1, dated October 2005
viii) Recruitment Letter 1, version 1, dated October 2005
ix) Participant Information Sheet, version 2, dated 1 December 2005
x) Letter of Informed Consent, version 1, dated October 2005
xi) Participant Consent Form, version 1, dated October 2005
xii) Information Letter, version 1, dated October 2005
xiii) Draft Interview Schedule, version 1, dated October 2005

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely

J ohn K erslake
Co-ordinator

Copy to (without enclosure): Dr Kate Davidson
Department of Sociology
University of Surrey
PhD Research Study

I am studying for a part-time PhD in Sociology at the University of Surrey and I am also a registered nurse. I worked for 10 years in the NHS and currently work part-time in a care home in Surrey.

I am researching into why female, mid-life, qualified nurses working in the NHS and care homes stay in nursing. There has been a lot of research into older nurses and how to retain them but very little published research into women in their 40s and early 50s. There is a distinct lack of research in this area and this study aims to fill some of this gap in knowledge and understanding of what motivates female mid-life nurses to stay in nursing.

I am actively recruiting women, aged 40-55 years, who qualified in the UK, and have been working as a nurse for 10 years or more, to participate in this research project.

The research is being conducted using a taped, one to one interview that takes about an hour to complete and involves discussing why nurses stay in nursing. I have enclosed a detailed information sheet which gives more detail about the study, for your information.

If you are able to help me in any way either by being willing to be interviewed or can pass on my details to any nurses who would be willing to participate I would be very grateful for any assistance. As I am a part-time student at the University of Surrey, I do not have an allocated desk, so the best way to contact is at:

E-mail: L.Durant@surrey.ac.uk

Telephone Number: 01xxx xxxx30 (Home)
0xxxxxxxxxxx3 (Mobile)

Yours sincerely,

Lesley Durant.
Participant Information Sheet

Study Title:

'Why do mid-life nurses working in the NHS and in care homes stay in nursing: a comparative study.'

Invitation

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. 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. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The average age of the British labour force is gradually rising. This is particularly relevant to health care where one in five nurses on the professional register in the United Kingdom (UK) is over 50 years of age. This has major implications for recruitment and retention policies within this sector. Surprisingly, there is a lack of research published about why qualified, female mid-life nurses stay in nursing and is virtually non-existent in the area of care homes. This study aims to address some of this deficit by exploring the working lives of qualified, mid-life women nurses age 40-53 in the NHS and care homes.

The principle aims are based upon a study to investigate why women nurses working in mid life stay in nursing and will involve exploring:

1. the career history of the participants.
2. what are participants motivations and orientations to work?
3. what are the positive/negative aspects of this type of work, including changes in the workplace and stressors?
4. are motivations/orientations - financial, fulfilment, time and effort already invested, attachment to the job/organisation, career development?
Why have I been chosen?

You have been chosen, along with 50 other participants, as you are 38-53 years of age, have trained in the UK, been qualified for 10 years or more and work in the NHS or a care home, therefore meet the criteria for the research.

Do I have to take part?

Taking part in the research is entirely voluntary, it is up to you whether or not you take part. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be interviewed face to face, for approximately one hour. You will be audio taped so that the data collected can be transcribed (copied in writing) and analysed by the researcher. You may be invited to take part in a group discussion at a later date. You may decline to take part in this discussion if you do not wish to be included. The information given in the initial interview will still be used unless you decide to withdraw from the study completely.

What do I have to do?

You have to talk about what it is like to be a nurse working in midlife. The researcher will ask you some questions to help you.

What are the possible benefits of taking part?

You will be contributing to much needed new research on the subject of mid-life nurses in health/social care.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information that is used in any published work, including direct quotes will be kept anonymous. The interview with you will be held in private to protect your confidentiality. Any information you disclose about your employer will also be kept confidential.

What will happen to the results of the research study?

The results of the research will be published in a PhD thesis and will be available to the public in the University of Surrey Library. A copy will also be kept in the Department of Sociology Library at the University of Surrey. This study will also be published in academic journals. You will not be identified in any published work/publication.
Who is organising and funding the research?

The Department of Sociology at the University of Surrey, Guildford is sponsoring the research as the researcher's PhD study. The researcher is not paid to conduct this study, as it is part of an academic course.

Will I get paid for taking part?

There is no payment for taking part in this study.

Who has reviewed the study?

