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Careers of Nurse Diplomates: Project Report No. 4

Adult Branch Diplomates: Starting Out

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CONTENTS

Page No

Acknowledgements... i
List of tables vi
List of tables in appendices... x
Executive summary xi

CHAPTER 1: BACKGROUND AND AIMS.. 1
1.1 Aims of research... 1
1.2 The project 2000 strategy: policies for reform 3
1.3 Relevance of research aims to current policy agenda... 7
1.4 Theoretical perspectives 15
1.5 Related research... 17
1.6 Main research questions 19

CHAPTER 2: RESEARCH DESIGN AND METHODS 20
2.1 Reasons for choosing a longitudinal design 20
2.2 Type of cohort to be selected... 22
2.3 Data collection instruments 23
2.4 Sampling decisions... 24
2.5 The pilot cohort... 27
2.6 Strategies to recruit and maintain the cohort 28
2.7 Questionnaire development and response rates.. 31
2.8 Data analysis and presentation... 35

CHAPTER 3: PROFILE OF THE COHORT AT QUALIFICATION...................... 36
3.1 Sex and age... 37
3.2 Ethnic group... 38
3.3 Educational background 39
3.4 Employment prior to course 43

3.5 Variations due to sex, age group and highest educational qualification................48
3.6 Spouse/partner 49
3.7 Children 51
3.8 Summary and discussion of key findings on profile 52

CHAPTER 4: DECIDING TO START THE NURSE DIPLOMA COURSE AND SELECTING ADULT BRANCH 57
4.1 Decision-making routes into nursing..58
4.2 Reasons for starting the nurse diploma course 61
4.3 Reasons for selecting the adult branch 66
4.4 Selecting the adult branch: choice and change...69
4.5 Applying for a nursing degree 70
4.6 Summary and discussion of key findings on routes and reasons...........................71

CHAPTER 5: OBTAINING A FIRST JOB 75
5.1 Plans immediately after qualification...76
5.2 Obtaining a first nursing job...77
5.3 Employing organization and contractual conditions 78
5.4 Setting...81
5.5 Age group and clinical specialty...82
5.6 Title and grade 86
5.7 Diplomates who had not obtained a first nursing job 86
5.8 Summary and discussion of key findings on first job..89

CHAPTER 6: OBTAINING A FIRST JOB IN THE COMMUNITY........................ 93
6.1 Setting of first job 94
6.2 Wanting a first job in a community setting 95
6.3 Reasons why diplomates did not obtain a first job in a community setting..........97
6.4 Reasons for not wanting first job to be based in each community setting 98
6.5 Summary and discussion of key findings on obtaining a first job in the community 100

CHAPTER 7: FUTURE PLANS - CERTAINTY AND CHOICE 103
7.1 Orientation towards nursing 104
7.2 Orientation towards working in the NHS 108
7.3 Preference for full or part-time hours 110
7.4 Directions in nursing - which clinical specialty?.. 110
7.5 Grade... 119
7.6 Summary and discussion of key findings on future plans 121

CHAPTER 8: CONTINUING PROFESSIONAL DEVELOPMENT...................... 124
8.1 Preceptorship 126
8.2 Plans to take degrees... 128
8.3 Plans to qualify for other parts of the register 132
8.4 Plans to apply for other courses in the first six months after qualifying 134
8.5 Summary and discussion of key findings on preceptorship and education 136

CHAPTER 9: CAREER GUIDANCE AND CAREER PLANNING...................... 140
9.1 Information and advice received during the nurse diploma course..................... 141
9.2 Views about the amount of guidance received 145
9.3 Discussions about career planning... 151
9.4 Awareness of strategies to inform career planning.. 152
9.5 Career guidance and career planning: differences between women and men 153
9.6 Summary and discussion of key findings on career guidance and planning 154

CHAPTER 10: SPOUSE/PARTNER AND CHILDREN: EFFECT ON DIPLOMATES' WORK AND CAREER PLANS....................... 157
10.1 Priorities accorded to work/career plans of self and spouse/partner 158
10.2 Effect of partner's income on hours diplomates will work 158
10.3 Influence of location of partner's work 159
10.4 Effects of children on work/career plans 160
10.5 Summary and discussion of key finding on partners and children...................... 162

CHAPTER 11: LOOKING FORWARDS **164**
11.1 Diversity of diplomates.......... 164
11.2 Career pathways: 166
11.3 Continuing professional development 168
11.4 Career guidance 170
11.5 Aspects of nurses' roles in the delivery of care.......... 171
11.6 Combining work and family 172
11.7 Association of profile variables with the likelihood of staying in nursing.......... 173
11.8 Choice and constraint 173
11.9 Conclusion 174

APPENDICES **175**
REFERENCES **238**

LIST OF TABLES

CHAPTER 3: PROFILE OF THE COHORT AT QUALIFICATION 36

Tables

3.1 Age at end of course: men and women 38
3.2 Ethnic group; women and men 39
3.3 Qualification gained prior to starting nurse diploma course 41
3.4 Highest level of academic qualification reached: women and men 43
3.5 Employment history; women and men 44
3.6 Summary and discussion of key findings on future plans 45
3.7 Employment profile: period spent in full-time employment by number of occupations 46
3.8 Full-time jobs held prior to start of diploma course 46
3.9 Previous employment in nursing, health or social care 47
3.10 Highest educational qualification by age 48
3.11 Marital status 49
3.12 Partner by marital status: women and men 50
3.13 Partner's occupation 50
3.14 Children living with respondent: women and men 51
3.15 Age groups of children living with respondent: women and men 52
3.16 Children not living with respondent: women and men 52

CHAPTER 4: DECIDING TO START THE NURSE DIPLOMA COURSE AND SELECTING THE ADULT BRANCH 57

Tables

4.1 Decision-making routes into nursing 59
4.2 Certainty about nursing when completing secondary education: women and men 61
4.3 Reasons for starting the nurse diploma course 63
4.4 Reasons for selecting the adult branch 68
4.5 Selecting the adult branch 69
4.6 Reasons given, by those who had wanted to change branch, for remaining on the adult branch 70

CHAPTER 5: OBTAINING A FIRST JOB 75

Tables

5.1 Plans immediately after qualification 76
5.2 Proportion of those who planned to obtain a first nursing job who had done so .. 77
5.3 Employing organization...... 78
5.4 Reasons for taking a first job outside the NHS...... 79
5.5 Length of contract...... 80
5.6 Full-time or part-time hours...... 80
5.7 Pattern of work hours...... 81
5.8 Setting...... 82
5.9 Age group of patients: 82
5.10 Age group of patients: combinations 83
5.11 Patient type 83
5.12 Clinical specialty 84
5.13 First job based in preferred clinical specialty? 86
5.14 Diplomates not planning to obtain a nursing job immediately after qualification subsequent plans in relation to nursing...... 87
5.15 Reason for taking agency/bank nursing after qualification 88
5.16 Diplomates who had obtained an agency/bank job: subsequent plans in relation to obtain a nursing job 88
5.17 Reason for not yet obtaining a first nursing job despite having applied: 89
5.18 Reasons for not having applied for a nursing job 89

CHAPTER 6: OBTAINING A FIRST JOB IN THE COMMUNITY 93

Tables

6.1 Setting(s) in which diplomates' first job would be based 95
6.2 Total number of diplomates with a first job in each of the three community setting 95
6.3 Did diplomates want to work in the setting in which their first job would be based 96
6.4 Settings in which diplomates who had not obtained a job would like their first job to be based 96
6.5 Reasons for job not being in each of the three community settings...... 97
6.6 Reasons for not wanting first job to be based in each community setting 99

CHAPTER 7: FUTURE PLANS - CERTAINTY AND CHOICE 103

Tables

7.1 Likelihood of working in nursing in the future 105
7.2 Certainty about job plans for 18 months and three years after qualification....... 107
7.3 Preferred employing organization when holding jobs in nursing........................ 109
7.4 Employing organization of jobs in which hoped to be working at 18 months and three years 109
7.5 Hours planned to work in future nursing jobs 110
7.6 The influence of course experience 112
7.7 The influence of course experience - those who experience each specialty during the nurse diploma course 114
7.8 Plans for taking a second job, by whether clinical specialty of first job was respondent's preference... 116
7.9 Time-scale for second job, by whether clinical specialty of first job was respondents preference 117
7.10 Clinical specialty of second job, in relation to that of first job........................... 118
7.11 Grade of job in which hoped to be working at 18 months and three years after qualification 120

CHAPTER 8: CONTINUING PROFESSIONAL DEVELOPMENT..................... 124

Tables

8.1 Wanting to have a preceptor in first job 126
8.2 Expectations of preceptorship.. 127
8.3 Length of time for which respondents would like preceptorship: women and men 128
8.4 Plans to obtain a degree 129
8.5 Reasons for planning to obtain a degree.. 130
8.6 Time-scale for starting a degree 131
8.7 Study leave arrangements for 131
8.8 Funding arrangements for degree 132
8.9 Reasons for not planning to obtain a degree.. 132
8.10 Planned time-scale for starting other branches.. 133
8.11 Planned time-scale for other parts of register 133
8.12 Reasons for taking courses 135
8.13 Time-scale for starting other courses... 135

CHAPTER 9: CAREER GUIDANCE AND CAREER PLANNING......................140

Tables

9.1 Guidance received about applying for first job 142
9.2 Guidance received about continuing education..143
9.3 Guidance received about career pathways..144
9.4 Views on amount of information and advice received - applying for first job....147
9.5 Views on amount of information and advice received - continuing education...148
9.6 Views on amount of information and advice received - career pathways...........149
9.7 With whom discussion had about career planning..151
9.8 Discussion wanted about planning a career..152
9.9 Awareness of strategies for career planning...153

CHAPTER 10: CONTINUING PROFESSIONAL DEVELOPMENT..................157

Tables

10.1 Priorities given to own and partners' work/career plans: women and men 158
10.2 Effect of partners' income on hours diplomates chose to work: women and men 159
10.3 Influence of partner's location of work on decision where to live: women and men 160
10.4 Effects of living on current location on work/career plans: women and men.....160
10.5 Effects on work/career plans of children living with respondent: women and men 161
10.6 Effects on work/career plans of children not living with respondent: women and men 162

LIST OF TABLES IN APPENDICES

3A.1 Details of full-time jobs held prior to starting the diploma course......................214
4A.1 Reasons for starting the nurse diploma course: women and men........................220
4A.2 Reasons for selecting the adult branch: women and men...................................221
4A.3a Selecting the adult branch: women...222
4A.3b Selecting the adult branch: men..222
7A.1a Likelihood of working in nursing 5 years after qualification by educational group and age 224
7A.1b Likelihood of working in nursing 10 years after qualification by previous health 224
7A.1c Likelihood of working in nursing 10 years after qualification by age group and ethnicity 225
7A.2 Number of diplomats who obtained a job in each specialty as a percentage of those whom experience during the course led to consider working in that specialty 226
7A.3 Influence of course experiences on attitudes towards specialty in which first job was based 227
7A.4 Clinical specialty: plans for 18 months after qualification.................................228
7A.5 Clinical specialty: plans for three years after qualification 229
7A.6 Plans to work in clinical specialties to whether respondents had obtained a first job in the specialty 231
7A.7 Grade: plans for 18 months after qualification: women and men 232
7A.8 Grade: plans for three years after qualification: women and men.......................232
8A.1 Plans to take a degree: women and men...233
8A.2 Plans to take a degree: by highest academic qualification obtained prior to nurse diploma 234
9A.1 Information and advice received: college variation...235
9A.2a Views on amount of information and advice received: women 236
9A.2b Views on amount of information and advice received: men 237

EXECUTIVE SUMMARY

1. AIMS, POLICY RELEVANCE AND METHODS

This report focuses on adult branch nursing diplomates at the point of qualification. It is the fourth report from a longitudinal study of the careers of those qualifying from all four branches of the diploma course (adult, mental health, learning disability and child) which replaced the traditional routes to registration as a nurse.

Findings presented are relevant to many aspects of the current policy agenda on workforce expansion, human resources initiatives, continuing professional development and career pathways. This agenda, set out in *Working Together* (DH 1998b*), Making a Difference* (DH 1999a) and *Health service of all the talents* (DH 2000b), has been reinforced in *The NHS Plan* (DH 2000c). To meet both the branch specific and the wider policy agendas, publication policy for the project is to report findings for each branch separately and to provide overview reports in which the main findings for each branch are compared and contrasted. This executive summary sets out key findings for adult branch diplomates at the point of qualification, together with their immediate and longer term policy implications.

The Project 2000 strategy, in which the traditional routes to registration as a nurse were replaced by the diploma course, represented a major reform of nursing education, and has far reaching implications for the structure of the nursing workforce and the care which its members deliver. Given the substantial financial and professional investment which the strategy entailed, there is considerable interest in the careers followed by those qualifying from the diploma course; consequently the Department of Health commissioned this research.

1.1 AIMS OF THE RESEARCH

The research has four aims:

1. Ascertain the diversity within the diplomate workforce at qualification and at subsequent time-points thereafter.

2. Describe diplomates' career plans and career pathways followed from qualification onwards.
3. Investigate subjects relevant to diplomates' careers: continuing professional development; career guidance; aspects of nurses' roles; quality of working life, and combining work and family.
4. Identify relationships between career plans, careers followed, and profile and experience variables

These aims were generated from those elements of the Project 2000 strategy which pertained to the careers of those qualifying from the diploma course and from the wider policy agenda on the recruitment, professional development and retention of nurses. The research design and interpretation of findings also take account of branch-specific policy issues

1.2 RESEARCH DESIGN AND METHODS

1.2.1 Choice of design

The research design is longitudinal with questionnaires sent to a cohort of diplomates at qualification and regular intervals thereafter. A longitudinal design was chosen because of the advantages it offers over cross-sectional designs in investigating careers. These advantages include: greater accuracy of recall about career events and accompanying decisions; ability to analyse change at the individual as well the aggregate level; the reduction of sample bias, the possibility of exploring the causal and temporal order of events, and the opportunity of including new issues that may arise during the project's lifetime.

1.2.2 Sample size and data collection

A nationally representative cohort for each branch was recruited from those qualifying from diploma courses in England between July 1997 and August 1998. Each branch was sampled separately; a one-third sample of the adult branch was drawn in order to obtain sufficient numbers in sub-groups of interest. The cohort was recruited prospectively, just prior to qualification. The research team met the students personally to request participation, since previous experience had shown that this achieved a much higher recruitment rate than invitation by post (Robinson and Marsland 1994). Data collection was by questionnaire in order to obtain sufficient numbers for reliable estimates and viable statistical analysis, and to achieve national representation. The first questionnaire (the subject of this report) was sent at qualification, with a second at six months and a third at 18 months after qualification.

1.2.3 Pilot work

Given the problem of compounding attrition at each phase of a longitudinal study, considerable attention was devoted to developing strategies to maximize initial participation rates and subsequent retention. A pilot cohort of 150 from each branch was recruited from intakes qualifying during the year preceding that of the main cohort, and with whom panel recruitment and maintenance strategies were tested and questionnaires developed. The latter employed a three-stage process. In stage 1 semi-structured interviews were held to determine content and explore understanding of terminology. In stage 2 draft questions, based on the interview material, were piloted and draft questionnaires then tested to assess clarity of routeing instructions and acceptability of length. In stage 3, draft versions of the questionnaire were tested by post; two postal pilots were used in the development of the ‘at qualification’ adult branch questionnaire.

1.2.4 Response rate

Eighty-seven per cent of those eligible to participate in the main study agreed to do so (1831/2109). The response rate for the first questionnaire was 87% (1596); this accounts for 76% of the sample.

1.2.5 Theoretical framework/related research

The research is informed by perspectives from the theoretical literature on careers; in particular by that which conceptualises careers as an interaction between individual choice and the enabling or constraining aspects of the social context (Bailyn 1989). Within this overall framework, various theories are drawn on to investigate aspects of careers; for example those which seek to explain differences in the career paths of women and men (Finlayson and Nazroo 1998), and those concerned with an individual’s career guidance community (Law 1981). In each of the separate branch reports, findings are compared with those of other studies which have focused specifically on the branch in question. Research which can be compared with adult branch diplomates at the point of qualification include a study of qualifiers from the traditional course (Robinson *et al* 1995) and studies of the diplomate course in which a few findings are presented separately for the adult branch members of the sample (Jowett 1995, May *et al.* 1997).

2. DIVERSITY OF DIPLOMATES

2.1 POLICY RELEVANCE OF RESEARCHING DIVERSITY

The first aim of the research is to ascertain the diversity within the diploma qualified nursing workforce in terms of demographic characteristics, educational background, and

routes into nursing and the different branches. Policies to increase diversity in nursing had been advocated by the UKCC in its Project 2000 proposals and this was subsequently re-affirmed by the UKCC and the Department of Health (UKCC 1999a, DH 1999a). The main rationales for attracting a greater diversity of people into nursing than hitherto have been the shrinking of the profession's traditional recruitment base of female school leavers, shortages of nursing staff, and the view that the workforce should more closely represent the communities which it serves (UKCC 1986,1987,1999a, DH 1999a). These policies had referred to nursing as a whole, however, and not to its separate branches; this research investigates diversity within each branch. The diversity which existed within the adult diploma nursing workforce at qualification is demonstrated in this first phase of the research.

2.2 FINDINGS ON DIVERSITY AT QUALIFICATION

2.2.1 Demographic characteristics

- **8% of the adult branch cohort were men and 92% were women.**

The Project 2000 target was to increase the proportion of male entrants to nursing (UKCC 1987). The proportion of men in the adult nursing workforce who qualified via the traditional route has remained constant at 6% from 1991 to 1998 (UKCC 1998). The UKCC figures for members of the adult nursing workforce who qualified from the diploma course show that the proportion of men is higher than that for the traditional route and varies between 9% and 10% from 1993 to 1998 (UKCC 1998). These national figures suggest that with the move to the diploma course there has been an increase in the proportion of men in the adult nursing workforce.

- **54% of the cohort were aged 20-24, 20% were 25-29 and 26% were aged 30 or older**

Comparison of these figures with those for traditional qualifiers suggest that there has been a shift towards older entrants for the diploma course in that 14% of the former were aged 30 or older (Robinson *et al.* 1995).

- **4% of the cohort were black or Asian, 94% were white**

A comparison of this figure with those for traditional qualifiers (Robinson *et al.* 1995) indicates little change. The figure is lower than those reported for nursing, midwifery and health visiting as a whole: 7% by Beishon et al (1995) and just under 8% by the Department of Health (DH 1997b).

2.2.2 Educational background

- **10% entered the course via the UKCC DC test and 10% via an access course**
- **27% had 5 O' levels or equivalent, but not A' levels or equivalent**

- **30% had A' levels but not a degree**
- **4% had a degree**
- **A wide range of vocational and academic qualifications had been obtained, each by a small proportion of the cohort**

Recommendations for increased diversity have focused on those without formal academic qualifications and those with two A' levels or higher. Comparison of findings for this adult branch diplomate cohort with traditional qualifiers (Robinson *et al.* 1995) suggest that the move to the diploma course has been accompanied by a small increase in those with degrees (2% to 4%) and a small decrease in those with A' levels (20% to 22%). Turning to those without formal academic qualifications, 16% of traditional qualifiers had entered via the UKCC DC test; a higher proportion than the 10% for the diplomate cohort. When the 10% who gained access to the diploma course via an Access course are included, then the comparison shows an increase from 16% to 20% for those entering adult nursing without formal academic qualifications.

2.2.3 Routes into adult branch nursing

- **84% had undertaken paid employment prior to starting the course**
- **69% had worked full-time, 57% of whom had worked full-time for three years or more**
- **Full-time jobs encompassed a diversity of occupations**
- **52% had previously worked in nursing/health/social care**
- **18% had spent a period of time in full-time childcare before starting the course**
- **Only 7% said that a suggestion from a careers teacher/officer had been important in their decision to take the course**
- **95% had chosen the adult branch prior to starting the course**

Recommendations to increase diversity include recruiting people who had previous experience of other occupations and those who have cared for children full-time; this diversity was reflected in this adult branch diplomate cohort and in this respect the cohort was similar to traditional qualifiers (Robinson *et al* 1995).

2.3 POLICY IMPLICATIONS OF FINDINGS ON DIVERSITY AT QUALIFICATION

2.3.1 Immediate implications of findings on diversity

While findings reported here relate to course qualifiers and not course entrants, it is suggested that to further increase diversity, greater emphasis needs to be placed on recruitment of men and members of ethnic minority groups. Moreover, it is important to ascertain whether members of these groups who do start the course are as likely as others to complete it, since if not, the potential for diversity will not be realized.

Recruitment strategies need to be targeted widely and not just at those nearing completion of secondary education, if the diversity of background which currently exists in the adult nursing workforce at qualification is to be maintained and perhaps increased. Careers services should play an increased role in bringing nursing to people's attention. As many potential recruits may not be in a position to access careers services, however, national and local advertising campaigns should also be regularly deployed.

2.3.2 Relevance of findings on diversity for later career stages

This first phase of the project demonstrated the diversity of the cohort at qualification. These findings provide a baseline for:

Demonstrating the extent to which the diversity which existed at qualification is maintained among those who remain in the adult nursing workforce as a whole and among those who work in different employing organizations, settings and clinical specialties.

Indicating the subgroups at which retention strategies should be targeted if diversity is to be retained in the workforce as a whole and in the organizations, settings and clinical specialties in which it is deployed.

In due course, the findings from this research will provide a baseline for comparing the diversity amongst the qualifiers from the adult branch of the revised diploma course which started in autumn 2000.

3. CAREER PATHWAYS

The second aim of the research is to describe diplomates' career plans and pathways from qualification onwards in relation to: retention in nursing; directions pursued within nursing, and career progression.

3.1 POLICY RELEVANCE OF RESEARCHING CAREER PATHWAYS

The need to improve retention of qualified nursing staff was highlighted by the UKCC in its 1986 Project 2000 proposals and is a major objective of the current government's plans for the health service (DH 1997a, 1999a, 2000c). Concern exists, however, not only about retention overall but also about shortages of staff in certain services. Although the ethos of the diploma course is for diplomates to feel adequately prepared to work in community as well as institutional settings, concern was expressed that this was unrealistic and the UKCC (1991) subsequently said that the newly qualified diplomate should work under the leadership of an experienced community practitioner. This research demonstrates plans and pathways of adult branch diplomates in relation to remaining in nursing overall, and directions pursued in terms of employing organizations, hospital and community settings, and clinical specialties. This first phase describes plans at qualification and immediate pathways pursued.

3.2 FINDINGS ON CAREER PLANS AND PATHWAYS

3.2.1 Nursing in the UK

a) Plans

- **95% planned to take up a nursing job immediately after qualifying**
- **Less than 1% did not plan to obtain a nursing job at any stage**
- **The majority thought it likely that they would be nursing at subsequent time-points: 6 months (92%); 18 months (91%); 3 years (85%); 5 years (76%), and 10 years (67%)**
- **For 5 and 10 years, other respondents were more likely to say that they were unable to say at this stage, rather than that it was unlikely that they would be in nursing**

At qualification, the majority of this adult branch cohort indicated an orientation to continue working in nursing in the UK and there was no sense of early attrition from the profession.

b) Obtaining a first job

- **91% of those planning to obtain a job immediately after qualifying had done so (nearly all had permanent as opposed to agency/bank jobs)**
- **Just under half of those who had not obtained a job were in the process of applying for one, or planned to do so within 6 months**

There was little indication of a lack of availability of jobs for newly qualified adult branch diplomates.

3.2.2 Employing organizations

- **98% of those with a first job said it was funded wholly (97%) or partly (1%) by the NHS**
- **Very few had wanted, but not been able to obtain an NHS job**
- **The NHS was the organization most likely to be specified for jobs diplomates hoped to hold at 18 months and three years after qualification**
- **47% said that their preference was to only hold jobs funded by the NHS, 50% that they would not mind working for other organizations**
- **The private sector was the non-NHS sector most likely to feature in diplomates' first job, and the private sector, charities and the Armed Forces in jobs diplomates hoped to hold at subsequent time-points**

This early orientation towards the NHS is unsurprising given that it is the organization in which diplomates were most likely to gain experience and with which they were most familiar. The increasing involvement of other organizations in the provision of care was, however, reflected in the plans and early pathways of some members of the cohort.

3.2.3 Setting

Of those with a first job:

- **97% had a first job based in hospital**
- **1% had a first job based in a residential setting**
- **2% had a first job in a setting which people visit (e.g. day hospital)**
- **2% had a first job in a setting which involved visiting people at home**

Although most diplomates had obtained a first job in hospital, the increasing provision of care in the community was reflected in the small proportion who had a first job in one or more community settings.

- **Views about feeling inadequately prepared to work in the community and/or preferring to consolidate experience elsewhere first, were much more marked in relation to visiting people at home than to either residential settings or settings which people visit**

It is important that preparation for, and experience of working in, the community are investigated in terms of these three distinct settings, since policy implications of findings in relation to each may be different. With regard to working in community settings in the early post qualification period, it is visiting people at home for which diplomates are most likely to need the support of an experienced community practitioner.

3.2.4 Clinical specialties

- **For each clinical specialty of which diplomates had had experience during the course, then with the exception of outpatients, theatres and care of elderly people, these experiences were more likely to have encouraged, than discouraged, them from considering working in the area in the future**
- **Diplomates' first jobs were in a diversity of clinical specialties, the most likely clinical specialty was general medicine (33%), followed by general surgery (22%), care of elderly people (16%) and cardiac (12%)**
- **Diplomates who had not been able to obtain their first job in their preferred clinical specialty were more likely than those who had been able to do so to plan moving onto a second job in a different clinical specialty six months or less after qualifying**
- **Looking ahead, the main point to emerge was lack of certainty about the clinical specialties in which diplomates hoped to be working**

Although some diplomates had taken a first job in a specialist field, most were uncertain about the clinical specialty of jobs in which they hoped to be working in the future. This uncertainty may reflect lack of sufficient expertise, and the knowledge upon which to base a decision about choosing to work in particular clinical specialties, combined with a desire to consolidate experience before embarking on a specialist career.

3.3 RELEVANCE OF FINDINGS ON CAREER PATHWAYS FOR LATER CAREER STAGES

Later phases of the research each describe diplomates' pathways in relation to staying in nursing, working in different employing organizations, settings, and clinical specialties and their reasons for the particular directions which they pursue. Over time, therefore, the research is building a up a much more comprehensive picture of the adult nursing workforce than has existed hitherto. The importance of the at qualification findings is in providing a baseline against which subsequent events can be compared. Little sense of likely attrition from nursing was evident from plans diplomates expressed at qualification. Later phases will show whether those diplomates who planned to stay in nursing do in fact do so, and if not what caused a change of mind. Pathways which diplomates wanted to follow but are unable to do so will be identified; investigation of reasons for this occurring may contribute to the development of strategies to improve staffing levels in services which have staffing problems. It will also show whether there are clinical specialties in which few diplomates wish to work, and whether there are specialties in which they do wish to work but find it difficult to obtain jobs.

4. CONTINUING PROFESSIONAL DEVELOPMENT

The third aim of the project is to investigate subjects relevant to diplomates' careers: continuing professional development; career guidance; combining work and family; aspects of nurses' roles, and quality of working life. Aspects of the first three were included in this first phase of the research.

4.1 POLICY RELEVANCE OF RESEARCHING CONTINUING PROFESSIONAL DEVELOPMENT

The importance of continuing professional development (CPD) for nurses featured strongly in the Project 2000 proposals (UKCC 1986) and this view has been reiterated in subsequent policy documents produced by the statutory and professional bodies for nursing and by central government (UKCC 1990, 1993, 1994, DH 1999a). These documents have identified, with varying degrees of emphasis, the role of CPD in individual career progress and retention, enhancing the quality of patient care, and meeting service needs. While aware of debates about whether CPD does enhance the quality of patient care, this research investigated diplomates' satisfaction with some aspects of CPD and its relevance to their career plans and pathways.

The first phase focused on expectations of preceptorship, heralded as a means of supporting newly qualified nurses in the transition from student to practitioner (UKCC 1990,1993). Plans to take courses were investigated in order to assess how much demand, and for which courses, there was likely to be at this early stage and the way in which courses featured in diplomates' career plans. A growing emphasis on nurses obtaining degrees has meant that for traditional and diploma educated nurses, this has increasingly come to be seen as an important aspect of promotion prospects. This first phase of the research investigated adult branch diplomates’ plans in this respect.

4. 2 PRECEPTORSHIP

4.2.1 Findings on preceptorship

Diplomates were asked if they wanted a preceptor in their first job and to rate the importance to them of 11 separate aspects of preceptorship.

- **97% of diplomates wanted to have a preceptor in their first job**
- **All 11 aspects of preceptorship were rated as very or quite important by the majority of diplomates**

- **In descending order of frequency, the proportion rating aspects as very important were: 1. constructive feedback on clinical skills (91%); 2. teaching new clinical skills (83%); 3. confidence building (63%); 4. helping me settle into the work environment (60%); 5. advice on professional issues (58%); 6. assisting in setting learning objectives (51%); 7. emotional support (50%); 8. someone to work alongside (31%); 9. someone to meet with on a regular basis (29%); 10. someone to confide in (29%); and, 11. discussing career plans (19%).**

There was a very substantial demand for a period of preceptorship after qualification, with a focus on clinical skills. This research advanced what is known about preceptorship by investigating the subject in terms of its constituent elements rather than as an undifferentiated whole.

4.2.2 Immediate policy implications of findings on expectations of preceptorship

Employers should ensure that all newly qualified adult branch diplomates nurses are allocated a preceptor, given the demand which exists for having this form of support in the early post-qualification period. This in turn will need supporting by the provision of training programmes to equip sufficient numbers of staff for the role of preceptor. Such programmes should include consideration of the separate elements of preceptorship identified for this research. Preceptors should ascertain the expectations held by their preceptees in order to appropriately focus the preceptorship which they provide.

These recommendations have time implications for clinical staff, both in providing preceptorship and attending courses on being a preceptor. Clinical staff, however, are already heavily committed with service delivery and supporting pre-registration students on clinical placements. Provision of preceptorship may well, as hoped, prove important for quality of care and retention of staff. Consequently workforce planners need to ensure that sufficient staff are available so that workloads can encompass provision of preceptorship. While this may increase costs in the short-term, these may be outweighed by longer-term benefits.

4.2.3 Relevance of findings on expectations of preceptorship to later career stages

The findings on preceptorship provide a baseline of expectations against which subsequent experiences during the first six months can be compared.

4.3 PLANS TO TAKE COURSES

4.3.1 Findings on plans to take courses

a) ***Degrees***

- **67% planned to obtain a degree, 29% were unsure about doing so**

Of those planning to obtain a degree:

- **76% saw this as a means of developing their career in nursing**
- **74% planned to start their degree more than six months after qualifying or were unsure as to when this would be**
- **58% planned to study part-time, 20% by credit accumulation and 12% full-time**
- **72% planned to take a degree in nursing, 17% in another subject and 10% were uncertain**
- **Just 4% said that they did not plan to obtain a degree**

The growing emphasis on nurses having a degree has not been unequivocally reflected in the plans of this adult branch cohort at the point of qualification. Moreover, of those who do plan to obtain a degree, some were uncertain about the subject and when to start.

b) Other branches

- **Just 4% planned to qualify for another branch, most likely child**
- **The planned start date was likely to be longer than six months after qualifying.**

c) Other courses

- **16% had applied, or planned to apply, during the first six months for courses other than degrees or other branches. ENB Course 998 (Teaching and assessing in clinical practice) was mentioned most often; by 11% of the cohort as a whole. Reasons for wanting to attend courses reflected individual career development and improving the quality of patient care.**

4.3.2 Relevance of findings on taking courses for later career stages

The next phase of the research investigates whether plans expressed at qualification to start degrees, other branches, and other courses in six months or less have been realised. Reasons given for not having started courses within this timescale indicate whether this was due to a change of plan on the part of the diplomate or to barriers such as lack of places, funding and study leave and lack of support by the diplomate's manager for

attending the course in question. The next phase of the research asks diplomates about their current plans to take courses, thus enabling an assessment to be made of changes in plans.

5. CAREER GUIDANCE

The third aim of the research includes investigating career guidance.

5. 1 POLICY RELEVANCE OF RESEARCHING CAREER GUIDANCE

Although not specifically mentioned in the Project 2000 proposals, it has been maintained in various policy documents that career guidance facilitates career development and planning, and thereby contributes to improved retention (e.g. DH 1988,1995). Career guidance is investigated throughout the course of the research; this first phase focused on guidance during the nurse diploma course. A distinction was made between information and advice about specific aspects of career pathways and discussions about career planning; collectively referred to here as career guidance.

5. 2 INFORMATION AND ADVICE DURING THE NURSE DIPLOMA COURSE

5.2.1 Findings on information and advice

In relation to topics in three areas (applying for first job, continuing education and career pathways), diplomates were asked whether they had received information and advice; if so had they wanted more, and if not had they wanted some.

a) Applying for first job

- **The majority (71% or more) had received guidance on job availability, performing at job interviews, completing application forms, and writing a CV**
- **Unmet demand was greatest for guidance about performing at job interviews with 62% wanting some or more guidance.**

b) Continuing education

- **66% had guidance about taking a degree**
- **Figures were lower for the three aspects of taking National Board courses: types of courses offered (52%), courses offered relevant to your particular ideas about the future (40%), and procedures for applying for courses (26%)**

- **Unmet demand was higher for National Board courses than for taking degrees: with 88% wanting some, or more, guidance about procedures for applying for clinical courses offered by the National Boards and 86% for guidance about which of these courses were relevant to their ideas about the future.**

c) Career pathways

- **Figures for receiving guidance were: 1. career pathways for those qualifying from the adult branch (53%); 2. developing a career in clinical practice (47%); 3. jobs for which your particular skills might be most suitable (40%); 4. management in the NHS (26%); 5. nursing research (26%); 6. opportunities for working abroad (26%) 7. opportunities for working outside the NHS (25%) and 8. nurse education (18%),**
- **Unmet demand was greatest for items 1 (84%) and 2 (81%)**

5.2.2 Immediate policy implications of findings on information and advice

The findings indicate that a substantial proportion of diplomates did not receive information and advice about many aspects of career planning during their nurse diploma course. The relatively large proportion who had received guidance about obtaining a degree is indicative of the increasing emphasis on degree level qualifications within the profession. The paucity of guidance about taking National Board courses is of concern, however, since it means that many diplomates are embarking upon their post-qualification careers without the knowledge necessary to make constructive decisions about continuing education in relation to career pathways; a concern voiced in the Department of Health's recent strategy for nursing, midwifery and health visiting (DH 1999a).

The research indicated that there is a considerable unmet demand for guidance and its lack is of concern to many diplomates, even at this early stage of their careers. Whilst students may have an expectation that guidance should be provided for them, recent years have seen increasing emphasis on the self-direction of, and individual responsibility for, career development. It is therefore essential that by qualification diplomates are equipped with the knowledge, skills and attitudes necessary to enable them to manage their careers proactively. The response to the lack of guidance revealed by this research should, therefore, not necessarily be increased provision of information and advice about the topics identified, but the introduction of career development programmes enabling students to identify, access and utilize the information and advice they require. Consideration also needs to be given as to how, and by whom, career development programmes are introduced into the diploma course.

5.3 DISCUSSIONS ABOUT CAREER PLANNING

5.3.1 Findings on discussions about career planning

- **44% of respondents had had some discussion about planning their career**
- **67% had discussions with a personal tutor, and/or other college staff and/or clinical staff**
- **Just 12% of respondents had had a discussion with staff of a university careers information/advisory service**
- **80% of those who did not have a discussion about career planning wanted one**

It is noteworthy that so few students had discussions with university careers services. It may be that such services do not advertise themselves to nurse diploma students for fear of being unable to cope with the demand. Alternatively, students may feel that university services are unable to provide the specialist information they require and therefore prefer to discuss career issues with those more closely connected with the profession. A further factor may be the accessibility of such services. The amalgamation of colleges of nursing and integration of nurse education with higher education means that nursing students may not be based on the campus where such services are located.

5.3.2 Immediate policy implications of findings on discussions about career planning

Again, these findings demonstrate a substantial unmet demand for guidance. Furthermore, the discussions which did take place were primarily with staff with whom students routinely had contact during the course. Whilst some such staff may provide accurate guidance there is a danger that, without relevant training, information and advice provided may be narrow and out of date, being based on their own past experiences rather than on current healthcare developments. If such staff are to be involved in providing career guidance, strategies are necessary to ensure that the information and advice they provide is accurate and up-to-date.

5.4 RELEVANCE OF FINDINGS ON INFORMATION/ADVICE AND CAREER PLANNING FOR LATER CAREER STAGES

The relationship of guidance received during the course to subsequent plans and events is complex and not uni-directional (Murrells and Robinson 1997) and we would not maintain that guidance received during the course necessarily has an influence on subsequent careers followed and patterns of retention. Career guidance is investigated at each later phase of the research.

6. COMBINING WORK AND FAMILY

The third aim of the project includes investigating diplomates' experiences of combining work and family.

6.1 POLICY RELEVANCE OF RESEARCHING COMBINING WORK AND FAMILY

In its Project 2000 proposals, the UKCC had emphasized the importance of support facilities for those with family commitments as a means of improving rates of retention in, and return to, nursing. The provision of family-friendly policies is high on the current policy agenda as a means of improving the quality of working lives of the workforce and as an aid to retention (DH 1998b, 1999a, 2000a,b,c). By investigating diplomates' experiences in these respects from qualification onwards, this research will be able to demonstrate the extent to which plans about combining work and family are facilitated, thwarted or changed. This first phase of the research indicated the extent to which some diplomates' career/work plans were affected by family circumstances at the outset of their post-qualification careers.

6.2 FINDINGS ON COMBINING WORK AND FAMILY

60% of diplomates had a spouse/partner, 23% had children living with them and 8% referred to children (their own or those of a spouse/partner) who did not live them. Questions about the effect of partner and children on work and career plans indicated the following:

- **28% had a partner whose level of income meant that they could chose to work part-time or not at all, however 29% said that their partner's level, or lack, of income meant that they had to work full-time or at least part-time**
- **5% said that having to live in a particular location because of their partner's job meant that their own choice of job was limited**
- **11% of the cohort said that they had children living with them who had an effect on their work/career plans and 1% said that this was the case in relation to children who did not live with them. For both groups, restricted geographical mobility and the need for a certain level of income were the main effects described**

6.3 POLICY IMPLICATIONS OF FINDINGS ON COMBINING WORK AND FAMILY

These findings indicate that when employers are considering ways of providing support for those with children, they should not overlook that this may be needed by some of those at the very start of their career.

7. CONCLUSION

As this summary has shown, the findings have a number of immediate policy implications relating to adult branch diplomates up to the point of qualification and also provide a baseline against which subsequent events can be compared. The value of a longitudinal design in the investigation of diplomates' careers is that their plans have been obtained near the time when formulated, rather than being subject to subsequent recall. Later phases of the research demonstrate how adult branch diplomates' careers progress, the changes and developments in their employment and continuing education plans, and their experiences of, and satisfaction with, working in nursing/ healthcare. Moreover, later phases will show the extent to which the diversity which existed at qualification is maintained among those who remain in nursing and how it differs across the various organizations and services in which they work.

CHAPTER 1: INTRODUCTION

1.1 AIMS OF THE RESEARCH

This report focuses on adult branch diplomates at the point of qualification. It is the fourth report from a longitudinal study of the careers of those qualifying from all four branches of the course (adult, mental health, learning disability and child). Findings presented are relevant to many aspects of the current policy agenda on workforce expansion, human resources initiatives, continuing professional development and career pathways. This agenda, set out in *Working Together* (DH 1998b), *Making a Difference* (DH 1999a) and *Health service of all the talents* (DH 2000b), has been reinforced *in The NHS Plan* (DH 2000c). To meet both the branch specific and the wider policy agendas, publication policy for the project is to report findings for each branch separately and to provide an overview report in which the main findings for each branch are compared and contrasted.

The Project 2000 strategy, in which the traditional routes to registration as a nurse were replaced by the diploma course, represented a major reform of nurse education and has far reaching implications for the structure of the nursing workforce and the care that its members deliver. Given the substantial investment that the strategy entailed, there is considerable interest in the careers followed by those qualifying from the diploma course. Consequently, the Department of Health commissioned a team based at the Nursing Research Unit (NRU), Kings College London, to investigate the careers of diplomates from the four branches of the course (adult, mental health, learning disability and child).

The aims of the research are to:

1. Ascertain the diversity within the diplomate workforce at qualification and at subsequent time-points thereafter.
2. Describe diplomates' career plans and career pathways followed from qualification onwards.

3. Investigate subjects relevant to diplomates' careers: continuing professional development; career guidance; aspects of nurses' roles; quality of working life, and combining work and family.
4. Identify relationships between career plans, careers followed, and profile and experience variables.

This first chapter demonstrates how these aims were generated from the changes which it was hoped would result from the Project 2000 strategy (Section 1.2); and their relevance to the current policy agenda for nursing and healthcare (Section 1.3). The research design is longitudinal with questionnaires sent at regular intervals to a cohort of diplomates who qualified between September 1997 and August 1998. Thus far questionnaires have been sent to the cohort at qualification and at six months and 18 months later. Each phase of the research is producing two kinds of policy relevant findings: those which have immediate implications for the career stage being investigated, and those which do not have immediate implications but provide a context for the interpretation of findings for subsequent career stages. Each phase of the research is therefore being reported in turn, so that those findings with immediate policy implications are widely available. As noted, each branch is being reported separately.

A large volume of research and a diversity of theoretical perspectives, are relevant to the understanding of diplomates' careers. Our approach in this first report is to provide an overview of these in order to set this research as a whole in context (Sections 1.5 and 1.6). In subsequent reports, greater detail is provided on the research and theoretical perspectives relevant to the particular career stage being reported. Thus, for example, research on providing preceptorship in the early post-qualification period is discussed in the report on diplomates' first six months after qualification. The questionnaire sent to diplomates 18 months after qualification investigates views and experiences of combining work and family, and so relevant research and theoretical perspectives on this subject are included in the third report.

The content of the rest of the report is as follows. Chapter 2 focuses on research design and methods. Findings are presented in Chapters 3 to 10. Chapters 3 and 4 focus on diversity in the cohort. Career plans and pathways are investigated in Chapters 5, 6 and 7. In Chapter 8 the focus moves to plans for continuing professional development and career guidance received during the course is the subject of Chapter 9. Views about the impact of spouse/partner's work and responsibilities for children on cohort members' own plans for the future are detailed in Chapter 10. Chapter 11 draws together the key findings and their policy implications.

1.2 THE PROJECT 2000 STRATEGY: POLICIES FOR REFORM

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) produced its report on the reform of nursing education in May 1986 (UKCC 1986) with a shortened and slightly revised version submitted to the then government in early 1987 (UKCC 1987). While the proposals' main concern lay with a reform of pre-registration education, attention also focused on the need for a comprehensive framework for continuing professional education and for a restructuring of the nursing workforce (UKCC 1986). The reports also made clear that the proposals for reform were closely interlinked with the need to improve supply for, and retention in, the nursing workforce (UKCC 1986, 1987). This research was commissioned in 1996 to investigate those aspects of the Project 2000 strategy pertaining to careers and which were of particular relevance to the wider nursing and healthcare policy agenda. This section outlines the key points in the Project 2000 strategy and identifies those which are included within the aims of this research (highlighted in italics). The next section (1.3) focuses on the current policy relevance of the four aims of the research.

1.2.1 Reforms in education and workforce structure

Reforming pre-registration education

The Project 2000 proposals recommended an 'uncoupling' of the link between education and service, given years of disquiet with problems attributed to a system in which students as health service employees were subject to service demands (Elkan and Robinson 1991, Bentley 1996). The proposals recommended that students should have full supernumerary[1] status, be responsible to educationalists rather than service managers, and receive a grant rather than a salary. In short, preparation of student nurses would be education rather than service led. The proposals also sought to simplify the diversity of routes to registration by replacing them with a three-year diploma course which commenced with a Common Foundation Programme of up to two years, followed by specialization in child, adult, learning disability or mental health nursing. It was argued that one of the benefits of such a structure was that students would gain experience in all four branches before selecting one in which to specialize.

As part of describing diplomates' career plans and pathways (Aim 2), this research ascertains the proportion of diplomates' who had made their choice of branch before starting the course, and the proportion who subsequently changed branch, or considered doing so.