The researcher's supervisor (Dr. Kate Davidson) and co-supervisor (Prof. Sara Arber) at the University of Surrey have reviewed this study. The University of Surrey Ethics Committee and the NHS South West Surrey Research Ethics Committee have also reviewed the study and given ethical approval.

Contact for further information:

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Thank you for reading the participant information sheet.

You will be given a copy of the information sheet and a signed consent form to keep.
Appendix 5: Consent Form

Centre Number:  
Study Number:  
Participant Identification Number for this study:

CONSENT FORM

Title of Project:  
‘Why do mid-life nurses working in the NHS and in care homes stay in nursing: a comparative study.’

Name of Researcher: Lesley Durant

Please initial box

1. I confirm that I have read and understand the information sheet dated 1.4.06 (version 2) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I agree to take part in this study.

Name of Participant ___________________________ Date ____________ Signature ____________

Researcher ___________________________ Date ____________ Signature ____________
Appendix 6: Interview Guide NHS

Date:

Time:

Participant No:

Location:

Interview Guide (NHS)

Tell me about your career history to date. (how long in nursing, specialties worked in, why choose nursing as career, career breaks and why, why have you stayed in/returned to nursing, alternatives to nursing and if so what and why?)

What are the positive aspects of nursing work (here/in previous locations) {probe}?

What are the negative aspects of nursing work here? {probe}

How do think the NHS is perceived by the public/media?

What effect does this have on you?

How do you feel this is different in the care home sector?

What motivates you to come to work? (Financial, fulfillment, sanity, attachment)

What is your attitude towards nursing? Do you see it as a job, career, vocation? Why?

Tell me about your work-balance. How does your work impact on your home life and home life on your work? How do you feel about this?

Why are you still in nursing?

Have you considered alternatives to nursing and if so what? Why?

What are your career aspirations?

- What would you like to be doing in 5 years time? Why?
- What would you like to be doing in 10 years time? Why?
- Can you see yourself leaving?
- Any thoughts on retirement?
How has nursing changed since you qualified (what, positive or negative?)
{probe}

How could your employer encourage nurses to stay/return to nursing?

How could the government encourage nurses to stay?

How do you feel about your job security?

What constraints do you feel there are in your organisation (stressors, problems)?

Do you feel you are listened to by: other professionals/colleagues
Management
Policy makers & Government

Have you anything else you’d like to add before we conclude?

(Thank the participant and re-emphasise contact details.)

Background Questions

1. Age
2. Marital status
3. Children/dependents
4. When qualified
5. Years in nursing
6. Highest educational qualification
7. Career break – how long
8. How long in current job
9. How long with current employer
10. Grade/Band/Job Title
11. Full / Part-time
12. Actively seeking alternative employment
13. Ethnicity
Appendix 7: Interview Guide Care Homes

Tell me about your career history to date. (how long in nursing, specialties worked in, why choose nursing as career, career breaks and why, why have you stayed in/returned to nursing, alternatives to nursing and if so what and why?)

How long ago did you leave the NHS and why? Any regrets?

Why did you choose to work here? Why did you choose to continue working in nursing (why have you stayed in/returned to nursing?)

What are the positive aspects of nursing work (here/in previous locations) {probe}?

What are the negative aspects of nursing work here? {probe}

How do you feel care homes are perceived by the public/media (kudos)?

How do you feel this is different to the NHS?

What effect does this have on you?

What motivates you to come to work? (Financial, fulfillment, sanity, attachment, altruism)

What is your attitude towards nursing? Do you see it as a job, career, vocation? Why?

Tell me about your work-balance. How does your work impact on your home life and home life on your work? How do you feel about this?

Why are you still in nursing?

What are your career aspirations?

What would you like to be doing in 5 years time? Why?

What would you like to be doing in 10 years time? Why?
Have you considered alternatives to nursing and if so what? Why?
How has nursing changed since you qualified? Are these positive or negative?
{probe}

How could your employer encourage nurses to stay?
How could your employer encourage nurses to return to nursing?
How could the government encourage nurses to stay?
How do you feel about your job security?
How do you feel you are listened to by:
  Management
  Colleagues
  Policy makers
  Government
  Your union (if have one)?

Have you anything else you’d like to add before we conclude?

(Thank the participant and re-emphasise contact details.)

Background Questions
  14. Age
  15. Marital status
  16. Children/dependents
  17. When qualified
  18. When left NHS
  19. Years in nursing
  20. Career break – how long
  21. How long in current job
  22. How long with current employer
  23. Grade/Band/Job Title
  24. Actively seeking alternative employment (in care?)
  25. Ethnicity