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[1] In the final proposals, full supernumerary status was modified to a 20% service contribution (UKCC 1987, p7). The UKCC's rationale for this change was that since students would *de facto* be making a contribution to service, recognition should be made by service managers of this practical contribution (UKCC 1987, p7)

The UKCC noted that health authorities were focusing on developing new services to meet the needs of particular client groups. Moreover, there was an increasing emphasis on providing care in community settings, on health promotion, on primary healthcare and on inter-agency collaboration. Nurse education, it was argued, should produce practitioners able to contribute to the planning, assessment and development of this increasing diversity of services. The UKCC urged 'a re-orientation of initial training towards the community and a lessening of the emphasis on high technology hospital care,' and asserted that the new course should ensure those qualifying were capable of 'assessing, providing, monitoring, and evaluating care in both hospital and community settings' (UKCC 1986, p40). The original proposals did caution, however, that those working in mental health and learning disability fields would require the guidance of a more experienced practitioner when visiting clients at home (UKCC 1986).

As part of describing diplomates' career plans and pathways (Aim 2), this research ascertains the extent to which diplomates want, and are able to obtain, jobs in community settings.

The UKCC also sought to enhance the standing of nurse education within the wider educational community. To this end it argued that the new diploma programmes should be academically validated and credible and lead to ‘qualifications which equate with the standard of an advanced educational qualification and which give entry to further courses’ (UKCC 1986, p84). Closer contact with the wider educational community was advocated through integration into, or closer links with, institutions of further or higher education.

Reforming continuing education

The UKCC saw the first level course as a first step only and recommended that a comprehensive framework of education beyond registration be developed. While recognizing that further work was needed to develop the details of such a framework, the UKCC identified its key aspects as providing opportunities to consolidate learning in the immediate post-registration period, for subsequent updating of knowledge and skills, and making provision for courses leading to qualification in areas of specialist practice. The essence of the pre-registration and post-registration reforms taken together was to provide a ‘building block pattern’ in which nurses could not only choose to specialize in a particular area but could also change career direction without having to ‘go back to the beginning’ (UKCC 1986, p53).

As part of investigating continuing professional development in the context of diplomates careers (Aim 3), this research included the two aspects identified by the UKCC - support

in the immediate post-registration period and opportunities for post-registration education.

Restructuring the workforce

A second group of proposals advocated revising the structure of the workforce, with the lynch-pin being a single level of registered practitioner, actively involved in the delivery and evaluation of care. As Elkan and Robinson (1991) note, emphasis on care-giving was a response to concerns identified by Pembrey (1985) that while registered nurses supervised and managed care-giving by others, they were often not directly involved themselves. The UKCC also proposed that enrolled nurse training should cease and that there should be a new grade of helper to assist the registered practitioner. Opportunities to move from the level of registered practitioner to that of specialist practitioner were also envisaged, although it was acknowledged that more work was needed to develop the content of the role of those moving to this level of practice.

As part of investigating aspects of nurses' roles in the context of diplomates' careers (Aim 3), this research investigates the amount of time they spend in direct patient/client care and their satisfaction, or otherwise, in this respect in the various jobs they hold.

A new type of practitioner

The Project 2000 proposals sought to change more than just the structure and content of nurse education. A change was sought in the whole attitude and approach which nurses brought to their work from that which had characterized the profession hitherto. Nurses were needed who could adapt to, and meet the demands of, a rapidly changing healthcare environment and one in which cost savings were very much on the agenda. Professional accountability was emphasized; nurses should take increased responsibility for the care they deliver through a commitment to research-based practice and a willingness to change practice. Continuing professional development was seen as the key to this increased accountability, and the course should inculcate a commitment to this from the point of qualification onwards. In short, the nurse of the future would be, 'A mature and confident practitioner, willing to accept responsibility, able to think analytically and flexibly, able to recognize a need for further preparation and willing to engage in self-development' (UKCC 1986, p33).

As part of investigating aspects of nurses roles in the context of displomates' careers (Aim 3), this research investigates the extent to which they are willing, and able, to change practice, and their opportunities for reflective practice.

1.2.2 Recruitment and retention

The second element of the Project 2000 strategy was that of improving workforce supply and retention. The hope was expressed that the implementation of the proposals for reform would improve morale throughout the profession and that this would encourage not only recruitment, but also retention. From the outset of its deliberations, the UKCC recognized the urgency of addressing the demographic changes which foreshadowed a decline in the nursing profession's traditional recruitment base of female school-leavers and which meant that the long-standing pattern of a high recruitment/high wastage workforce had to be changed. By the mid 1980s, reports of shortages of nurses were already in evidence, although this picture varied by specialty and by region (Bosanquet and Gerard 1985).

Recommendations concerned with recruitment focused on attracting groups other than the female school-leaver and included: an increase in the number of men from 500 to 2500 *per annum*; an increase in the number of mature entrants from 3000 to 4000 *per annum*; a broadening of the qualification entry gate to facilitate the entrance of an additional 4500 people and attracting a higher proportion of people with two A' levels or more (UKCC 1987). While attracting more mature entrants was important, the UKCC nonetheless recognized that nursing would also have to make strenuous efforts 'to attract young people into nursing' and that it was 'imperative to interest them in health service careers at an earlier age than $17^1/_2$ or 18' (UKCC 1987, p13). A review of current recruitment arrangements was therefore advocated, including advertising and the role of the careers service (UKCC 1987, p13).

This research ascertains the profile of those qualifying from the course (Aim 1) and, through comparisons with those qualifying from traditional courses, indicates whether the move to the diploma course has been accompanied by greater diversity along the various dimensions identified: sex; age, and educational background.

Later phases of the project demonstrate the extent to which the diversity which exists for the cohort at qualification is maintained amongst those who remain in nursing (Aim 1).

The UKCC also argued that wastage from training should be tackled, and suggested a modest UK target of a reduction from 21% to 19% (UKCC 1987, p12). Health service managers were urged to set new targets for reducing wastage of qualified staff, and increasing the number of returners through improved advertising, re-orientation courses, more flexible working arrangements, and greater provision of support facilities for those with family commitments (UKCC 1987, p12-13).

This research investigates patterns of retention in, and return to, nursing (Aim 2).

This research investigates diplomates' views and experiences of combining work and family (Aim 3).

1.2.3 Changing to the diploma course

In May 1988, the Conservative government accepted the UKCC's case for the reform of nurse education, although concern about its staffing implications meant this acceptance was conditional on further work on widening access into nursing, and the development of proposals concerning the role and training of the support worker (Elkan and Robinson 1991). The government also acknowledged the need for further work and discussion on the framework for continuing education, the concept of the specialist practitioner, the number and status of nurse teachers and funding for mature students (Le Var 1997). From 1989 onwards successive waves of colleges changed to the new course.

From the outset of the Project 2000 proposals being advocated, concern was expressed that diplomates would have insufficient practical experience to be competent and confident at the point of qualification (Cole 1986, Dickson 1986). Since the course was introduced, there have in fact have been concerns about the extent to which it has equipped diplomates with practical skills at the point of qualification (UKCC 1999a, DH 1999a). This issue was addressed in several research projects (e.g. Jowett 1995, Luker *et al* 1996); while findings revealed a deficit of practical skills they also suggest that this is overcome quite quickly with early post-qualification experience. However, continuing anxiety has now led to a decision to increase the practical component of the course and to increase the time spent in the branch programme to two years, following a one year common foundation programme. The revised course was launched in 16 sites in autumn 2000 (DH 2000b para.5.51) with the majority of other colleges following suit in 2001 (DH 2000c para. 9.17).

1.3 RELEVANCE OF RESEARCH AIMS TO CURRENT POLICY AGENDA

The cohort which is the subject of this research began their course in 1994/5 and qualified during the academic year following the Labour government coming to office in May 1997. The health service which they entered had, however, been shaped to a considerable degree by the various policies implemented by the preceding Conservative governments. The dominant feature of these policies was to achieve efficiency and value for money while at the same time ensuring effectiveness through a variety of quality control measures. A number of authors commented that aspects of these policies, such as increasing the proportion of support workers, increasing patient throughput, and earlier

discharge, created an environment in which it was difficult to fulfil the aspirations of the Project 2000 strategy (Luker *et al* 1996, Veitch *et al* 1997).

The Labour government's proposals for the NHS also stipulated that efficiency and quality should be the cornerstones of the Service, but sought to replace the internal market with a more integrated and collaborative approach to the planning and provision of care (DH 1997a). While an ambitious range of targets have been set to increase standards in the quality and delivery of care, acknowledgement has also been made of the investment in staff which is required if these targets are to be met (DH 1997a, 1998a,b, 1999a, 2000a,b,c). Focusing on nursing in particular, then targets have been set to increase the number in post, set most recently at an extra 20,000 (DH 2000c). Moreover, a range of measures have been identified to improve the quality of their working lives, expand their roles, create new career pathways, and to provide continuing professional development programmes which meet their aspirations as well as the needs of the service (DH 1998a,b, 1999a, 2000a,b). As the following sections demonstrate, the four aims of this research are relevant to much of this agenda.

1.3.1 Recruiting and retaining a diverse workforce

The first aim of the research is to ascertain the diversity within the diplomate workforce at qualification and at subsequent time-points thereafter.

Increasing the diversity in the nursing workforce was a key feature of the Project 2000 proposals, (Section 1.2.2) with recommendations to increase the proportion of men, mature entrants, those with two or more A' levels and those without formal academic qualifications. Although increasing the proportion of people in the nursing workforce from ethnic minority groups was not specifically mentioned in the Project 2000 proposals, this was the subject of a range of policy initiatives in the early 1990s by the Department of Health, the UKCC, the ENB and individual health authorities and colleges (National Audit Office 1992).

The question of diversity in the NHS workforce as a whole was highlighted in *Working Together*, with a call for leaders and managers in the NHS to 'plan effectively at national and local level to ensure that we recruit and retain a workforce which has the capacity, skills, diversity and flexibility to meet the demands on the Service' (DH 1998b para.2.3). Turning to nursing, then policies focused on increasing the number of training places (DH 1999a para.3.4) and on attracting a more diverse group of people than hitherto, in order that the composition of the profession more directly reflects the people it serves (DH 1999a para.3.7) and that the NHS meet its recruitment needs (DH 1999a para.4.9). Particular reference was made to making training more accessible to those seeking a

second or third career, those with family or other carer commitments, people from ethnic minority groups, and those who wished to upgrade vocational qualifications (DH 1999a para 3.7). These policies were reinforced by the UKCC (1999a) in its review of pre-registration education; this emphasized the need to modify programmes to attract a greater diversity of people, given the continuing decline in the numbers of young people joining the workforce and the NHS nurse staffing shortages (UKCC 1999a para 3.1). In summary, recruiting a more diverse group of people into nursing than hitherto remains high on the policy agenda. However, it is important not only to recruit a more diverse group of people, but also to ensure that this diversity is maintained throughout the course and on into the qualified workforce.

This research provides information on: the diversity in the workforce at qualification as manifest in the four separate branches of nursing; a comparison with qualifiers from traditional courses; the extent to which the diversity in the diplomate cohort is retained among those who continue to work in nursing and, in due course, a baseline for comparing diversity among qualifiers from the revised diploma course.

1.3.2 Career pathways: retention, direction and progression

The second aim of the project is to describe career plans and pathways from qualification and is relevant to policies in three interrelated areas: retention overall, directions pursued within nursing and career progression.

Retention in Nursing

Turning first to retention overall, then the Project 2000 strategy was concerned with improving retention as well as recruitment to nursing, given the predicted decline in the numbers of potential entrants and concomitant shortages in the workforce (UKCC 1986, 1987). Although this concern continued during the late 1980s (Price Waterhouse 1988, NHS Management Board 1989), by the time the first cohorts of diplomates in the UK completed the course, there was a surplus of newly qualified nurses in some regions (National Audit Office 1992) who were finding it difficult to obtain jobs (Thompson 1990, Turner 1990, Cresswell 1992, Dickson 1993). As the decade has progressed, however, concerns about a shortage of nurses have re-surfaced: key objectives of the current administration are to increase the number of nurses in the NHS through campaigns to attract new recruits and to encourage the return of those who have left, and through the development of strategies to increase the likelihood of retaining those in post (DH 1999a, 2000c).

This research is investigating the movements of the diplomate cohort in and out of nursing in the UK and their reasons for staying in, leaving and/or returning to nursing.

Directions in Nursing

Concerns about retention focus not only on the overall number of nurses, but also on retention in the NHS as opposed to other employing organizations, and the numbers wishing to work in the various different settings, services, and clinical specialties. Although campaigns to encourage returners have seen an increase in the numbers of nurses in post (DH 1999a), concern remains about the numbers in particular branches such as mental health and in specialties such as intensive care and theatre nursing (Nursing Times 2000). While information exists on which clinical specialties and services are most likely to suffer from staff shortages, much less is known about whether nurses initially intend to work in them but are subsequently prevented from doing so (through, for example, lack of courses required to work in particular specialties) or are put off by the nature of the work and /or conditions once having done so.

This research describes diplomates' career plans to provide an indication of likely destinations, compares these with subsequent pathways followed, and investigates reasons as to why plans are not fulfilled .

In preparation for the pathways emerging in community settings, the UKCC had recommended that at qualification the registered practitioner should be equally prepared to work in non-institutional and institutional settings (UKCC 1986). Further impetus for these developments came with the NHS and Community Care Act of 1990. Considerable alarm was expressed by community nurses that newly qualified diplomates would be able to practise in non-institutional settings without further preparation, as it was feared that they would have neither the experience nor confidence to do so (Gough *et al*. 1993). Subsequently, as Clark (1993) observes, the UKCC modified its position, suggesting instead that the Project 2000 diplomates would be a valuable addition to the community team, but only under the leadership of an appropriately prepared 'community healthcare nurse' (UKCC 1991, 1994). While problems with some aspects of the policy of providing care in the community have been recognized, for example in relation to the needs of particular client groups, it remains a central policy objective which continues to be reflected in the ethos of the diploma course.

This research investigates diplomates' reasons for deciding to work, or not to work, in community settings, whether and at what stage they may feel inadequately prepared to work in these settings, and the career pathways which they follow in the community services.

Nurses were also diversifying their roles in ways which opened up new career pathways, such as that of clinical nurse specialist and nurse-practitioner. Further diversity in career

pathways emerged with the blurring of boundaries between the traditionally distinct arenas of practice, management, education and research and the creation of new posts such as lecturer-practitioner; career progression came increasingly to be seen as a 'climbing frame' rather than a step ladder (DH 1995). Expansion and diversity of career pathways has proceeded apace in the late 1990s, with nurses expanding their roles into areas such as prescribing and continuing to develop a range of nurse-led services (DH 1999a, 2000c).

This research investigates the extent to which these various career pathways feature in diplomates' plans, the extent to which these are fulfilled, and the factors which may constrain this process.

Career Progression

The third aspect of career pathways with which the research is concerned is that of career progression. As part of a drive for greater efficiency, many organizations in the 1990s adopted a policy of removing middle management layers of the staff hierarchy (Collin and Watts 1996); in the NHS this has had the effect of truncating the clinical career ladder for nurses (Mangan 1993) and reports emerged in the mid 1990s of posts above F or G grades being removed (Williams 1996). The system has also come to be regarded as constraining career planning and progression, making it difficult to move sideways into a different clinical specialty or service and to remain in clinical practice while advancing career and earnings (DH 1999a para 2.28). Consequently a new career framework has been proposed, with a first level of health care assistant, followed by three broad ranges for nurses: registered practitioner, senior registered practitioner and consultant nurse (DH 1999a para.5.6). It is hoped that this new framework will provide better career progression, provide opportunities to combine or move laterally between jobs in practice, education and research and that the nurse consultant level will encourage experienced and expert nurses to remain in practice.

This research investigates diplomates' plans for career progression, the extent to which these plans are fulfilled, and the factors which may constrain this process.

1.3.3 Continuing professional development

The third aim of the research is to investigate subjects relevant to nurses' careers: continuing professional development; career guidance; aspects of nurses' roles; quality of working life, and combining work and family.

Turning first to continuing professional development (CPD), then the Project 2000 proposals had emphasized its importance to nursing, focusing on support for the newly qualified practitioner and the development of a programme of post-registration education

(Section 1.2.1). A series of documents emerged from 1990 onwards focusing on the following aspects of such a programme: a period of preceptorship for the newly qualified nurse (UKCC 1990, 1993), maintaining and developing professional knowledge and competence through activities such as attendance at study days (UKCC 1990), and the development of courses leading to specialist qualifications which would enable nurses to pursue specific directions in the profession (UKCC 1994). The UKCC maintained that a programme of continuing professional development would make a positive contribution to job satisfaction and career development, and thus to retention, while at the same time enhancing the quality of care delivered by practitioners (UKCC 1990, 1994). For the current government, CPD has been an integral part of the policy agenda for the NHS from the outset. Intentions were signalled in *The New NHS* that the government proposed to work with the professions to reach a shared understanding of the principles that should underpin effective CPD and the respective roles of the state, the professions and individual practitioners in supporting this activity (DH 1997a para 6.10).

Details of policies for CPD were set out in *A First Class Service* (DH 1998a); it was defined as a process of lifelong learning which encompassed a range of opportunities for learning on-the-job, as well as attending courses (DH 1998a para.3.37). In this document, the objectives espoused for CPD echoed those of the UKCC in that they were to improve the quality of care delivered and to enable professionals to fulfil their potential and develop their careers, but it was also stressed that CPD should meet the service development needs of the NHS. A more integrated approach was needed to match the legitimate aspirations of health professionals with local service development needs and patients' expectations (DH 1998a para.3.33). The document also emphasized the role of CPD in retention, maintaining that local health service employers must recognize the value of appropriately managed CPD programmes in attracting, motivating and retaining high calibre professionals, and managers and other healthcare workers (DH 1998a para 3.37).

For nurses, midwives and health visitors CPD strategies were set out in *Making a Difference* (DH 1999a). With careers no longer the planned and ordered progression they once were, and the need to train and retrain to maintain competence, lifelong learning was seen as an essential part of modern working life to which NHS organizations and individual practitioners should be committed (DH 1999a para 2.27). As well as attending courses, CPD was to include the learning that takes place at work through 'experience, critical incidents, audit and reflection, supported by mentorship, clinical supervision and peer review' (DH 1999a para.4.20). Concern was expressed that practitioners and employers were confused by the proliferation of courses and lack of clear links to career paths (DH 1999a para. 4.15) and that a more focused framework was needed; a concern

which had been voiced by the UKCC in its Project 2000 proposals some 13 years earlier. In two recent policy documents (DH 2000b, c), emphasis has again been placed on the importance of CPD; this time with a focus on its role in developing a more flexible approach to career progression and facilitating moves within and between professions; examples given include enabling nurses to switch to careers in medicine (DH 2000c para. 9.18).

Particular mention was made in the UKCC proposals of nurses having the opportunity to use their nurse diploma as a credit towards obtaining a degree (UKCC 1986). Since then there has been a growing emphasis on the acquisition by nurses of degrees. An increasing number of higher education institutions are offering three-year degree programmes leading to registration, and for traditional and diploma educated nurses, degrees have come to be seen as an increasingly important aspect of promotion prospects (Hewison *et al* 1999). This trend has recently been underlined in that a first or masters level degree is likely to be required for promotion to the senior registered practitioner level of the new career framework (DH 1999a p.35).

This research investigates CPD in diplomates' career plans and pathways and includes: preceptorship; clinical supervision; support; meeting PREP requirements, and continuing education. Given the various policy objectives outlined above for CPD, the research focuses on whether diplomates are able to attend the courses they consider are necessary for their career progress, or if there appears to be a conflict between these on the one hand and available resources and the CPD priorities of the organizations in which they work on the other.

In this first phase of the research, aspects of preceptorship and continuing education were investigated.

1.3.4 Career guidance

Guidance on career planing was not specifically mentioned in the Project 2000 proposals, although recommendations for its provision extend back to the Briggs Report, (Committee on Nursing 1972) in which counselling, including career guidance, was identified as an urgent top priority. At that time guidance was recognized to be important, both in terms of staff welfare and for improving standards of patient care. Sixteen years later, career guidance featured in a Department of Health publication *The Way Ahead,* as a means of facilitating nurses' careers and as an important retention strategy (DH 1988). Subsequently, as traditional hierarchical career structures gave way to greater organizational diversity and lateral career pathways, the importance of

strategies to help individuals manage their careers was emphasized (DH 1995). By this time the ethos in career planning had shifted towards encouraging individuals to actively manage their own careers and to have a flexible approach to career planning.

This research investigates the receipt of career guidance during the diploma course and from qualification onwards.

1.3.5 Aspects of nurses' roles in the delivery of care

Some of the policies concerning the role of nurses in the delivery of care may have an influence on diplomates' decisions to take or leave particular jobs and on the direction in which they chose to pursue their careers. The UKCC (1986) had advocated that the practitioner of the future should be actively involved in the delivery and evaluation of care, committed to research-based practice and be willing to challenge and change established practice (Section 1.2.1). Since the publication of the Project 2000 proposals, the climate in which nurses are developing their careers has increasingly been characterized by policies for their roles to be extended to take on a much greater range of tasks than hitherto, many previously regarded as the domain of medical staff, and to increasingly take the lead in developing new services (DH 1997a, 1999a, 2000c).

This research investigates diplomates' satisfaction with aspects of their role in the delivery of care and its relationship with their career decisions

1.3.6 Quality of working life

Improving the quality of working life of NHS staff has been heralded as a key objective of the current government, in recognition that to do so is likely to enhance the quality of care which staff are able to deliver and to increase the likelihood that they will wish to remain in the service. First signalled in *The New NHS* (DH 1997a), the details of this 'human resources' strategy have been set out in subsequent policy documents (DH 1998b, 1999a, 2000b,c) and have included the following: reducing injury and violence to staff; developing flexible, family-friendly employment policies; improving relationships between staff and their managers, and providing more secure contracts of employment. A major initiative has been launched to ensure that the NHS makes progress in meeting targets set for improvements in these and other aspects of working life (DH 1999a). Satisfaction with the quality of their working life is relevant to the career pathways pursued by diplomates in three respects: decisions to remain in or leave particular jobs; to pursue specific directions within nursing and healthcare, and decisions to leave altogether.

This research investigates diplomates' satisfaction with a range of aspects of working life and its relationship with career decisions.

The Improving Working Lives initiatives are also concerned with ensuring equality of opportunity for career development and progress. In nursing, there has long been concern about inequalities in these respects for members of ethnic minority groups and women, and despite a number of initiatives to improve this situation, lack of progress has recently been highlighted (DH 1999a). Targets to reduce these inequalities for nurses, and for other health professionals, have recently been set (DH 2000a).

This research investigates the career progress of the women and men in the diplomate cohort and, where numbers are sufficient, of other subgroups

1.3.7 Combining work and family

The adverse impact of combining work and family on career progress and on retention within nursing has been longstanding (Davies and Conn 1993). Strategies to change this situation are very much a part of the current human resources framework for all health professionals (DH 1998b, DH 2000a) as well as for nurses (DH 1999a). Strategies include family friendly policies - such as flexible working and childcare support - and ensuring that staff do not have to take a drop in grade after a maternity break (DH 2000a).

This research investigates diplomates' plans and experiences in relation to combining work and family.

1.4 THEORETICAL PERSPECTIVES

Having set out the policy relevance of the aims of the research, this section outlines the theoretical perspectives which inform the research. As the foregoing sections have shown, the aims of the research take a broad brush approach to careers; from macro perspectives on, for example, numbers remaining in nursing at specified time points and factors associated with retention, to micro perspectives on aspects of experience, for example preceptorship. Although the remit is wide, it was considered essential to have a definition of career and an overarching analytic framework within which to formulate design and analysis.

The concept of career is much debated in social sciences. Some writers have securely linked 'career' to the world of work, but differ as to whether careers should relate only to vertical mobility (e.g. Wilensky 1961) or should encompass horizontal as well as vertical mobility (Super 1957). Others have argued for a wider usage and refer to the entry into,

and construction of, a range of adult life experiences; domestic life, parenthood and leisure, as well as work (Crompton and Sanderson 1990, Brannen and Moss 1991, Banks *et al.* 1992). Our approach to nurses' careers is to regard these as the sequence of events and experiences concerning employment in the years after qualification and the ways in which these intersect with other life events.

Given that the project is concerned with exploring the directions which nurses pursue after qualification, a framework in which careers are seen as an interaction between choice and constraint was selected as being the most appropriate. An early strand in the theoretical literature on careers and which emanated from developmental psychology, conceptualised careers as the outcome of individual choice; the best known exponent of this perspective was Super (eg Super 1957). Opposing views were offered by sociologists (initially and most notably by Roberts 1981), who argued that career histories are determined not by individual choice, but by the extent to which they are enhanced, limited, or determined by, for example socio-economic status, educational achievement, sex and ethnicity, employment opportunities and recruitment and retention policies. Subsequent writing in the field has argued for a more interactive approach. Early work in this interactive genre, for example Nicholson and West (1989), suggested that models for understanding careers need to incorporate both the occupational choice and the opportunity structure perspective. In similar vein, Bailyn (1989) maintained that careers depend on the interaction of individual agency and the constraining or enabling aspects of the social context and Arthur *et al.* (1989) suggest that the importance of this interactive perspective is to illuminate ways of linking the development of individuals to the achievement of organizational objectives. More recent discussions about career patterns have been located within debates about the relative influence of cultural factors, such as the prevailing ethos about combining work and family, as well as individual agency and structural factors (eg Evetts 1994, Halford *et al.* 1997).

Adult branch diplomates at the point of qualification - the group of nurses with which this research is concerned - have made an initial choice of occupation. An interactive perspective is adopted in the design of questionnaires and interpretation of findings for each subsequent phase of their careers; in particular the extent to which plans are realised, together with the factors which have constrained or facilitated this process.

Within this overall interactive framework, various other theories are being drawn on to explore aspects of careers. For example, whether observed differences in the career progress of men and women can be explained by theories of differences in human capital (education and training), differences in orientation to work and home, and organisational barriers to women's career progression. Nicholson and West's (1989) conceptualisation

of careers as a series of transition cycles is a relevant perspective for understanding nursing careers. After the initial transition from student to qualified nurse, a nurse's career is likely to involve transitions between jobs, specialties and employing organizations, and may also entail movements in and out of nursing. This study of diplomates' careers focuses on such transitions and the reasons for making them. Career guidance is explored throughout the course of the project and Law's community interaction theory informs this aspect of the research (Law 1981). Law posited that career development is the result of the impact of social exchanges between individuals, and that the 'plurality of perspectives' means that individuals can and should get help from people who have no guidance training, credentials or designation for guidance (Law 1981, p154).

1.5 RELATED RESEARCH

Other work on nursing, relevant to this research, includes the following: studies of aspects of the Project 2000 strategy; studies of nurses' working experiences and career directions pursued, and that which focuses on nurses working in specific branches of the profession. Research on nurses' careers also sits within the wider body of research on occupational and professional careers. As noted in Section 1.1 of this chapter, the approach taken to the presentation of this research is to include other work at the point when it relates to the particular stage of diplomates' careers being reported. For the 'at qualification' stage of the research, the literature review therefore focused on the characteristics, course experiences and career plans of newly qualified nurses. This review included studies of those who had qualified from the diploma course to compare with our own findings and second those who had qualified from traditional courses in order to assess differences between the two groups. As our research focused separately on each branch, our intention, as far as possible, was to make comparisons with other research on the same branch.

In considering findings for the adult branch cohort, therefore, the above literature was reviewed to identify a) studies which included findings relating specifically to adult branch diplomates and with which our own might be compared and b) studies of adult nurses who had taken the traditional routes to qualification as an RGN and which would afford a comparison with adult branch diplomates.

1.5.1 Studies including adult nurses qualifying from traditional courses

As observed earlier, a large volume of research exists on the various aspects of the profile and careers of nurses who qualified via the traditional route to registration. While most of these studies include adult nurses, in the main findings are reported for all nurses and separate information for adult nurses is not available (e.g. Mackay 1988, Soothill *et al.*

1994). Some studies do focus specifically on the careers of adult nurses in the years after qualification (e.g. Skevington and Dawkes 1988, Luker *et al.* 1996). The former study relates only to nurses in one health district; the latter drew national samples of three years of qualifiers, but response rates were low at 23%, 22% and 35% and so have limited usefulness for comparative purposes. The study which affords the most direct comparison with adult branch diplomates at the point of qualification is the corresponding phase of a longitudinal study of the careers of registered general nurses (Robinson *et al.* 1995). The sample for the Robinson *et al.* (1995) study included half those qualifying from courses held in three regional health authorities. All members of the sample were sent a questionnaire shortly after completion of the course; the response rate was 88% (n=1015). The participants in this study of traditional qualifiers were asked many of the same questions asked of our adult branch diplomate cohort and so findings from the two studies are compared in several of the subsequent chapters in this report. Reference is made to the main report from the project (Robinson *et al.* 1995), to published articles (Marsland 1996, Robinson *et al.* 1997) or to a PhD thesis (Marsland 1997).

1.5.2 Studies including adult nurses qualifying from diploma courses

Of the studies which focus solely on the diploma course, separate findings for adult branch qualifiers are reported by White *et al.* (1994), Jowett *et al.* (1994), Jowett (1995), Luker *et al.* (1996) and May *et al.* (1997). The study by White *et al.* (1994) explored the relationships between teaching, support, supervision and role modelling on the diploma course in two districts; adult and mental health branch students were included and some profile data are presented separately for each branch. The initial study by Jowett *et al.* (1994) sought to investigate the process of implementing the new Project 2000 courses in six of the 13 demonstration districts in England, all of which offered the adult branch. The design of the study was longitudinal; a sample of 77 students was interviewed at regular intervals from the beginning to the end of the course. Most of the group (n=59) were taking the adult branch; 54 remained in the study until the end of the course and 48 replied to the follow-up study (Jowett 1995). Profile data are not presented separately for each branch, some information on employment destinations is provided. As part of a study exploring diplomates' 'fitness for purpose', Luker *et al.* (1996) obtained data on demographic characteristics, courses taken and jobs held since qualification, career intention, and reasons for leaving nursing if already done so, from three years of qualifiers of adult branch diplomates (Luker *et al.* 1996). Response rates were low for all three years (19%, 41% and 39%) and so the usefulness of these data for comparative purposes is limited. May *et al.* (1997) undertook an evaluation of teaching and learning processes and educational outcomes in the ten programmes in six of the 12 Scottish Colleges; all offered the adult branch. Profile data are not reported separately for the adult branch diplomates, but data on their employment destinations were available for all

six colleges. Findings from these studies are compared with our own in subsequent chapters of this report.

1.6 MAIN RESEARCH QUESTIONS

The four aims of the research, set out in section 1.1, are all pursued at each stage of the cohort's careers. At the start of each phase of the research, a series of research questions is generated which focuses on the stage in question. Those generated for the at qualification phase of adult branch diplomates' careers, are set out at the beginning of the relevant chapters of this report.

CHAPTER 2: RESEARCH DESIGN AND METHODS

This chapter describes the research design and methods adopted for the project; sections are as follows:

- Reasons for choosing a longitudinal design (Section 2.1)
- Type of cohort to be selected (Section 2.2)
- Data collection instrument (Section 2.3)
- Sampling decisions (Section 2.4)
- The pilot cohort (Section 2.5)
- Strategies to recruit and maintain the cohort (Section 2.6)
- Questionnaire development and response rate (Section 2.7)
- Data analysis and presentation (Section 2.8)

The design adopted is that of a quantitative study in which large nationally representative cohorts of diplomates from all four branches of the course are surveyed by questionnaire at qualification and at intervals thereafter. The overall aims and design of the project are the same for all four branches but details of method have been adjusted as appropriate for the needs of each. Throughout the following account, specific reference is made to methods adopted for the adult branch when these differed from those adopted for the other three branches.

2.1 REASONS FOR CHOOSING A LONGITUDINAL DESIGN

Careers of diplomates could have been explored by means of a cross-sectional study. This could have taken the form of either a survey in which diplomates are asked on one occasion only to recall past events and decisions and to describe their current work situation and future intentions, or a series of surveys, each focusing on diplomates at a different stage post-qualification. A longitudinal design, in which a cohort of diplomates is surveyed at regular intervals (i.e. a panel study) was chosen, however, since it offers substantial advantages when compared with cross-sectional designs.

2.1.1 Accuracy and validity

A single cross-sectional survey with a retrospective element raises the question of

accuracy of recall and the validity of data recollected over a long time-span. Respondents can be asked about past career events and accompanying decisions, but these may be subject to various inaccuracies: events may be forgotten, or only partially remembered; others may be misplaced in time (Social and Community Planning Research 1988, Uncles 1988, Menard 1991, Diamond and McDonald 1992). Recall distortion may also be a problem in that past career intentions may be reported inaccurately as a result of *post-hoc* rationalisation of a work history that did not accord with original plans (Uncles 1988, Rose *et al.* 1991).

2.1.2 Analysis of change at the micro level

Panel studies permit analysis of change at the individual or micro level, as well as at the aggregate or macro level (Lievesley and Waterton 1985, Social and Community Planning Research 1988, Uncles 1988, Rose *et al.* 1991). As Rose *et al.* (1991) comment, whereas repeated cross-sectional surveys, such as the General Household Survey, monitor trends in the population over time, a panel study can document movements of individuals, or groups of individuals, in and out of particular states (such as employment) as well as overall population trends. Panel studies can facilitate an understanding of the dynamic processes prior to an individual being in a particular state at a particular time. In the context of careers of diplomates for example, two individuals may be holding a nursing job at a given moment in time, but have reached this position by different routes, and for very different reasons; one might have worked continuously in one job since qualification, whereas the other held a series of short-term jobs with lengthy intervals in between. Panel studies allow for exploration of different career paths and the extent to which they relate to original intentions.

2.1.3 Other advantages

When estimating change over time, for a given number of respondents, a panel study allows for greater precision of estimates than repeated cross-sectional surveys (Lievesley and Waterton 1985, Social and Community Planning Research 1988, Uncles 1988, Rose *et al.* 1991). This is because there is nearly always a positive correlation between measurements on the same unit on two successive occasions and, in estimating change, the variance is smaller if the same units are maintained (Cochran 1977). Moreover, panel studies afford the possibility of exploring the causal and temporal order of events and, unlike retrospective cross-sectional surveys, are not subject to sample selection bias (Davies 1987). Panel studies also provide researchers with the opportunity to include new issues that may arise during the project's lifetime; in this case, changes in the organization of health and social care services and in the provision of care.

2.1.4 Other decisions about project design

In view of the foregoing, a decision was made that diplomates' careers should be studied by means of a longitudinal design. Within the framework of a longitudinal design, decisions had to be made about the type of cohort to select; choice of data collection instrument, and size and structure of the sample. Decisions were made on the basis of experience gained on previous projects in the programme (Robinson *et al.* 1995, Robinson *et al.* 1996), discussions with the Department of Health and the project's Advisory Group, official figures, exploratory work undertaken in three regional health authorities and a pilot study.

2.2 TYPE OF COHORT TO BE SELECTED

2.2.1 Which courses to include

The project focuses only on nurse diplomates. Consideration was given in discussion with the project's Advisory Group as to whether degree courses (which were already replacing diploma courses in some colleges), and post-registration courses, should also be included. A decision was taken not to do so: first, aspects of the design are labour intensive and additional resources would have been required, and second, concern focused on the diploma course as the route by which most nurses would be qualifying.

2.2.2 Retrospective or prospective cohorts

A second consideration was whether the cohort should be recruited prospectively (i.e. those about to qualify) or retrospectively (i.e. those who qualified prior to the project start date). For findings on careers of a group of diplomates to be representative, it is essential that all those eligible are included, i.e. all those who qualify, even if they do not practise subsequently, or do so for a short time only. Moreover, in a project in which retention is a main concern, those who leave are of particular interest. An earlier project in the programme had shown that establishing contact with all members of a group who qualified some time ago presents immense problems (Robinson and Marsland 1994). A decision was made, therefore, to recruit a cohort just prior to qualification.

2.2.3 Time period for cohort recruitment

The period of cohort recruitment was a year; this was in order to obtain sufficient numbers and to include those starting a course at different points within the academic year. College[1] staff involved in previous projects, and in exploratory work for this project, suggested that autumn intakes may include more school-leavers than spring intakes, whilst the latter may include more mature entrants than the former. It was important, therefore, to ensure that intakes from both periods were included. Recruiting

[1] For brevity 'college' is used to refer to the school, college, department, institute or faculty in which the diploma courses were based

the cohort within a limited time period allowed for comparability in that panel members share some aspects of initial and continuing conditions; for example the prevailing economic climate and the introduction of new policies in the health service generally and in nursing in particular. The year selected was August 1997 to July 1998.

2.2.4 Methods for recruiting and maintaining the cohort

Although a longitudinal design was adopted for the reasons outlined in Section 2.1, it was recognized that this design presents the problem of decreasing viability over time through respondent attrition. Attrition at each stage of data collection could lead to increasing loss of representativeness, since those who do respond might differ markedly from those who do not (Douglas and Blomfield 1973, Hoinville and Jowell 1978, Goldstein 1979, Cohen and Manion 1980, Waterton and Lievesley 1989). Consequently, it was recognized that every effort had to be devoted to ensuring that as high a proportion of the cohort as possible is recruited into the study at the outset and that high response rates are maintained thereafter. Several strategies for reducing attrition from cohorts of nurses had been used with success in earlier projects in the programme and so were deployed from the outset in this project. We met students personally to invite them to participate in the project and maintained regular contact with them thereafter. Stamps, as opposed to pre-franked and freepost envelopes, were used, following evidence-based recommendations by Scott (1961) and Oppenheim (1992). Non-respondents were followed up with three reminders, with another copy of the questionnaire enclosed on each occasion.

2.3 DATA COLLECTION INSTRUMENT

2.3.1 Opting for questionnaires

Although high response rates are more difficult to achieve with self-completion questionnaires than by individual interviews (Cartwright 1983), questionnaires were the choice of data collection instrument in this study. The sample size required for reliable estimates and viable statistical analysis (to test for differences between subgroups, for example, women and men) was such that it could be achieved only by postal questionnaire given the resources available to the research team and the need for national representation. The substantial volume of research existing on nurses' careers meant that sufficient information existed upon which the design of a structured questionnaire could be based. Nonetheless it was recognized that validity of research into diplomates' careers might necessitate inclusion of topics not included in research on careers of other groups of nurses. Moreover, the items in questions about, for example, job satisfaction might differ in some respects for diplomates. It is recommended that the development of structured questionnaires includes preliminary qualitative work, as the best way of ensuring that questionnaire content is meaningful to participants (Hoinville and Jowell 1978, Morton-Williams 1985). Consequently, the pilot work undertaken for the

development of each questionnaire commenced with a qualitative phase, in which in-depth interviews were held with a sample of diplomates representing the main subgroups in the cohort in order to explore these issues.

2.3.2 Separate questionnaires for each branch

As Oppenheim (1992) observes, one of the fundamental principles of questionnaire design is ensuring that the content is of direct relevance to the experiences and concerns of the study group for whom it is intended. While essential for purposes of validity, relevance also enhances the likelihood of a high response rate. In the current study this was particularly important for the three smaller branches (child and learning disability as well as mental health) since their members often feel that their interests and concerns are overlooked in favour of those of adult branch members (Elkan *et al.* 1993, White *et al.* 1994, May *et al.* 1997). In view of the foregoing, we decided to produce separate questionnaires for each branch. The aim in designing the four questionnaires was to achieve a balance between as great a degree of comparability as possible, while, at the same time, retaining the essential differences between the branches.

2.3.3 Data collection time-points

The first questionnaire is sent at qualification in order to understand decisions and events from the outset of a diplomate's career. For two reasons, the second questionnaire is sent six months later: questions about support in the early post-qualification period (e.g. preceptorship) can be asked when such events are fresh in participants' memory, and nurses are often most mobile during the early months after qualification and a longer interval might run the risk of loss of contact. Subsequent intervals are longer for three reasons: to reflect reduced mobility of the cohort; to avoid irritation by too frequent requests for questionnaire completion, and to allow sufficient time for data processing and analysis between data collection points. The next two time-points for data collection are at 18 months and three years after qualification and the one proposed thereafter is at five years. A decision on intervals was made at the outset of the project, since its design entails asking diplomates what they plan to be doing at specified time-points in the future, and then sending a questionnaire at each of these time-points which asks about the fulfilment or otherwise of plans.

2.4 SAMPLING DECISIONS

Sampling decisions concerned the size of each branch and the means by which a nationally representative sample of each could be obtained.

2.4.1 Sampling unit

An aim of most surveys is to make the sample design as straightforward as possible; a common starting point, therefore, is to consider the viability of taking a simple random sample (without replacement) from a single sampling frame (Cochran 1977, Särndal *et al.* 1992). Such an approach was, however, impractical for this study, since the decision to recruit by personal visit meant that selecting students randomly would have necessitated hundreds of individual visits and complex arrangements with colleges. Other sample designs had therefore to be considered. The choice of design was driven primarily by structural considerations (i.e. how and where nurses are taught) and, consequently, college of nursing was selected as the primary sampling unit (PSU). The immediate advantage of using colleges as PSUs was that it would be possible to meet with students within pre-determined teaching groups.

2.4.2 Sampling branches independently

Sampling the four branches together, and thus including all branches from each selected college, would have the practical advantage of reducing the number of colleges involved; this in turn would reduce the number of negotiations necessary to gain access to students. The disadvantage, however, was that the size of the intakes of students for each branch tends to differ, and so it would be necessary to include more colleges for those branches with smaller intakes. We therefore decided to sample for each branch separately.

2.4.3 Sample size

In order to design the sample for each branch, information was required on the actual numbers expected to qualify from each branch during the selected year. This information was not available, however, and at this stage estimates were made from the number who started each branch. We were able to obtain this information from the ENB for all regional health authorities for the 1993/94 period. We also obtained, by means of personal contact, intake figures for 1993/94 and 1994/95 for three regions. On the basis of the ENB figures, and the degree of correspondence which existed between these and the figures obtained through personal contact, it was proposed to sample one-third of adult branch diplomates; this would provide a sample size of 1000-1400. As much information as possible about likely intake size was obtained from the three regions contacted personally, in order to determine how many intakes would be needed to achieve the proposed sample size.

2.4.4 Sampling colleges

At the time when the study was being designed, 48 colleges of nursing existed in England and to ensure representativeness, we decide to sample at least a half of these. Simple random sampling of colleges, however, does not in itself guarantee that the resulting sample will be representative of the population from which it is drawn and consideration of the factors that might bias findings and/ or increase variability was therefore necessary.

In particular, the findings might vary geographically, and so it was important to ensure that the sample was not over-represented with colleges from the southern (or northern) half of England. The sampling frame of colleges was therefore stratified by region and the same proportion of colleges was to be selected from each. The number of colleges (PSUs) was small (48) by survey standards and at least two colleges needed to be sampled from each region to estimate the within stratum variance.

2.4.5 Sampling autumn and spring intakes

Another decision concerned the sampling of autumn and spring intakes (see 2.2.3). Two options existed: to sample autumn and spring intakes independently from each other (Option 1) or to recruit both the spring and autumn intakes from each selected college (Option 2). It was recognized that Option 2 would be more sensitive than Option 1 in estimating a possible seasonal effect, since it has an efficient hierarchical structure for analysis purposes. Option 2, however, also had a number of drawbacks. Some colleges had an autumn but not a spring intake (or the reverse, although this occurred less often). This could result in an under-representation of either the autumn or spring intakes. Moreover, although Option 1 would be less efficient at estimating a seasonal effect, it would include more colleges in the overall sample than Option 2. Option 1 also allowed for greater control of the final sample size so that the proportion sampled in autumn and spring would be similar. We therefore decided to sample autumn and spring intakes independently.

2.4.6 Sampling subgroups of intakes

A further decision concerned whether sampling should be based on whole intakes, or subgroups of intakes. ENB figures demonstrated that intake sizes for the different branches varied, with adult branches tending to be the largest. Mergers between schools of nursing, prior to integration with higher education, mean that most regions now have fewer than eight colleges. If a college was used as the sampling unit, then the small sampling fraction for the adult branch could potentially lead to an unrepresentative sample, since only one college could be selected in each region. It was recognised that a better strategy would be for sub-groups of intakes to be used as the sampling unit, since this would allow for a more representative sample; for example, four colleges could be sampled from eight, and a sub-group representing a quarter of each of the total intake for the college sampled from each. Moreover, in earlier projects in which the research team had met with students in person to ask them to participate, the proportion agreeing to do so was higher in meetings with smaller groups. The feasibility of arranging meetings with sub-groups of intakes was, however, unknown. Information was also required on completion and recruitment rates in order to determine how many students to approach in the main study to achieve the desired sample size.

2.5 THE PILOT COHORT

2.5.1 The need for pilot work

In order to finalise the sample size and composition, pilot work was required to provide information on the following: the size and structure of college intakes; the numbers expected to qualify from each branch during the study period, and the expected proportion who would agree to take part. From the outset of the project, it was also recognized that recruitment and maintenance of the cohort, and development of questionnaires in the context of a four branch longitudinal study would require pilot work. The next section describes the pilot cohort recruited for these purposes.

2.5.2 Size and structure of the pilot cohort

The pilot cohort was required for the lifetime of the project. It had to be recruited from intakes completing in Autumn 1996 and Spring 1997 so that it could 'run ahead' of the main study cohort. Six hundred (150 from each branch) was regarded as the minimum size for the pilot cohort, given the need for subgroups of interest to be included and the likelihood of attrition between the development of each questionnaire.

Although pragmatics dictated that the cohort needed to be easily accessible, confining recruitment to one part of the country risked the exclusion of important regional variations (e.g. course/branch and job availability, employment conditions for newly qualified nurses). It was decided, therefore, that the pilot cohort should consist of a 'core' (relatively accessible) group (n=400) and an 'extended' (more geographically dispersed) group (n=200) and an approximate 2:1 autumn/spring ratio.

Figures used for sampling decisions about the pilot cohort were ENB intake figures, i.e. the number of students starting courses in the year in question (August 1993 to July 1994) at each college. An estimation of student attrition was therefore required, to ensure that selected colleges contained sufficient numbers of completing students. Anecdotal information indicated that attrition may be as high as 30% (Naish 1993) and so, for the pilot study, a cautious estimate of 25% was used. Information obtained during the pilot study would then enable a more accurate estimate of numbers of students completing courses to be made for the main study. Using this 25% attrition estimate, it was necessary to select approximately 200 students from each branch to ensure that 150 from each would be accessed. As 100% recruitment into the pilot study cohort could not be guaranteed, the figure for each branch was then increased to between 210-260.
Following a review of the ENB information about colleges and the branches which they offered, 19 colleges were selected to provide diversity in terms of the branches which were offered and the range of clinical settings in which placements were based. Adult branch intakes in these colleges ranged from 57 to 204 students. We proposed to select

20 students from each of 11 intakes in 9 of the colleges to give a sample of 220. The following sections describe the work undertaken with the pilot cohort to develop recruitment strategies, to finalise the sample design and to design the questionnaire, and the outcome for the main study in each respect.

2.6 STRATEGIES TO RECRUIT AND MAINTAIN THE COHORT

A decision had already been made to meet students to invite them to participate in the project, since experience in previous projects had demonstrated that this achieved a much higher recruitment rate than invitation by post (Robinson and Marsland 1994). Moreover, the meeting provided the opportunity to obtain addresses through which contact could subsequently be maintained with those who agreed to take part. The recruitment meeting was thus central to the success of the project; it was a 'one-shot' chance to recruit as high a proportion as possible of those eligible to participate. Although the strategy had proved successful in the past, its transferability to diploma students could not be guaranteed. It was not known how easy it would be to negotiate access to students who were now part of the higher education system. Moreover, it was not known whether the emphasis on research in the diploma course, and the likelihood that students had already been involved in projects, would make them more or less likely to wish to participate in this research.

2.6.1 Piloting recruiting strategies

Four aspects of the recruiting strategy were piloted with the autumn intakes, revised and then re-piloted with the spring intakes. First, access had to be negotiated to each intake of students. Exploratory work had indicated that it would be preferable to recruit each branch separately, since attendance was often lower at combined sessions and agreement to participate more difficult to secure. The head of each college was approached in the first instance for permission to meet with selected intakes of students. The main lessons from the pilot study were a) the length of time it took to contact the staff involved with the students on a regular basis and who were in a position to make arrangements for a meeting, and b) the need for diplomacy at all times, especially where lines of responsibility between personnel were not entirely clear.

Second, various approaches were piloted for the format and content of the meeting. Students seemed more willing to participate if the presentation focused specifically on their branch. We emphasized the fact that questionnaires would be branch specific and that findings would be analysed separately for each branch. At an appropriate moment, forms were circulated which those willing to participate were asked to complete; information requested included: current address; a second, more permanent address, and other details to facilitate re-establishing contact if this was lost. We tested the length and content of the presentation strategies to encourage discussion, the best moment to

circulate the agreement to participate forms, and the optimum number of researchers present for different group sizes. Agreement to participate rates were 85% for the autumn intakes and 93% for the spring.

With students affiliated to, or integrated within, higher education, attendance at lectures and meetings such as the one we proposed was not always compulsory. The third aspect of the piloting therefore focused on strategies to maximize attendance at the recruitment meetings. This proved to be particularly important for the adult branch. As noted in Section 2.4.6 we had decided to sample subgroups of the large adult intakes. However, in some colleges meetings could only be arranged with the whole intake (50-75 students) and in others, although it was possible to meet with a subgroup, the minimum size was 30. In both events attendance at the meetings was poor, and agreement to participate was more difficult to secure than for the smaller groups in other colleges. Although, as noted above, 85% of those who attended the meeting agreed to participate, only 55% of those eligible to attend the meeting did so. Various strategies to access and recruit random samples of large intakes were discussed with college staff and students, but all presented difficulties. We decided, therefore, to attempt to recruit the whole intake and devote further attention to strategies to maximize attendance and increase willingness to participate. The former focused on choosing days when the intake was most likely to be in college and arranging the meeting before or after a session with high appeal for students. When a large proportion of an intake failed to attend the recruitment meeting, usually due to time-tabling errors, arrangements were made for a repeat visit, if possible. For the spring intakes, the attendance rate improved to 69% and the agreement to participate rate to 93%.

Finally, the fourth aspect of piloting concentrated on recruiting those who had not attended the meeting but were eligible to take part in the study. Various strategies were tested including writing to the non-attendee, and leaving a recruitment pack to be passed on by colleagues and/or course leaders. During the autumn phase, this entailed sending a recruitment pack via a colleague who had attended the meeting. Only 6% of adult branch non-attendees responded. During the spring phase additional strategies were piloted: sending recruitment packs via course leaders as well as colleagues, obtaining information to enable us to contact the student direct, and changes to the enclosed letter and form. Recruitment rates of non-attendees improved dramatically to 70%.

The strategies described above were tested and revised throughout the period when the pilot cohort qualified. The level of recruitment of those eligible to participate achieved for the autumn intakes (49%) was improved for the spring intakes (86%)· Taking the autumn and spring intakes together, 591 adult branch students were identified as having completed the course; 60% (356) agreed to be members of the pilot cohort.

Once people are recruited into a cohort for a longitudinal project it is important to keep in regular contact in order to maintain their interest in the project and to lessen the likelihood of loss of contact (Waterton and Lievesley 1989). Those who were recruited into the pilot cohort more than one month before they were due to be contacted about involvement in development of the first questionnaire were sent a reminder to maintain interest, and a form to notify us of any change of address. Subsequently, they have been sent regular reports on the project's progress and summaries of findings. A change-of-address form and freepost envelope has been included on each of these occasions to help ensure that contact is not lost with pilot cohort members when they move. Each change of address received has been acknowledged with a personal letter of thanks.

2.6.2 Recruiting the main study cohort

During the pilot study, information was obtained from three sources which enabled more precise sample size estimates to be made for the main study. These are shown as 1, 2 and 3 in Figure 2.1; details are as follows. The first source (1) relates to figures provided by the ENB for the total intake for autumn 1994 and spring 1995 (i.e. for those expected to qualify in autumn 1997 and spring 1998). Completion rates (2) are based on the proportion likely to qualify as indicated by colleges in the pilot study. The recruitment rate (3) is the percentage of completers likely to agree to participate in the study; this was based on the recruitment rates achieved during the spring phase of the pilot study[2]. The number of students who would enter the study under a full census of half of the colleges (4) could then be estimated by multiplying the intake figure by the completion percentage and then by the recruitment percentage.

Figure 2.1 Estimated number of adult branch participants under a full census

1	ENB intake figures	7214
2	Completion rate	81%
3	Recruitment rate	83%
4	Estimated number of participants	4850

The sampling fraction for the adult branch could not be determined precisely before the main study commenced. As already described, large intakes and the difficulty of sampling subgroups posed problems both for the achievement of a nationally representative sample and for obtaining the optimal size of group to maximise agreement to participate. The strategy adopted was to stratify the sampling frame by region, take at least half the colleges from each, and to sample the autumn and spring intakes separately.

[2] Due to the project schedule it was necessary to make estimates for the main cohort before pilot work was completed. Hence the percentage recorded in 3 is lower than the 89% of the pilot cohort spring intakes who agreed to participate

Approximately 25% of colleges had intakes exceeding 100 and until the sampled colleges were contacted it would not be known how these intakes were sub-divided for teaching purposes. In the larger colleges, therefore, the policy was to sub-sample when possible and then re-weight results for sub-sampled intakes. The consequence of this approach was that the sample size for the adult branch was likely to exceed the 1000-1400 initially specified in the sample design. In the event 37 colleges were selected from the eight regions and 62 groups from 46 intakes were randomly selected for inclusion. This provided a sample size of 2109 students. Negotiations to meet with these intakes were successful and the recruiting strategies described in Section 2.6 were deployed. The mean size of groups visited was 34 with a range of 11 to 84. Eighty-seven per cent of those eligible to take part agreed to do so (1831/2109).

2.7 QUESTIONNAIRE DEVELOPMENT AND RESPONSE RATES

2.7.1 The piloting process

The pilot study for developing the questionnaire for each branch had three stages and pilot cohort members were involved in one or more. Attention was devoted throughout to key tenets of questionnaire design: simplicity of wording; optimum length of questions; avoiding leading questions and double barrelled questions; ordering of items within questions and clarity of routeing instructions (e.g. Oppenheim 1992, Czaja and Blair 1996).

Stage 1: In-depth interviews

In the first stage, one-to-one in-depth interviews were held to determine questionnaire content. A topic guide was used; the content was informed by previous projects, other research, and the policy and professional issues reviewed in Chapter 1. The emphasis, however, was on keeping the interview as open as possible, to ensure that interviewees could raise those issues important to them. Another aim of these first stage interviews was to explore common understanding of terminology. Members of the adult branch pilot cohort invited to take part in these interviews were selected to represent as wide a geographical spread as possible and to include both women and men.

Stage 2: Testing drafts in interview

In the second stage, questions were drafted on the basis of the interview material, and then tested in face-to-face interviews with further members of the pilot cohort. The aim at this stage was to assess whether items within closed questions were comprehensive and relevant and whether instructions within questions were clear. The questions were then

assembled into a draft questionnaire; this was tested in further interviews to assess whether routeing directions within questions, and to other questions, were clear, and whether the length of the questionnaire was acceptable. The draft questionnaire was modified and re-tested until it was sufficiently developed for interviewees to work through on their own. Further members of the adult branch pilot cohort were invited to take part in this stage and were selected on the same criteria as for Stage 1.

Stage 3: Piloting postal versions

In the third stage of the piloting process draft versions of the questionnaire were tested by post. The focus at this stage was whether respondents were able to answer questions without assistance, and whether directions were followed correctly. In addition to completing the questionnaire, participants were asked to record their comments using the ‘comments sheets’ provided. For each section respondents were asked whether any questions were unclear or difficult to answer, whether there were any questions in which the choices offered did not fit their particular circumstances, whether the instructions were easy to follow, and for any other comments and criticisms. They were also asked how long it had taken them to complete the questionnaire and for their views about the information provided in the covering letter. Whilst we recognized the additional burden this placed on respondents, it seemed essential to obtain as much information as possible about the experience of completing the questionnaire before it was finalised. The likely response rates for the main cohort were also assessed at this stage.

The pilot cohort for each branch was large enough for two postal pilots and for a third if necessary. One hundred members of the adult branch pilot cohort were sent the first version of the postal questionnaire. Once sufficient questionnaires had been returned an assessment was made of the following: the points made on the comment sheets; whether there were any items in questions which no-one had ringed and which could be considered for omission, and places where respondents were most likely to have followed instructions incorrectly and thus where greater clarity was needed. The questionnaire was revised accordingly and re-piloted with a further 98 members of the adult branch pilot cohort.

2.7.2 Aspects of questionnaire terminology

The rationale for the inclusion and design of each question is outlined in the relevant findings chapters. Some aspects of terminology related to the questionnaire as a whole, however, and so are detailed here.

In order to document career plans and careers followed, it was necessary to have a phrase which described the kinds of jobs about which detailed information was required from diplomates. Pilot work showed that some diplomates were planning to obtain jobs after qualification which they did not describe as nursing jobs but which used nursing skills and knowledge. The use of the phrase 'a nursing job' led to inaccurate responses, and so was not used. The phrase which emerged as relevant to all diplomates was 'a job that uses knowledge and skills obtained during your nurse diploma course'. Although rather cumbersome, this phrase was used throughout the questionnaire, followed by examples tailored for each branch. For readability in this report, however, the phrase 'nursing job' is used.

In building up diplomates' event histories of nursing jobs we wanted to distinguish between those which were agency or bank nursing jobs and those which were not. Reasons for taking the two kinds of jobs may be very different. People may, for example, take agency jobs out of choice because of the flexibility which they offer, or out of necessity in the absence of a more permanent position. The phrase 'a permanent nursing job' was piloted as a way of defining jobs which were not agency or bank jobs. This proved to be problematic, however, since people with short-term contracts did not regard their jobs as permanent.

In the event, therefore, the two types of jobs were distinguished: an agency or bank job, or a job which is not an agency or bank job. For readability in this report, however, the phrase 'nursing job' is used for those jobs which are not agency or bank jobs.

2.7.3 Tailoring the questionnaire for adult branch diplomates

Three aspects of questionnaire design were tailored to the specific nature of each branch: clinical specialties and services, examples and the relevance of certain questions. The range of clinical specialties encompassed in adult nursing was identified from the following: literature on adult nursing, discussion with the project's Advisory Group and other experts, and work with the pilot cohort. Some questions benefited from the inclusion of examples which pertained specifically to each branch, although the questions themselves did not need to be branch specific. Including examples helped participants understand, and complete, some long and complex questions. This approach was used, for example, in questions on plans to take courses and on working in the community.

There were two sections of the questionnaire in which questions were not the same for all branches. Questions about community settings were more extensive for the learning disability branch than for the other three, since pilot work showed that these diplomates were much more likely to be working in these settings. Questions on plans to qualify for other parts of the register were also branch specific.

2.7.4 Other aspects of questionnaire design

Linking between questionnaires

Since one of the aims of the study is to explore the relationship between career plans and careers followed, questions on plans in the first questionnaire had to be constructed in such a way that the information obtained could be written into the respondent's second questionnaire. This could then be followed with questions to ascertain whether plans had been fulfilled and, if not, reasons for this being the case.

User-friendliness

From the outset of the project it was apparent that lengthy questionnaires would be needed to cover the number of topics relevant to understanding diplomates' careers. Moreover, a multi-routed format would be necessary to encompass the diversity of experiences and plans. It was therefore essential to achieve a sufficiently appealing design to militate against attrition at each phase of data collection. (A copy of the final questionnaire is in Appendix 2 A 1).

2.7.5 Response rates

Of those recruited into the main cohort 87% (1596/1831) returned the first questionnaire. This was achieved through a four stage mailing process. The first questionnaire was sent to the cohort member's current address. Four weeks later non-respondents were sent a second copy to the second address, if provided. The third and fourth mailings, also at four weekly intervals, were sent to various combinations of addresses, depending on the information provided by the cohort member at the recruitment meeting. The response rate for the first mailing was 65%; three follow-ups achieved an increase to 79%, 83% and 87% respectively.

As indicated in Section 2.2.4, every effort was made to maximise recruitment into the study and maintain high response rates thereafter to mitigate against loss of representativeness through non-response. Nonetheless it was important throughout the course of the research to assess the extent to which non-respondents differed from respondents. At this first stage the only information available for non-respondents was college, qualifying set and sex. Most colleges provided only one qualifying set and there was little variation in non-response between women and men. Consideration was given to asking college staff for anonomised demographic data about each set as a whole in order to compare these with comparable data obtained from respondents. Initial enquiries, however, revealed lack of comparability of information within and between colleges and, given the demands already made on college personnel (described in Section 2.6), we thought that such a request might prove excessive. At the six months phase of

data collection however, comparisons are made between respondents and non-respondents in terms of information provided in the at qualification questionnaire.

2.8 DATA ANALYSIS AND PRESENTATION

The returned questionnaires were edited by the research team. Coding and production of the database were undertaken by a data processing bureau (SPSS-MR). Most of the analyses have been undertaken using the SPSS-MR survey analysis software 'Quanvert': additional analyses have been performed in SPSS and SAS.

Considered in isolation, the 'at qualification' questionnaire is a cross-sectional survey with a retrospective element and is reported as such in this report. The analysis of data takes account of the complex sampling design (multi-stage cluster sample within geographical strata). Appropriate weighting is used to adjust for unequal selection probabilities. In addition, variance estimation and modelling procedures (e.g. regression) make adjustments for intra-cluster correlation (i.e. between respondents of the same set or college) as described in Lehtonen and Pakhinen (1994). The requirements of variance estimation have been met using the package SUDAAN (a comprehensive package for survey data analysis) which has been written specifically for this purpose (Lavange *et al*. 1991). Procedures for linking the 'at qualification' findings to those from subsequent questionnaires, and for creating and analysing event histories, will be described in the report on the six months data.

Percentages and numbers are shown throughout the report. Percentages have been rounded to whole numbers; this means that occasionally totals do not sum to 100%. On some occasions the number in a cell is very small and although percentages are shown for consistency with the rest of the table, these percentages need to be interpreted with caution. Throughout the report information is provided about non-response to each question; in most cases this was a very low proportion (less than 5% of respondents). Adding the weights to the analysis means that numbers occasionally do not sum to the exact totals shown; a footnote to this effect is included below tables where this occurs. The 5% level has been adopted throughout as the criterion for statistical significance.

CHAPTER 3: PROFILE OF THE COHORT AT QUALIFICATION

The first aim of the research is to ascertain the diversity within the diploma qualified adult nursing workforce. As discussed in chapter 1 (section 1.2.2 and 1.3.1) policies to increase diversity were advocated by the UKCC in its Project 2000 proposals (UKCC 1986, 1987) and this was subsequently re-affirmed by the UKCC and the current government (UKCC 1999a, DH 1999a, 2000a). The main rationales for attracting a greater diversity of people into nursing than hitherto have been the shrinking of the profession's traditional recruitment base, a shortage of nursing staff, and the view that the workforce should more closely represent the communities which it serves (UKCC 1986, 1987, DH 1999a, 2000a). Recommendations have focused on increasing the proportion of men, mature entrants, members of ethnic minority groups, those without formal academic qualifications, those with two A'levels or more, and those who have worked in other occupations and/or spent a period of time in full-time childcare. These recommendations have referred to nursing as a whole and not to its separate branches; this research, however, ascertains diversity within each of the four separate branches. The first phase ascertained the profile of each branch at qualification.

A profile of the adult branch cohort at qualification was provided in relation to a) demographic characteristics and pre-course experience (findings reported in this chapter) and b) routes into nursing (findings reported in chapter 4). In relation to a), questions for this phase of the research were as follows:

- What is the sex and age distribution of the cohort? (Section 3.1)
- What proportion of the cohort come from ethnic minority groups? (Section 3.2)
- What was the educational background of the cohort prior to starting the course? (Section 3.3)
- Are sex, age and highest educational qualification statistically independent? (Section 3.4)
- What was the employment profile of the cohort prior to starting the course? (Section 3.5)
- What proportion of the cohort had a spouse/partner? (Section 3.6)

- What proportion of the cohort had children, and how many spent a period in full-time childcare prior to starting the course? (Section 3.7)

It is important to note that findings relate to those who had completed the course and no information is available on whether attrition during the course differed by subgroup.

3.1 SEX AND AGE

One thousand five hundred and ninety six people returned the questionnaire. These respondents account for 87% of those sent a questionnaire (n=1831) and 76% of those eligible to have been recruited into the study (n=2109). Ninety-two per cent (1465) of respondents were women and 8% (131) were men.

As Table 3.1 shows, the majority of respondents were in their 20s when they completed the course, with just 26% (416) aged 30 or over. Men tended to be slightly older than women at this time, with a mean age of 28.8 compared with 26.6 for women. The youngest age group (20-22) can be regarded as having started their diploma course as 'school leavers' since most of the people in this group will have started their nursing course straight after leaving school/college. Thus, just over one-third (35%, 558) of respondents started the diploma course straight or soon after leaving school/college. Women were significantly more likely than men to be in this youngest age group (37%, 536 vs. 17%, 22 $p<0.001$). Conversely men were significantly more likely than women to be 30 or over (38%, 50 vs. 25%, 366 $p<0.01$). Considering sex and age together, 68% (1089) of the cohort comprised women in their 20s.

Table 3.1 Age at end of course: women and men

Age	Women No.	Women %	Men No.	Men %	All respondents No.	All respondents %
20-22	536	37	22	17	558	35
23-24	279	19	20	15	298	19
25-29	274	19	40	30	314	20
30-34	126	9	25	19	151	9
35-39	130	9	13	10	143	9
40-44	74	5	10	8	84	5
45 and above	36	2	2	1	38	2
Not stated	11	1	0	0	11	1
Total	1465	100	131	100	1596	100
Mean	26.8		28.8		26.9	
Median	24		27		24	
SD	6.9		6.6		6.9	
Range	20-60		21-47		20-60	

3.2 ETHNIC GROUP

The format for the question on ethnic group was adopted from that used in the British Social Attitudes Study (Social and Community Planning Research 1989); findings are shown in Table 3.2.

Table 3.2 Ethnic group: women and men

	Women		Men		All respondents	
Ethnic group	No.	%	No.	%	No.	%
Asian origin: All	18	1	3	2	21	1
Indian origin	11	*	1	1	12	*
Pakistani origin	4	*	0	-	4	*
Other Asian origin	3	*	2	*	5	*
Black origin: All	30	2	6	5	36	2
Caribbean	13	*	0	-	13	*
African origin	15	1	6	4	21	1
Other black origin	2	*	0	-	2	*
White origin: All	1385	95	120	92	1505	94
British origin	1258	86	115	87	1373	86
Irish origin	92	6	3	2	94	6
Other white origin	31	2	2	2	33	2
White	4	*	0	-	4	*
Other: All	21	1	1	*	22	1
Mixed origin	10	*	0	-	10	*
Other	11	*	1	1	12	*
Total	1465	100	131	100	1596	100

The majority of respondents described themselves as of white British origin (86%, 1373). Just 4% (57) of respondents came from the Asian and Black communities. Most studies which have focused on ethnic group of nurses (e.g. Beishon *et al.* 1995) have not regarded Irish nurses, or those of other white origin, as belonging to an ethnic minority group. If the Irish nurses, those of other white origin, and those of mixed origin in this study are thus regarded, then the proportion of respondents from ethnic minority groups in the current study rises from 4% (57) to 9% (151). Differences between the sexes were small, although men were significantly more likely than women to be of Black or Asian origin (7%, 9 vs. 3%, 48 $p<0.05$).

3.3 EDUCATIONAL BACKGROUND

Participants were asked for information on a variety of academic, professional and vocational qualifications. They were also asked whether they had been required to undertake an Access course or the UKCC DC test in order to gain a place on the nurse diploma course. The age range of participants necessitated asking about a wide variety of qualifications; school certificate, GCE O' levels and 16+ qualifications, as well as the

more recent GCSE qualification. Furthermore, the national and international basis of diploma course recruitment required the inclusion of Scottish, Irish and overseas qualifications. Some participants had completed further and/or higher education and so questions were included on obtaining the following: Ordinary and Higher National Certificates; diplomas; degrees; and clerical, commercial, technical, business and professional qualifications. More recently, as part of the strategy to widen the entry gate into nurse education, national vocational qualifications at level 3 have been accepted for entrance; these qualifications were also included in the list.

The data obtained are presented as follows: the range of qualifications obtained and the proportion of respondents obtaining each (Section 3.3.1), the proportion who entered via an Access course or the UKCC DC test (section 3.3.2) and the highest level of academic qualification obtained (Section 3.3.3).

3.3.1 Range of qualifications

The range of qualifications obtained are listed in Table 3.3, together with the proportion of respondents who had obtained each.

Table 3.3 Qualifications gained prior to starting nurse diploma course

Qualification		(n=1596) No.	%
CSE	Grade 1	181	11
	Grades 2-5	122	8
GCSE	Grades A-C	996	62
	Grades D-G	637	40
O' level (GCE)	Grades A-C or 1-6	342	21
	Grade D or below	129	8
A' level (GCE)	Grades A-E	530	33
A/S level	Grades A-E	76	5
SCE Ordinary/Standard	Grades A-C or 1-3	14	1
SCE Higher	Grades A-C	6	*
SCE Higher	Grade D	3	*
Scottish leaving certificate (higher)		1	*
Irish leaving certificate ordinary level	Grades A-C	52	3
Irish leaving certificate higher level (before 1992)	Grades A-D	18	1
Irish leaving certificate higher level/honours (in and after 1992)	Grades A-C and D1-D3	38	2
Matriculation Examination of the National University of Ireland	Grades A-D or 1-4	2	*
Overseas qualifications		22	1
National Vocational Qualification (NVQ/SVQ) - level 3		21	1
General National Vocational Qualification (GNVQ) - advanced (or GSVQ level 3)		17	1
Higher National Certificate/Diploma (BTEC or former HNC/HND)		61	4
National Certificate/Diploma (BTEC or former BEC/TEC/ONC/OND)		176	11
SCOTVEC modules		1	*
Diploma of higher education		29	2
Degree		69	4
Professional qualifications		79	5
Secretarial qualifications		121	8
Other qualifications		156	10

Academic qualifications

Sixty-two per cent of respondents (996) had obtained GCSEs at grades A-C, over a fifth (21%, 342) had obtained O' levels at grades A-C or 1-6, and 11% (181) had obtained

CSEs at grade 1. One-third (33%, 530) of respondents indicated that they held one or more A' levels.

Four per cent (69) had a degree and 2% (29) indicated that they had obtained a diploma in higher education. The subjects of these degrees and diplomas included both healthcare related (e.g. diploma in health and social welfare) and those unrelated to healthcare (e.g. BA in geography).

Vocational qualifications

Four per cent (61) of respondents had obtained a Higher National Certificate/ Diploma, 1% (21) a National Vocational Qualification and 1% (17) a General Vocational National Certificate/Diploma. Eleven per cent (176) indicated that they had obtained a National Certificate/Diploma.

Professional qualifications

Five per cent (79) of respondents had professional qualifications prior to starting the course. These varied and included qualifications in catering, insurance, teaching, and in health and social care. Specific qualifications relating to nursing, health or social care included six people with a preliminary certificate in social care and five people with a National Nursery Education Board qualification.

3.3.2 Entrance via UKCC DC test and Access courses

Ten per cent (158) of respondents gained access to the diploma course via the UKCC DC test, and 10% (152) via an Access course.

3.3.3 Highest level academic qualification obtained

Respondents were grouped according to the highest level of academic qualification obtained prior to starting the nurse diploma course (Table 3.4). This enabled an assessment of the academic profile of the cohort, analysis of whether plans varied by level of qualification obtained prior to starting the course, and comparisons to be made with other studies. Four per cent (68) had obtained a degree and 1% (21) a DipHE. Thirty per cent (483) reported A' levels as their highest qualification. As Table 3.4 shows, more respondents entered with two A-levels than either one or three A' levels. Slightly fewer (29%, 457) had started the course with five O' levels or equivalent (or a National Certificate/Diploma or NVQ level 3). Twenty-seven (2%) respondents joined the course with four O' levels but had not been required to take the UKCC DC test or an Access course. However, some of those who did gain entry via these routes also reported

having four O' levels, suggesting that criteria for entry vary from one college to another. A comparison of the figures for women and men indicate that a higher proportion of men than women entered the nurse diploma with a degree (6%, 8 vs. 4%, 60) and a higher proportion entered via the UKCC DC test (22%, 29 vs. 9%, 129). On the other hand, a higher proportion of women than men entered with five O' levels (28%, 405 vs. 23%, 30), and with three A-levels (9%, 130 vs. 1%, 1).

Table 3.4 Highest level of academic qualification reached: women and men

	Women		Men		All respondents	
Qualification	No.	%	No.	%	No.	%
Degree	60	4	8	6	68	4
Diploma in higher education	15	1	6	5	21	1
HNC/HND	44	3	3	2	47	3
A' levels						
Three (or more)	130	9	1	1	131	8
Two	176	12	19	15	195	12
One	146	10	11	8	157	10
5 O' levels (or equivalent)	405	28	30	23	435	27
National Certificate/Diploma	18	1	1	1	19	1
NVQ Level 3	3	*	0	-	3	*
1-4 O' levels, but no DC test or Access course	27	2	0	-	27	2
Overseas qualifications only	5	*	0	-	5	*
Entry through						
Access course	142	10	10	8	152	10
UKCC DC test	129	9	29	22	158	10
Qualifications held, no details given	22	1	2	*	23	1
No answer	142	10	10	8	152	10
Total	1464	100	131	100	1596	100

NB 1 person came in on the DC test although also held a degree

3.4 EMPLOYMENT PRIOR TO COURSE

As part of developing a profile of the cohort, participants were asked for information about their previous employment history. They were asked to state the title of, and length of time spent in, each full-time and part-time job since age 16 and prior to starting the nurse diploma course. Instructions were provided to exclude holiday jobs and part-time jobs undertaken while at school and/or college. Data obtained were used to construct an employment profile for the cohort, to indicate the range of full-time occupations in which

members had worked prior to starting the course, and to indicate the number who had worked in nursing, health or social care on a full- or part-time basis.

3.4.1 Employment profile

Table 3.5 shows the proportion who had held full- and/or part-time jobs. Eighty-four per cent (1344) of respondents had worked in paid employment prior to starting the course.

Table 3.5 Employment history: women and men

	Women		Men		All respondents	
Hours	No.	%	No.	%	No.	%
Full-time only	454	31	53	40	507	32
Part-time only	194	13	13	10	206†	13
Full-time and part-time	373	25	24	18	397	25
Full-time and no answer for part-time	176	12	22	17	199†	13
Part-time and no answer for full-time	34	2	1	1	35	2
Not worked	179	12	15	11	194	12
No answer	55	4	4	3	58†	4
Total	1465	100	131†	100	1596	100

† See note about weighting on p35

The most common employment history, for both women and men, was to have worked full-time only. Women were significantly more likely to have worked part-time than men (41%, 601 vs. 29%, 38 $p<0.05$).

A total of 69% (1102) of respondents indicated that they had worked full-time at some stage prior to commencing the nurse diploma course. The length of time spent in full-time employment ranged from less than one year to more than 20 years. Over half (55%, 604) of those who had worked full-time had done so for less than five years (Table 3.6). Of the men and women who had worked full-time, men were significantly more likely than women to have done so for five years or more (66%, 65 vs. 40%, 405 $p<0.001$).

Table 3.6 Period spent in full-time employment: women and men

Period of time	Women No.	Women %	Men No.	Men %	All respondents No.	All respondents %
Less than 1 year	117	12	4	4	121	11
1 year or more but less than 3 years	315	31	15	15	330	30
3 years or more but less than 5 years	140	14	13	13	153	14
5 years or more but less than 10 years	275	27	30	30	305	28
10 years or more but less than 15 years	85	8	17	17	102	9
15 years or more but less than 20 years	33	3	12	12	45	4
20 years or more	12	1	7	7	18	2
No answer	27	3	1	2	29	3
Total	1003	100	99	100	1102	100

In exploring the employment profile of the cohort, interest focused on the diversity of individuals' employment experiences, for example whether people had worked in only one full-time occupation and if so, for how long, or had experience of two or more full-time occupations. Thirty-three per cent (526) of the cohort had worked in one full-time occupation only, whereas 36% (572) had worked in two or more. Table 3.7 shows number of occupations (one, or two or more) and the length of time spent in full-time employment. Of those who had worked in only one full-time occupation, the majority (66%, 349) had done so for less than three years. Just 11% (175) of the cohort as a whole had come into adult nursing after a period of three years or more in one occupation. Of those who had held two or more occupations, 64% (368) had worked for five years or more.

Table 3.7 Employment profile: period spent in full-time employment by number of occupations

Period of time	One occupation only No.	%	Two or more occupations No.	%
Less than 1 year	111	21	10	2
1 year or more but less than 3 years	237	45	93	16
3 years or more but less than 5 years	73	14	79	14
5 years or more but less than 10 years	78	15	227	40
10 years or more but less than 15 years	18	3	84	15
15 years or more but less than 20 years	4	1	40	7
20 years or more	2	*	17	3
No answer	2	*	22	4
Total	526	100	572	100

NB 4 of the 1102 who had worked full-time did not provide details of occupations

3.4.2 Range of occupations

Full-time jobs were allocated into occupational categories using a system devised by the Office of Population Censuses and Surveys (OPCS 1995). Part-time jobs were categorized only in terms of whether they could be regarded as a nursing, health or social care job, since detailed information about, for example, numerous part-time jobs in bar and hotel work were of little relevance to the study.

The proportion of respondents working in each OPCS category is shown in Table 3.8

Table 3.8 Full-time jobs held prior to start of diploma course

Occupational category	(n=1596) No.	%
Personal and protective service occupations	642	40
Clerical and secretarial occupations	400	25
Sales occupations	174	11
Associate professional and technical occupations	111	7
Managers and administrators	93	6
Craft and related	51	3
Plant and machine operatives	39	2
Professional occupations	22	1
Other occupations	70	4
Inadequately described/not stated	155	10

The most frequently held previous occupations were those in personal and protective services (40%, 642). A quarter of respondents (25%, 400) had worked in clerical and secretarial jobs. Details of jobs within each category, presented in Appendix 3A.1, show that the cohort had worked in a very wide range of occupations prior to starting the course.

3.4.3 Previous employment in nursing, health or social care

Just over half (52%, 823) of the cohort (52%, 769 of women and 41%, 54 of men) had worked in jobs which could be regarded as nursing, health or social care, prior to starting the course. Thirty-one per cent (490) had worked in full-time jobs only, 13% (215) in part-time jobs only and 7% (118) in both full- and part-time. As Table 3.9 shows, the most frequently held job, both full-time and part-time, was care assistant. These were also the two most commonly cited part-time jobs.

Table 3.9 Previous employment in nursing, health or social care

	Full-time (n=1596)		Part-time (n=1596)	
Previous employment	No.	%	No.	%
Care assistant	343	21	217	14
Assistant nurse/nursing auxiliary	193	12	96	6
Child care (e.g. nanny)	64	4	28	2
Welfare, community and youth worker	31	2	5	*
Dental nurse	26	2	3	*
Nursery nurse	20	1	10	*
Nurse[1]	14	*	4	*
Medical technician, dental auxiliary	6	*	1	*
Hospital ward assistant	4	*	1	*
Matron, houseparent	4	*	0	-
Other health associate professional	4	*	0	-
Ambulance staff	2	*	0	-
Social/probation worker	2	*	0	-
Physiotherapist	1	*	3	*
Medical radiographer	0	-	1	*

[1] The cohort does not include diplomates who held a previous first-level nurse qualification. The respondents who recorded previous employment as 'nursing' were therefore likely to be State Enrolled Nurses or to have worked as assistant nurses/nursing auxiliaries

3.5 VARIATIONS DUE TO SEX, AGE GROUP AND HIGHEST EDUCATIONAL QUALIFICATION

The relationship between age (five groups: 20-22, 23-24, 25-29, 30 and over, other) at qualification, highest educational qualification (five categories: degree, sufficient for degree entry, not sufficient for degree entry, entry via access course or DC test, other), and sex were explored using a log-linear modelling approach (SAS procedure CATMOD). Tests of independence between pairs of variables (interactions) in a model consisting of all main effects and two-way interactions showed the following. Sex and age group (χ^2 = 20.35, 3df, p<0.001), age group and highest educational qualification (χ^2 = 250.46, 14df, p<0.001 were all statistically associated. Sex and highest educational qualification (χ^2 = 2.91, 4df, p>0.05) were the only pair of variables that were statistically independent in the multivariate model specified above.

Tables 3.1 and 3.4 show that women are more likely to be under 30 than men, and to have gained entry with qualifications not sufficient for degree entry (i.e. one A' level or less) and not to have gained entry via an access course or DC test, whereas men were more likely than women to have gained entry via an access course or DC test (30%, 40 vs. 18%, 271) though the latter appears to be confounded in the model by age.

Table 3.10 shows a breakdown of highest educational qualification by age group. It is apparent from this table that most of those in the youngest age group (20-22) entered either with qualifications sufficient for degree entry or with qualifications that did not require them to take an access course or DC test (84%, 466) and compares with 42% (173) in the 30 and over age group.

Table 3.10 Highest educational qualification by age

	Age group									
	20-22		23-24		25-29		30+		All	
Qualification	No.	%	No.	%	No.	%	No.	%	No.	%
Degree	0	-	7	3	29	9	32	8	68	4
Sufficient for degree entry	200	36	98	33	54	17	40	10	394	25
Not sufficient for degree entry	266	48	126	42	119	38	132	32	647	41
Access/DC test	21	4	22	7	83	27	179	43	311	19
Other	70	13	45	15	28	9	32	8	176	11
All	557	100	298	100	313	100	416	100	1596	100

NB 11 respondents did not give details of their age

3.6 SPOUSE/PARTNER

All participants were asked whether they had a spouse/partner. Questions on this topic often use the formulation:

1 single
2 married/in a stable relationship/living with a partner
3 divorced/separated
4 widowed

Pilot work for our previous studies has shown, however, that this format does not allow for accurate and consistent recording of respondents' particular circumstances (Marsland *et al.* 1996). For example, of those who were single and in a stable relationship, some ringed 2, whereas others ringed 1. Other respondents who were divorced but in a stable relationship with a partner were uncertain whether to ring 2 or 3. The alternative of just asking people whether they have a spouse/partner also proved confusing for some of those who were married. Consequently, in the current study separate questions were asked about marital status and about having a spouse/partner.

Taking marital status first, Table 3.11 shows that just over two-thirds (69%, 1104) described themselves as single.

Table 3.11 Marital status: women and men

	Women		Men		All respondents	
Marital status	No.	%	No.	%	No.	%
Single	1011	69	94	71	1104†	69
Married	362	25	27	20	389	24
Divorced	66	4	8	6	74	5
Married but separated	18	1	0	-	18	1
Widowed	2	*	1	1	4†	*
Not stated	6	*	1	1	8†	*
Total	1465	100	131	100	1596†	100

† See note about weighting on p35

Sixty per cent (954) of respondents indicated that they had a spouse/partner[1]; Analysis of having a partner by marital status shows that those with a partner fell into all four of the marital status categories (Table 3.11). The findings indicate the importance of asking

[1] Hereafter, for readability, the term 'partner' is used to refer to spouse/partner.

about marital status and partner separately, since it provides clear information about the proportion of respondents with a spouse/partner. In subsequent analyses it is this information, rather than marital status, which is used.

Table 3.12 Partner by marital status: women and men

	Women with a partner		Men with a partner		All respondents with a partner	
Marital status	No.	%	No.	%	No.	%
Single	485	55	38	54	523	55
Married	362	41	27	38	389	41
Divorced	28	3	4	6	32	3
Married but separated	8	1	0	-	8	1
Widowed	1	*	1	2	2	*
Not stated	1	*	0	-	1	*
Total	884†	100	70	100	954†	100

† See note about weighting on p35

Findings on effects of partner on respondents' work/career plans are presented in Chapter 10.

The 954 respondents who had a partner were asked to specify his/her occupation and responses were categorized according to the OPCS system referred to in Section 3.5.2 (Table 3.12).

Table 3.13 Partner's occupation

	(n=954)	
Occupations	No.	%
Craft and related occupations	173	18
Managers and administrators	102	11
Associate professional and technical occupations	126	13
Personal and protective service occupations	99	10
Professional occupations	77	8
Clerical and secretarial occupations	60	6
Other occupations	29	3
Plant and machine operatives	46	5
Sales occupations	27	3
Inadequately described/not stated	202	21

The most frequently held occupations were those in craft and related occupations (18%, 173). The most frequently mentioned job was that of nurse (53 of the 126 respondents in associate professional and technical occupations category).

3.7 CHILDREN

Previous NRU research has shown that respondents' work and career plans may be affected by four different sets of circumstances, singly or in combination, concerning children (Robinson *et al.* 1995). These are:

1. respondent's children living with them
2. respondent's own children not living with respondent (either because they live with a former partner or have left home)
3. children living with respondent who are not respondent's own
4. a partner's children who do not live with respondent

Participants were asked whether each of these sets of circumstances applied to them, and the effects that each had on their work/career plans (findings on the latter are presented in Chapter 10).

Twenty-four per cent of women (346) and of men (31) had children of their own.

3.7.1 Children living with the respondent

As Table 3.13 shows, the most frequent circumstance was for respondents to have no children living with them (74%, 1179). Twenty-three per cent (374) had children living with them.

Table 3.14 Children living with respondent: women and men

	Women		Men		All respondents	
Children living with respondent	No.	%	No.	%	No.	%
Own child(ren) only	308	21	20	15	328	21
Partner's child(ren) from a previous relationship	26	2	3	2	30†	2
Own child(ren) and children of partner from a previous relationship	13	1	3	2	16	1
No children[1]	1077	74	103	79	1179†	74
Unable to allocate	41	3	2	2	43	3
Total	1465	100	131	100	1596	100

1 Includes no children of own or partner, and children of own or partner who do not live with respondent
† See note about weighting on p35

Respondents were also asked for the ages of the children who lived with them and, as Table 3.14 shows, children of school age, i.e. 5-11 and 12-16, predominated.

Table 3.15 Age groups of children living with respondent: women and men

	Women (n=353)		Men (n=26)		All respondents (n=379)	
Age of children	No.	%	No.	%	No.	%
0-4	46	13	11	42	56	15
5-11	182	52	11	42	191	51
12-16	185	53	5	19	190	51
17+	71	20	2	8	73	20
No answer	26	7	5	19	31	8

3.7.2 Children not living with respondent

Only a minority of respondents (8%, 130) referred to children (either their own or those of a partner) who did not live with them (Table 3.15).

Table 3.16 Children not living with respondent: women and men

	Women		Men		All respondents	
Children not living with respondents	No.	%	No.	%	No.	%
Own child(ren) only	50	3	8	6	58	4
Partner's child(ren) from a previous relationship	60	4	3	2	62†	4
Own child(ren) and partner's child(ren) from a previous relationship	6	*	4	3	10	1
No children who do not live with respondent	1321	90	112	85	1434†	90
Unable to allocate	28	2	4	3	32	2
Total	1465	100	131	100	1596	100

† See note about weighting on p35

3.7.3 Childcare prior to course

Eighteen per cent (285) of respondents indicated that, prior to starting the nurse diploma course, they had undertaken full-time childcare. The total length of time spent in full-time childcare ranged from less than six months to over 15 years.

3.8 SUMMARY AND DISCUSSION OF KEY FINDINGS ON PROFILE

Given that one of Project 2000's strategic aims is to attract a more diverse group of people into nursing than hitherto, to what extent has this been achieved in relation to adult

branch diplomates? Here we summarize the key findings on the cohort's profile, and where data are available for qualifiers from traditional courses, compare the findings with these.

3.8.1 Sex and age distribution of the cohort

- **8% of the adult cohort were men; 92% were women**

The Project 2000 target was to increase the proportion of male entrants to 25% (UKCC 1987). This figure related to nursing overall, and it was not specified whether it should vary for the different branches of nursing. The proportion of men in the adult nursing workforce who qualified via the traditional route has remained constant at 6% from 1991 to 1998 (UKCC 1998). The UKCC figures for members of the adult nursing workforce who qualified from the diploma course show that the proportion of men is higher than that for the traditional route and varies between 9% and 10% from 1993 to 1998 (UKCC 1998). These national figures suggest that with the move to the diploma course there has been an increase in the proportion of men in the adult nursing workforce.

Members of our cohort were at the point of qualification and so the most direct comparison is afforded by a cohort of traditional qualifiers at the same stage. The study by Robinson *et al.* (1995) of RGNs in three regions enables such a comparison, and reports a figure of 8% (79) of men. These figures suggest that there has been no change in the proportion of men in the adult nursing workforce at qualification.

- **Just over half of the cohort (54%) were aged 20-24; 20% were 25-29; 26% were 30 or over**
- **Women were significantly more likely than men to be in the youngest (20-22) age group, while men were significantly more likely to be in the eldest (30 or over) age group**
- **Just over two-thirds of the cohort (68%) comprised women in their 20s**

The Project 2000 target was to increase the number of mature entrants to the course from 3000 to 4000 (UKCC 1987). A comparison of these findings with those for traditional course qualifiers (Robinson *et al.* 1995), suggests a shift towards older entrants for the diploma courses; 71% of traditional qualifiers were 20-24, compared with 54% of diplomates. Corresponding figures for other age groups were 14% vs. 20% for those aged 25-29 and 14% vs. 26% for those aged 30 or over. These findings suggest a change in the direction advocated by the UKCC. It is important that recruitment strategies are tailored to attract a wide range of age groups in order to maintain this diversity.

Despite the foregoing, 68% of the diplomate cohort were women in their 20s. Consequently, the likelihood of career breaks for pregnancy and childcare will need to be taken into account by workforce planners.

3.8.2 The proportion of the cohort from ethnic minority groups

- ***86*% were of white origin, mainly British**
- ***4*% of the cohort were Asian or Black**
- ***6*% were of Irish origin**

A comparison of these figures, with those obtained in our earlier study of traditionally qualified adult nurses (Robinson *et al.* 1995), suggests little change in the ethnic composition of the newly qualified adult nursing workforce. The figures for the diplomate cohort of 86% white British origin, 4% Black or Asian origin and 6% Irish origin compare with 84%, 3% and 8% for the traditionally trained cohort respectively.

It is possible that there was a greater non-response to the questionnaire sent to traditionally qualified and/or the diploma qualified Black and Asian nurses than from their white counterparts. It was not possible, however, to assess whether this was the case. The representation of Black and Asian nurses in the adult diplomate cohort is lower than figures which have been reported for nursing, midwifery and health visiting as a whole. Beishon *et al.* (1995) found 7% of those working in the nursing profession belonged to ethnic minority groups; more recently the Department of Health has provided a figure of just under 8% (DH 1997b).

3.8.3 Educational background of cohort prior to starting the course

- **10% entered the course via the UKCC DC test**
- **10% gained entry via an Access course**
- **27% had five O' levels or equivalent, but not A' levels or equivalent**
- **30% had A' levels but not a degree**
- **4% had a degree**
- **A wide range of vocational and professional qualifications had been obtained, each by a small proportion of respondents**

The Project 2000 proposals argued for greater diversity of educational background in the nursing workforce (UKCC 1987), and certainly diversity in this respect was exhibited by this adult diplomate cohort. The only other study of diplomates to report separately on pre-course qualifications held by adult branch entrants is that by White *et al.* (1994); the sample appeared baised towards those with higher academic qualifications in that none of

the 30 members of the sample had entered via the UKCC DC test; 50% (15) had O' levels, 40% (12) had A' levels or a diploma, and 10% (3) had a degree.

In particular, however, the Project 2000 proposals argued for an increase in the workforce of both those with two A' levels or more and those who possessed no formal academic qualifications. A comparison of the figures for this diplomate cohort with those obtained for our earlier study of traditionally trained qualifiers (Robinson *et al.* 1996) provides an indication of the extent to which these increases have been achieved for newly qualified adult nurses. Although a slightly higher proportion of diplomates than traditional qualifiers entered the course with a degree (4% vs. 2%), a slightly smaller proportion had two or more A' levels or equivalent (20% vs. 22%).

Turning to those without formal academic qualifications, 16% of traditional qualifiers had entered via the UKCC DC test; a higher proportion than the 10% for the diplomate cohort. When the 10% who gained access to the diploma course via an Access course are included, then the comparison shows an increase from 16% to 20% for those entering adult nursing without formal academic qualifications.

3.8.4 Employment profile of the cohort prior to starting the course

- **The majority (84%) had undertaken paid employment prior to starting the course; 69% had worked full-time, of whom 57% had worked full-time for three years or more**
- **Full-time jobs encompassed a diversity of occupations**
- **Just over half (52%) had previously worked in nursing/health/social care**

As part of the quest for a more diverse nursing workforce, the Project 2000 strategy recommended an increase in mature entrants who had worked in other occupations prior to starting a nursing course. The above findings demonstrate that the adult cohort certainly includes a substantial proportion of entrants with such experience. Similar findings emerged from our earlier study of traditional qualifiers, in that 78% had undertaken paid employment prior to the course and 63% had worked full-time in a diversity of occupations. Thirty-nine per cent of traditional qualifiers had worked full-time for two years or more (Robinson *et al*. 1995), whereas 57% of diplomates had done so for three years or more. In summary, similar proportions of both cohorts had worked prior to their course, but diplomates were more likely to have been in full-time employment for longer than traditional qualifiers. In essence then, adult nursing already fulfilled the criterion of a workforce containing a substantial proportion of those with previous experience in other occupations, and this tradition increased with the move to the diploma courses.

Previous experience of healthcare work featured in the employment histories of just over half the diplomate cohort; this was nearly twice the corresponding figure of 26% for traditional qualifiers (Robinson *et al.* 1995).

3.8.5 Details of spouse/partner and children at qualification

- **60% had a spouse/partner; 25% were married**
- **23% had children living with them, most likely of school age**
- **18% had spent a period in full-time childcare prior to starting the course**

The effect, of partner and/or children on work and plans for the future is explored in Chapter 10. Suffice it to say here that many adult nurses were starting their post-qualification careers with these particular personal circumstances which have the potential to affect their career decisions. Findings for traditional qualifiers (Robinson *et al.* 1995) showed a smaller proportion with a partner (48% compared with 60% of diplomates) and a smaller proportion who had children living with them (14% compared with 23% of diplomates).

3.8.6 Conclusion

In summary, the adult cohort encompassed a diversity of demographic characteristics, personal circumstances and previous education and employment experiences. The cohort met Project 2000 recommendations for a more diverse workforce in some respects: there was an increase in the proportion who were mature entrants; an increase in the proportion who had worked full-time for two or more years; and a small increase in both those with higher academic qualifications and those without formal academic qualifications. The proportion of male qualifiers and those from ethnic minority groups, however, showed little change with the move from the traditional to the diploma course. These 'baseline' data on the cohort will enable assessments to be made in due course as to whether subsequent retention in nursing differs by the various subgroups. If so, this will have implications for retention strategies if diversity is to be maintained within the workforce.

CHAPTER 4: DECIDING TO START THE NURSE DIPLOMA COURSE AND SELECTING THE ADULT BRANCH

This chapter presents further findings on diversity within the adult branch cohort; this time on the routes and reasons behind the decision to start the nurse diploma course and the adult branch. The routes by which people decide to start a nurse diploma are varied; for example, they may know that they want to take a nursing course while still at school and apply to do so as soon as possible, or they may pursue a different occupation and decide to try nursing during a period of unemployment. Information about diversity of routes into nursing, and the factors which underlie individuals' decisions both to start the nurse diploma course and to select the adult branch, will contribute to ensuring that recruitment strategies are targeted effectively.

In the original Project 2000 proposals it was left open whether the choice of branch could be made 'at the outset of the course, or part way through the common foundation' (UKCC 1986, p47). Pye and Whyte (1996) suggested that if students were able to delay choosing a branch until after the CFP, they would make a more informed decision about the branch of nursing to which they were best suited. Furthermore, if students made the 'right' decision about their branch of nursing, they may be less likely to leave the profession either during the course or soon after registration. Information about whether entrants are able to obtain a place on their branch of choice, and whether they are able to subsequently change branches should they so desire is important, since those who selected adult as a second or third choice may be more likely to leave this branch of nursing than those for whom it was first choice.

Issues of choice are also relevant to the decision to take a diploma course rather than a nursing degree. Over recent years increasing emphasis has been placed on nurses obtaining degrees. Furthermore, degree level qualifications have become commonplace in other occupations. It therefore seemed likely that some participants may have preferred to have taken a nursing degree but, having been unable to gain a place on a degree course, took the diploma course instead. This could have implications both for

retention (those for whom a diploma was second choice may be more likely to leave nursing), and for the demand for one year post-registration degrees.

In view of the above, research questions at this stage of the project were as follows:

- What were the routes by which people decided to start the nurse diploma course? (Section 4.1)
- What was the relative importance of different types of reasons for starting the nurse diploma course? (Section 4.2)
- What was the relative importance of different types of reasons for selecting the adult branch? (Section 4.3)
- Was adult the first choice of branch for those who took it? (Section 4.4)
- What proportion of diplomates applied to take a nursing degree course? (Section 4.5)

4.1 DECISION-MAKING ROUTES INTO NURSING

Sixteen statements which describe the different routes by which people make the decision to apply for a nurse diploma course were presented to participants (Table 4.1). The statements were derived from an earlier study of registered general nurses (Robinson *et al.* 1995) and from pilot work for the current study. The 16 statements demonstrate the diversity of routes by which people make the decision to start a nursing course, and that they may do so while at school, while in another occupation, or while raising a family. Participants were asked to ring the statement which most closely described their own situation. The phrase 'by the time I was completing secondary education' is used in several of the statements. In the questionnaire this is defined as 'the time you finished full-time continuous education at school/college during your teenage years'.

4.1.1 The sixteen decision-making routes

Table 4.1 shows the proportion of adult branch diplomates who selected each statement. The first two were selected by the largest proportion of respondents 17% (273) and 14% (218) respectively.

- I wanted to take a nursing course by the time I was completing secondary education and applied as soon as possible. I did not apply for any other courses or occupations.
- I did not know what I wanted to do by the time I was completing secondary education and tried one (or more) occupations, and then decided to take a nursing course.

Table 4.1 Decision-making routes into nursing

		Women		Men		All respondents	
	Decision-making route	No.	%	No.	%	No.	%
1	I wanted to take a nursing course by the time I was completing secondary education and applied as soon as possible. I did not apply for any other courses or occupations.	267	18	6	4	273	17
2	I did not know what I wanted to do by the time I was completing secondary education and tried one (or more) occupations, and then decided to take a nursing course.	187	13	31	24	218	14
3	By the time I was completing secondary education, I had decided to work and/or study full-time for a subject other than nursing (eg banking, English degree, physiotherapy) and did so, and later on decided to take a nursing course.	180	12	28	22	208	13
4	I wanted to take a nursing course by the time I was completing secondary education, but needed/decided to obtain some additional qualifications before applying.	171	12	10	8	181	11
5	I knew I wanted to take a nursing course by the time I was completing secondary education, but decided to take a break before applying.	158	11	5	4	162	10
6	Nursing was one of a number of options I wanted to pursue by the time I was completing secondary education, and I made a final decision to take a nursing course after gaining some relevant experience.	144	10	17	13	161	10
7	I did not want to take a nursing course by the time I was completing secondary education, but after raising a family decided to do so.	90	6	6	4	96	6
8	I wanted to take a nursing course by the time I was completing secondary education but was dissuaded from doing so by others. I decided to do something other than nursing and then applied later.	70	5	5	4	75	5
9	I wanted to take a nursing course by the time I was completing secondary education, and decided to do so after raising a family.	46	3	0	-	46	3
10	I had applied for a number of courses/ occupations including nursing by the time I was completing secondary education, but nursing was my first choice.	34	2	2	2	36	2
11	I wanted to take a nursing course by the time I was completing secondary education, but could not get on a course of my choice and so decided to do something other than nursing and then applied later.	28	2	2	1	29	2
12	I wanted to follow an occupation(s) other than nursing by the time I was completing secondary education, but my application for the other(s) was unsuccessful, and so I then took a nursing course.	20	1	2	2	22	1

...Continued...

Table 4.1 (cont.) ***Decision-making routes into nursing***

	Decision-making route	Women		Men		All respondents	
		No.	%	No.	%	No.	%
13	By the time I was completing secondary education, I did not consider job options as I had decided to raise a family, and later decided to take a nursing course.	19	1	0	-	19	1
14	By the time I was completing secondary education I had decided to follow an occupation(s) other than nursing, and during a period of unemployment decided to apply for a nursing course.	8	1	10	8	18	1
15	I wasn't sure what wanted to do by the time I was completing secondary education so applied for a number of courses/ occupations including nursing. My applications for some/all of the others were unsuccessful and so I then took a nursing course.	9	1	3	2	12	1
16	I wanted to follow an occupation(s) other than nursing by the time I was completing secondary education, but thought my grades would not be high enough and so applied to do a nursing course.	10	1	2	1	12	1
	No answer	28	2	3	2	31	2
	Total	1465	100	131	100	1596	100

Overall, just 7% of respondents (115) decided to take a nursing course after having raised a family (statements 7 and 13). Gaining relevant experience (statement 6) assisted 10% (161) of respondents in deciding to start the nurse diploma course. Just 2% (34) took a nursing course because they were unable to follow their occupation(s) of choice (statements 12 and 16).

While statement 1 accounts for 17% (273) of respondents, women were significantly more likely to ring it than men (18%, 267 vs. 4%, 6 $p<0.001$). In contrast, statement 2 was selected by a significantly higher proportion of men than women (24%, 31 vs. 13%, 187 $p<0.001$). Other differences between the sexes are apparent. Men were significantly more likely than women to decide to take a nursing course after pursuing full-time study or work in a subject other than nursing - statement 3 (22%, 28 vs. 12%, 180 $p<0.01$) and during a period of unemployment - statement 14 (8%, 10 vs. 1%, 8 $p<0.001$).

4.1.2 Choice and timing in the decision to take a nursing course

The 16 statements in Table 4.1 can be grouped into three categories according to the certainty they express about nursing when completing secondary education.

1) nursing was respondent's first choice at that time
(Statements 1, 4, 5, 8, 9, 10 and 11)

2) nursing was not respondent's first choice at that time
(Statements 3, 7, 12, 13, 14 and 16)

3) respondent was unsure about nursing at that time
(Statements 2, 6 and 15)

As Table 4.2 shows, nursing was first choice for one-half (50%, 802) of respondents at the time they were completing secondary education. The findings for women and men are, however, quite different; women were significantly more likely than men to state that nursing was their first choice (53%, 772 vs. 23%, 30 $p<0.001$), whereas men were significantly more likely than women to say that it was not (37%, 48 vs. 22%, 326 $p<0.001$).

Table 4.2 Certainty about nursing when completing secondary education: women and men

	Women		Men		All respondents	
Choice	No.	%	No.	%	No.	%
Nursing was first choice when completing secondary education	772	53	30	23	802	50
Nursing was *not* first choice when completing secondary education	326	22	48	37	374	23
Unsure about nursing when completing secondary education	340	23	51	39	391	25
No answer	28	2	3	2	31	2
Total	1465	100	131†	100	1596†	100

† See note about weighting on p35

This summary of respondents' decision-making routes into three categories will be used in subsequent analyses to be undertaken in the study; for example, to ascertain if retention patterns differ by whether nursing was a first choice or not.

4.2 REASONS FOR STARTING THE NURSE DIPLOMA COURSE

Participants were presented with a range of 19 reasons for starting the course and asked to indicate the importance of each in their own decision according to a four point scale, ranging from 'very important' to 'not at all important'. A 'not applicable' option was also provided both to make the question possible for all respondents to answer, and to provide

additional information on the factors underlying respondents' decision to start the nurse diploma course.[1]

The question focused on reasons for starting the course, rather than on reasons for wanting to be a nurse, since pilot work showed that collateral reasons also exist; for example, the opportunity to work outside the UK, or to study for an occupation while receiving a bursary.

The 19 reasons encompassed six broad themes:

- working with people
- career-related
- previous contact with healthcare
- personal
- collateral
- suggested by others

Findings for each of the reasons are presented thematically in Table 4.3.

4.2.1 Working with people

The two reasons for starting the nurse diploma course most frequently rated as important both relate to working with people. For item 1 'wanted an occupation caring for people' and item 2 'wanted an occupation working with people' 96% (1537) of respondents ringed either 'very important' or 'quite important'. Indeed, out of all nineteen reasons listed, the item most frequently ringed as 'very important' was item 1: 'Wanted an occupation caring for people' (71%, 1128). A further 25% (399) of respondents ringed this reason as 'quite important'.

4.2.2 Career-related

Career-related reasons were also regarded as important in the decision to start the course. Gaining a professional qualification (item 4) was important for 89% (1414) of respondents, while 87% (1396) wanted an occupation with career prospects (item 5). Eighty-four per cent (1340) saw it as important that nursing would offer a variety of career pathways (item 6).

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[1] Consderation was given to undertaking a factor analysis to identify underlying variables or factors that explain correlations between the 19 reasons. Such an analysis could, however, only be undertaken with respondents who answered all 19 reasons and did not ring not applicable for any reason. Only 50 respondents satisfied this requirement and so factor analysis was not pursued.

4.2.3 Previous contact with healthcare

Contact with healthcare through previous work experience was, for many people, an important reason for starting the course. Item 8 ('Enjoyed the contact with patients/clients while undertaking paid work in a health/social care organization') was ringed as either 'very important' or 'quite important' by 60% (953) of respondents. The 'not applicable' column in this item also provides useful information: 30% (483) ringed 'had no experience of this'. Thus, 69% (1096) had some experience of working in a health/social care organization prior to starting the nurse diploma course (17 people did not provide an answer). Of those for whom the statement was applicable, therefore, 87% (953) considered it to be important.

Previous voluntary experience was also an important factor in many respondents' decision (item 9). Thirty-eight per cent (599) stated that having enjoyed contact with patients/clients while undertaking voluntary work was important in their decision to start the nurse diploma course. The 'not applicable' column shows that 50% (794) had undertaken no relevant voluntary work prior to starting the course. Of the 49% (775) who had done voluntary work, 77% (599) considered having enjoyed this to be important in their decision to start the course.

Some overlap exists between the 69% (1096) who had prior experience of relevant paid work, and the 49% (775) who had prior experience of relevant voluntary work. Twenty-four per cent of respondents (391) ringed either 'very important' or 'quite important' to both items 8 and 9, demonstrating that they had enjoyed both types of work. Nineteen per cent (297) ringed 'not applicable' to both items, indicating that they had had no previous contact with patients/clients in either a paid or a voluntary job.

Table 4.3 Reasons for starting the nurse diploma course

	Very important		Quite important		Not very important		Not at all important		Not applicable		Not stated	
Reasons	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Working with people												
1 Wanted an occupation working with people	1128	71	399	25	44	3	7	*			18	1
2 Wanted an occupation caring for people	1122	70	415	26	30	2	7	*			22	1
3 Wanted to make a positive contribution to peoples' lives	793	50	657	41	98	6	23	1			26	2
Career-related												
4 Wanted to gain a professional qualification	877	55	537	34	130	8	33	2			19	1

Table 4.3 (cont.) Reasons for starting the nurse diploma course

Reasons	Very important No.	%	Quite important No.	%	Not very important No.	%	Not at all important No.	%	Not applicable No.	%	Not stated No.	%
5 Wanted an occupation with career prospects	737	46	659	41	152	10	29	2			19	1
6 Thought nursing would offer a variety of career pathways	622	39	718	45	163	10	70	4			24	1
7 Wanted a change in direction from my current job	336	21	244	15	112	7	81	5	786	49	37	2
Previous contact with healthcare												
8 Enjoyed the contact with patients/clients while undertaking paid work in a health/social care organization	477	30	476	30	102	6	41	3	483	30	17	1
9 Enjoyed the contact with patients/clients while undertaking voluntary work	246	15	353	22	107	7	69	4	794	50	27	2
10 Experience of illness of family/friends	169	11	340	21	347	22	251	16	464	29	25	2
11 Experience of being a patient	78	5	188	12	286	18	322	20	699	44	25	2
Personal												
12 Thought nursing was something for which I was particularly suited	760	48	712	45	83	5	19	1			22	1
13 Wanted a job in which I would feel needed	261	16	683	43	416	26	214	13			22	1
14 Thought nursing would offer similar satisfaction to that gained in caring for my children	44	3	94	6	112	7	140	9	1186	74	21	1
15 Religious vocation	26	2	77	5	130	8	190	12	1145	72	28	2
Collateral												
16 Having an NHS bursary provided a greater income than a student grant	265	17	303	19	297	19	702	44			29	2
17 Thought it would provide the opportunity to work abroad	208	13	366	23	408	26	466	29	126	8	23	1
Suggested by others												
18 Suggested by family and/or friends	74	5	224	14	248	16	216	14	808	51	25	2
19 Suggested by a careers teacher/officer	28	2	83	5	124	8	124	8	1215	76	22	1

Experience of illness - another form of contact with healthcare - was an important reason for starting the course for a small proportion of respondents. Personal experience of

illness, or illness among friends and family, was considered to be an important reason by 17% (266) and 32% (509) of respondents, respectively. Forty-four per cent (699) had no experience of being a patient (item 11), while 38% per cent (608) indicated that experience of being a patient was not important in their decision to start the nurse diploma course. Similarly, 37% (598) considered experience of illness among family or friends (item 10) not to be an important reason for starting the course; 29% (464) had no experience of this.

4.2.4 Personal

Reasons related to personal attributes were, for many respondents, important in their decision to start the nurse diploma course. Ninety-two per cent (1472) of respondents thought nursing was something to which they were particularly suited (item 12), while 59% (944) considered it important that they wanted a job in which they would feel needed (item 13).

4.2.5 Collateral

Having an NHS bursary which provided a greater income than a student grant (item 16) and the opportunity to work outside the UK (item 17) were both reasons which respondents frequently regarded as not important in their decision to start the course. Indeed, 63% (999) of respondents regarded having an NHS bursary as not important to their decision. Similarly, for 55% (874) of respondents the opportunity to work abroad was not an important reason for starting the nurse diploma course. Thirty-six per cent (574), however, regarded the opportunity to work abroad as important to their decision to start the nurse diploma course.

4.2.6 Suggested by others

Friends or family suggested starting a nursing course to 48% (762) of respondents; 19% (298) indicated that such suggestions were important in their decision to start the course. Just over a fifth of respondents (22%, 359) had nursing suggested to them by a careers teacher or officer, 31% (111) of whom considered this suggestion to be important in their decision; this latter figure accounts for 7% of the cohort as a whole.

4.2.7 Reasons for starting the diploma course: differences between women and men

It was thought that women and men may have different reasons for starting the nurse diploma course, so analysis was undertaken separately for each sex (Appendix 4A.1). Women were significantly more likely than men to cite reasons related to personal factors: thought nursing was something for which I was particularly suited (93% vs. 83% $p<0.001$); wanted an occupation caring for people (96% vs. 91% $p<0.05$), and thought

nursing would offer similar satisfaction to that gained in coming for my children (9% vs. 4% $p<0.05$). Men were significantly more likely than women to cite reasons related to career direction: wanted a change in direction from my current job (57% vs. 34% $p<0.001$), and thought it would provide the opportunity to work abroad (45% vs. 35% $p<0.05$). Men were also significantly more likely than women to say that nursing was suggested by family and/or friends, (27% vs. 18% $p<0.05$).

4.3 REASONS FOR SELECTING THE ADULT BRANCH

Participants were presented with a list of 11 reasons for selecting the adult branch, and asked to indicate the importance of each in their decision (Table 4.4). The word 'select' was used instead of 'choose', since pilot work showed that some respondents did not regard their decision as a choice because, for various reasons, the branch was the only one available to them.

As with reasons for starting the nurse diploma course, reasons for selecting the adult branch encompassed a number of themes:

- personal
- previous contact with this type of work
- career-related
- constraints
- experience during nurse diploma course

4.3.1 Personal

By far the most important reasons for selecting the adult branch were item 1 'Interested in this type of work/area of nursing', and item 2 'Thought I was particularly suited to this branch of nursing'. These were ringed as either 'very important' or 'quite important' by 97% (1543) and 92% (1464) of respondents, respectively.

4.3.2 Previous contact with this type of work

Enjoying experience in type of work/area of nursing before starting the course (item 3) was considered important by 57% (911) of respondents. However, disregarding those for whom this statement was not applicable, i.e. those without experience before the course, 88% of those with relevant experience saw it as important in their decision to take the adult branch.

4.3.3 Career-related

The majority of respondents rated career opportunities offered by the adult branch in comparison with opportunities offered by the other branches (item 5), as an important reason for selecting this branch; 77% (1223) of respondents considered this item to be important. Just over one-third of respondents (34%, 541) rated the opportunity to work abroad as an important reason for selecting this branch.

4.3.4 Constraints

Items 7, 8 and 9 relate to constraints participants may have experienced regarding their choice of branch. However, the findings show that few of the adult cohort selected this branch due to the circumstances explored; just 10% (157) recorded that their preferred branch was not available at the college(s) of their choice at the time they were applying, for 6% (102) adult was the only branch available at the college(s) of their choice, and 7% (112) were not offered a place on their preferred branch and so chose adult instead. Moreover, for each of these circumstances less than half of those for whom they were relevant indicated that the constraint was important to their decision.

4.3.5 Experience during nurse diploma course

Experience of clinical placements during the CFP led some respondents, who had originally selected another branch, to change to the adult branch. For 7% (118) of respondents, enjoying adult placements during the CFP was an important reason in their decision to select the branch (item 10). Similarly, disliking placements in other branches (item 11) was important in the decision to change to the adult branch for 3% (54). For both these items, 90% (1432) ringed 'not applicable' because they selected the adult branch before the CFP. (Branch selection is addressed in more detail in Section 4.4.)

Table 4.4 Reasons for selecting the adult branch

	Reasons	Very important No.	%	Quite important No.	%	Not very important No.	%	Not at all important No.	%	Not applicable No.	%	Not stated No.	%
Personal													
1	Interested in this type of work/area of nursing	1080	68	463	29	29	2	9	1			15	1
2	Thought I was particularly suited to this branch of nursing	879	55	585	37	86	5	24	1			22	1
Previous contact with this type of work													
3	Before starting the nurse diploma course I had enjoyed experience of this type of work/area of nursing	521	33	390	24	98	6	31	2	539	34	17	1
4	Knew people who worked in this area of nursing	184	12	374	23	346	22	171	11	505	32	15	1
Career-related													
5	Thought it offered broader career opportunities than other branches	730	46	493	31	210	13	145	9			19	1
6	Thought it would provide the opportunity to work abroad	222	14	319	20	350	22	400	25	282	18	22	1
Constraints													
7	My preferred branch was not available at the college(s) of my choice at the time I was applying	35	2	35	2	26	2	61	4	1407	88	32	2
8	Only branch available at college(s) of my choice at the time I was applying	30	2	15	1	20	1	37	2	1471	92	23	1
9	Was not offered a place on preferred branch, and chose adult branch instead	23	1	8	*	26	2	55	3	1460	91	24	2
Experience during course													
10	During the CFP I particularly enjoyed placements in this branch	86	5	32	2	9	1	6	*	1432	90	31	2
11	During the CFP I disliked placements in other branches	23	1	31	2	24	1	37	2	1432	90	49	3

4.3.6 Reasons for selecting the adult branch: differences between women and men

Analysis to ascertain whether any differences existed in the reasons given by women and by men for taking the adult branch revealed differences on similar dimensions to those for reasons for starting the nurse diploma course (see 4.2.7). Thus women were significantly more likely than men to cite 'thought I was particularly suited to this area of nursing'

(92% vs. 85% p<0.01), whereas men were significantly more likely than women to think the adult branch would offer opportunities to work abroad (44% vs. 33% p<0.01), and to have known people who worked in this area (46% vs. 34% p<0.01). (Details are in Appendix 4A.2.)

4.4 SELECTING THE ADULT BRANCH: CHOICE AND CHANGE

Although in the original Project 2000 proposals (UKCC 1986) the timing of branch selection was left open, 94% (1500) of the adult cohort were required to select a branch before starting the nurse diploma course. The majority of these (95%, 1432) selected the adult branch, 2% (24) the child branch, 2% (24) the mental health branch, and 1% (12) the learning disability branch. (Eight people did not provide an answer.) Thus, for just 4% (60) of respondents, the adult branch was not their initial choice, and they changed during the CFP.

Those who selected the adult branch at the outset were asked whether they wanted to change branch during the course (Table 4.5). Of the 95% (1432) who selected the adult branch before the CFP, 15% (213) wanted to change branch during the course.

Table 4.5 Selecting the adult branch

Selection	No.	% of those who selected adult before CFP	% of total cohort
Selected adult before CFP and:	1432	100	90
• did not want to change to another branch	1181	82	74
• wanted to change to another branch	213	15	13
• did not answer about changing branch	38	3	2
Selected another branch before CFP and changed to adult	60	n/a	4

The 213 respondents who wanted to change from the adult branch were asked why they did not do so; the reasons are shown in Table 4.6. The majority (78%, 166) of those who considered changing branch decided to stay on the adult branch. Seventeen per cent (37) of those who considered changing branch found it was not possible within their college of nursing.

Table 4.6 Reasons given, by those who had wanted to change branch, for remaining on the adult branch

Reason	No.	%
I considered changing branch, but decided to stay on this branch	166	78
It was not possible for me to change branch within the college	37	17
Other	7	3
Not answered	3	1
Total	213	100

The 37 respondents who had been unable to change to another branch were asked what they felt about having qualified from the adult branch. Eighteen were pleased that they did not change branches and ten, although satisfied with the qualification, still wished they had changed branch during the course. (Nine people did not provide an answer.)

Although differences did exist between women and men in relation to selection of the adult branch (Appendix 4A.3), none were significant.

4.5 APPLYING FOR A NURSING DEGREE

Participants were asked whether they had applied for a place on a nursing degree course at any time before starting their diploma course. Pilot work showed that there were three main reasons why participants took a diploma rather than a degree course: i) not obtaining the qualifications required for entrance to a degree course; ii) preferring the diploma as it was viewed as being more practical and thought to facilitate a more specifically clinically orientated career, and iii) preferring the location of the college offering the diploma course to that of the college(s) offering the degree course. Pilot work indicated, however, that very few participants had applied for a nursing degree course and so, for reasons of space, respondents were not asked why they decided to start a diploma rather than a degree course.

Just 8% (125) of respondents did apply for a place on a nursing degree course at some point before starting the nurse diploma course; women and men were equally likely to have done so (8%, 115 vs. 8%, 10). It was originally thought that some participants may have wanted to undertake a nursing degree but, having been unable to gain a place on a degree course, taken a diploma course instead. The data show that this is likely to be the case for only a few respondents.

4.6 SUMMARY AND DISCUSSION OF KEY FINDINGS ON ROUTES AND REASONS

The diversity of Project 2000 diplomates is evident not only in their demographic characteristics and experience prior to the course (Chapter 3), but in their decision-making routes to taking a nurse diploma course and, more specifically, the adult branch. Here we summarize the key findings and, in particular, consider their implications for recruitment and retention strategies. Reference is made to comparable findings which exist on adult nurses who qualified from traditional courses.

4.6.1 Routes and reasons

- **Adult branch diplomates came from a variety of backgrounds, including the following: after working in another occupation(s); after studying another subject; after a period of time spent raising a family, or after a period unemployment**

- **Nursing had been first choice for 50% when completing secondary education, was not first choice for 23%, and 25% had been uncertain about nursing at this time**

Comparisons with traditional qualifiers (Robinson *et al.* 1995) reveal that they had also come from a diversity of backgrounds. The fact that this diversity continues to exist for diplomates, indicates that recruitment strategies should be widely targeted and not just aimed at those nearing completion of secondary education.

- **Careers services appeared to have played only a minor role in successful recruitment of diplomates, with just 7% citing a suggestion from a careers teacher/officer as important in their decision to take the course, and 76% having received no such suggestion**

There would seem to be an increased role for careers services in bringing nursing to people's attention. Many potential recruits, however, may not be in a position to access careers services and so alternative approaches such as the Department of Health's advertising campaigns are likely to be an important element of recruitment strategies.

- **In relation to starting the diploma course the two reasons relating to working with people were those most frequently rated as important (very important or quite important); 96% in both cases. These were followed by thinking that nursing was something for which the respondent would be particularly suited (92%) and wanting to make a positive contribution to people's lives (91%). Career opportunities followed next in frequency; in particular gaining a professional qualification (89%), and wanting an occupation with career prospects (87%)**

These findings suggest two points for consideration. First, it is important that those qualifying from the adult branch are given the opportunity to provide hands-on care. A skill mix pattern which requires nurses to manage the care given by others, rather than

being involved in direct care-giving themselves, could result in dissatisfaction with nursing work. Second, the findings also suggest that opportunities to develop a career in nursing are important for this cohort; lack of such opportunities to do so could contribute to attrition.

- **Reasons identified as important in selecting the adult branch were most likely to be concerned with interest in (97%), and perception of suitability for (92%), this area of nursing. These were followed by the view that adult nursing offered broader opportunities than other branches (77%)**
- **The opportunity to work abroad was cited as an important reason for taking the nurse diploma course by 36% of respondents, and as an important reason for selecting the adult branch by 34%**

A substantial proportion of the adult cohort may nurse overseas for a period in the future. Subsequent questionnaires will demonstrate whether these respondents do work abroad and, if so, whether they return to the UK nursing workforce at a later date.

Other studies of diplomates which have included those from the adult branch (e.g. O'Neill *et al*. 1993, Jowett *et al.* 1994) have not reported reasons for starting the course separately for each branch, and so comparison with the adult diplomate cohort in this study is not possible. Robinson *et al.* (1995) asked students why they wanted to qualify as a nurse and did not ask separately about nursing overall and adult nursing in particular. Moreover in the traditional qualifiers study, respondents were asked to ring those reasons which were important in their decision, whereas in the diplomate study, respondents were asked to rate the importance or otherwise of each reason. Nonetheless, some broad comparisons can be made between traditional qualifiers and diplomates. Eighty-seven per cent of traditional qualifiers ringed wanted an occupation with promotion prospects; the same proportion of diplomates rated wanting an occupation with career prospects as very or quite important. Similar proportions of both groups regarded obtaining a qualification that would enable them to work abroad as important: 41% of traditional qualifiers vs. 39% of diplomates. Differences emerged in relation three reasons. A greater proportion of diplomates than of traditional qualifiers identified working with people, and wanted to feel needed as important in their decision to take the course: 96% vs. 74% and 59% vs. 18% respectively. Differences also emerged in the proportion for whom level of income available during the course was an important reason; thus 36% of diplomates rated an NHS bursary as providing a greater income than a student grant as important, whereas 20% of traditional qualifiers ringed earning money while training as important.

4.6.2 Effect of previous experience

- **Previous experience featured strongly - 69% had prior experience of paid health/social care work, 87% of whom cited this as an important reason for starting the nurse diploma course; corresponding figures for voluntary work were 49% and 77%. Similarly, 65% had had experience of caring for adult patients; of these respondents, 88% cited enjoying this as an important reason for selecting the branch**

The study of traditional course qualifiers by Robinson *et al.* (1995) showed that 79% reported that working in a paid health care job had a positive effect on their decision to take nurse training; the corresponding figure for voluntary work was 72%. Although these findings seem to indicate that work experience in health/social care will encourage recruitment, it should be noted that no inference can be made about the direction of the relationship between such prior experience and the decision to take a nursing course. While people may be influenced by their work experience, it is also possible that those interested in nursing choose to gain relevant experience before starting a course. At the very least, however, the findings suggest that this experience is a factor in reinforcing individuals' interest in this area of work. It is not possible, however, to tell from data collected for either study, how many people are deterred from starting a nursing course by such experiences.

4.6.3 Selecting the adult branch: choice and change

- **94% of the adult cohort were required to select a branch prior to starting the CFP**
- **95% of these selected the adult branch before they started the nurse diploma**
- **82% of those who selected the adult branch at the outset did not consider changing branch during the course**
- **Of those who considered changing branch, most (78%) subsequently decided not to do so**
- **37 people (2% of the cohort) wanted to change branch but could not do so within their college. Of these, 18 were eventually pleased that they did not change branch and 10 still wished that they had changed branch**

Together these findings indicate that most of the adult cohort had selected that branch through choice, either prior to starting the CFP, or having started on a different branch and later transferred. Although some students had wanted to transfer from the adult branch, most decided not to do so. The findings suggest therefore that the majority of those who completed the adult branch were satisfied with their selection. The original UKCC proposal was that branch selection should be made after the CFP (UKCC 1986). Recognizing the pragmatic obstacles of such an approach, however, the current system

which appears to exist in many colleges (i.e. an initial branch selection but relative flexibility for subsequent transfer) is a reasonable compromise.

4.6.4 Applying for a nursing degree

- **Just 8% of respondents applied for a place on a nursing degree at some point before starting the nurse diploma course**

Later questionnaires will indicate whether those who had applied to take a nursing degree prior to starting the diploma course, subsequently obtain a degree.

4.6.5 Differences between women and men

- **When completing secondary education, nursing was significantly more likely to be a first choice for women than for men**
- **Men were significantly more likely than women to rate reasons related to career directions as important in their decision to start the nurse diploma course and to select the adult branch, whereas women were significantly more likely than men to rate reasons related to personal factors**

CHAPTER 5:
OBTAINING A FIRST JOB

The second aim of the research is to describe diplomates' career plans and career pathways followed from qualification onwards and, as indicated in chapter 1 (section 1.3.2), is relevant to policies in three interrelated areas: retention overall; directions pursued within nursing, and career progression. The policy agenda focuses not only on retention in nursing overall; but also on retention in different employing organizations, settings and clinical specialties. Of particular importance therefore, are the directions which diplomates wish to pursue and the extent to which their plans are realised. This chapter focuses on career plans and pathways, as they relate to diplomates' first jobs. Although this is only the start of a career, several questions relevant to policies concerned with retention and direction, arise from diplomates' experiences at this early stage. First, is there any sense of early attrition from nursing and/or difficulties in obtaining a first job? Of particular note in relation to the latter are nurses taking agency/bank jobs in the absence of more permanent positions and/or jobs being offered on very short-term contracts only. The NHS, as the major employer of nurses and the one with which they are most familiar at qualification, is likely to be diplomates' first destination. Nonetheless some may have wanted a job in the NHS and not been able to obtain one, or have opted at the outset for a non-NHS organization. Turning to clinical specialties, then questions arise as to whether diplomates are able to obtain a job in their preferred specialty.

Given the foregoing, research questions on career plans and pathways in relation to first job were as follows:

- What proportion of diplomates planned to obtain a nursing job immediately after qualification? (Section 5.1)
- Of those who planned to obtain a nursing job, how many had done so? (Section 5.2)
- In which employing organizations were first jobs based - were those who wanted to work in the NHS able to do so? What were the contractual conditions of the job? (Section 5.3)
- In which settings were first jobs based? (Section 5.4)

- With which age groups and in which clinical specialties were first jobs based; were these diplomates' preferences? (Section 5.5)
- At which grade/pay-scale point were diplomates appointed? (Section 5.6)
- What were the plans/experiences of those who had not obtained a nursing job? (Section 5.7)

5.1 PLANS IMMEDIATELY AFTER QUALIFICATION

Ninety-four percent (1498) of respondents had qualified by the time they returned the first questionnaire. (Nineteen people did not provide an answer.) Of the 5% (80) who had yet to qualify, 54% (43) were retaking an assessment, assignment or examination, 30% (24) were making up sick leave, and 8% (6) had not yet been notified of qualification. Of those who provided responses under 'other', two were making up time having been on maternity leave, and three were completing an assignment. All 80 still intended to qualify. Of those who had qualified, all had applied to the UKCC for registration or intended to do so.

All participants were asked about their plans immediately after qualifying. The options offered are shown in Table 5.1. Most (96%, 1528) intended to undertake paid employment in the UK (although not necessarily in nursing). The majority (89%, 1418) planned to work full-time, including 9% (135) who planned to combine this with part-time study. (Courses which respondents planned to take are detailed in Chapter 8).

Table 5.1 Plans immediately after qualification

Plans	No.		%	
Full-time paid employment in the UK	1283	1418	82	89
Full-time paid employment in the UK and part-time study	135		9	
Part-time paid employment in the UK	79	109	5	7
Part-time paid employment in the UK and part-time study	19		1	
Part-time paid employment in the UK and full-time study	12		*	
Not to take up paid employment in the UK	37		2	
No answer	31		2	
Total	1596		100	

The 1528 respondents who planned to take up paid employment in the UK immediately after qualification were asked whether this would be a nursing job. Nearly all (1522) said

that this was the case; 95% of the cohort as a whole[1]. Of these 1522, 95% (1450) had already qualified, and 5% (72) had still to do so.

5.2 OBTAINING A FIRST NURSING JOB

Since piloting revealed that it was possible to obtain a job prior to qualifying, all 1522 respondents who planned to take up a nursing job immediately after qualification were asked if they had obtained one. As Table 5.2 shows, the majority of those who had qualified (92%, 1345) had already done so. Sixty-nine per cent (50) of the 72 who had not yet qualified had also obtained a first nursing job. In total, 91% (1385) of those who planned to obtain a nursing job had done so (87% of the cohort as a whole).

Table 5.2 Proportion of those who planned to obtain a first nursing job who had done so

	Qualified		Not yet qualified		All respondents	
Obtained a first nursing job	No.	%	No.	%	No.	%
Yes	1335	92	50	69	1385	91
No	112	8	22	31	134	9
No answer	2	*	0	-	2	*
Total	1450†	100	72	100	1522†	100

† See note about weighting on p35

The 1385 respondents who had obtained a nursing job were then asked whether this job was agency/bank nursing; this was the case for 3% (43). These respondents were asked why they had obtained an agency/bank job at this stage, and their subsequent plans. These findings are presented in Section 5.7.2.

The 134 respondents who had not yet obtained a first job were asked why this was the case. These findings are presented in Section 5.7.3.

The 1340[2] respondents who had obtained a nursing job which was not agency/bank nursing were asked for a variety of information about this job:

[1] Of the six other respondents, four planned to take up a non-nursing job, and the other two did not specify the type of job s/he planned to obtain.

[2] Weighting of the figures means the numbers of those who had obtained a nursing job (1340) and those who had obtained an agency/bank job (43) do not sum exactly to the 1385 in Table 5.2.

- employing organization and contractual conditions (length of contract, pattern of hours, whether the job was rotational, qualifications required) (Section 5.3)
- setting (Section 5.4)
- age group and clinical specialty (Section 5.5)
- title and grade (Section 5.6)

5.3 EMPLOYING ORGANIZATION AND CONTRACTUAL CONDITIONS

5.3.1 Employing organization

Table 5.3 shows that most of the 1340 respondents had obtained a job working in the NHS (97%, 1301), with a further 1% (10) having obtained a job jointly funded by the NHS and a non-NHS organization (together these respondents account for 82% of the cohort as a whole). Two per cent (23) of those with a first job had obtained this in a non-NHS organization, most frequently a private healthcare company.

Table 5.3 Employing organization

Employing organization	No.		%	
NHS	1301		97	
Jointly funded by the NHS and a non-NHS organization	10		1	
Non-NHS				
• Private healthcare company/employer	14	} 23	1	} 2
• Charity	1		*	
• Other	8		1	
No answer	6		*	
Total	1340		100	

Of the 1311 people whose first job was solely or partly funded by the NHS, 69% (904) (57% of the total cohort) would be working in the trust (or one of the trusts) in which their course placements had been based and 29% (378) would be working in an outside trust. Seven respondents did not know whether their first job was in the trust(s) in which course placements had been based. Twenty-two did not provide an answer.

Further analysis explored whether differences existed between colleges in the proportion of qualifiers who did and did not obtain jobs in one of the trusts in which their course placements were based. Of the 37 colleges, none retained all their qualifiers, 23 retained 70% or more, and all but four retained at least one-half of their adult branch diplomates.

The 23 respondents whose first job was not in the NHS were asked if they would have preferred to have obtained a job in the NHS. The most frequent response was 'don't mind' (8). Six indicated that they would have preferred an NHS job, seven that they would not, and two failed to answer.

Reasons for taking a first job outside the NHS were explored using an open question; responses are summarized in Table 5.4.

Table 5.4 Reasons for taking a first job outside the NHS

Reasons	(n=23) No.
Conditions of employment	6
Working in Armed Forces	6
Lack of availability of NHS jobs	4
Other	3
Working in the prison service	2
Wanted/liked this clinical specialty/setting	2
Geographical location	1
Quality of care	1
No answer	1

The two most frequently mentioned reasons were conditions of employment (6), (most of which related to pay and the working environment) and working in the armed forces (6). Four respondents mentioned the lack of availability of NHS jobs.

The 23 respondents whose first job was outside the NHS were also asked if they intended to return to the NHS in the future. Ten indicated that they were unsure, seven intended to return, and five did not intend to do so, and one failed to answer.

5.3.2 Length of contract

Almost two-thirds of respondents (61%, 820) had obtained a job with an open-ended or permanent contract. Twenty-two per cent (291) had fixed-term contracts, of which the majority were for either six months or a year (Table 5.5).

Table 5.5 Length of contract

Length	No.		%	
Open-ended/permanent contract	820		61	
Fixed-term contract				
• Less than six months	16		1	
• Six months	148		11	
• 7-11 months	4	291	-	22
• Year	64		5	
• Longer than one year	49		4	
• Length not stated	9		-	
Not sure whether fixed or open	202		15	
No answer	27		2	
Total	1340†		100	

† See note about weighting on p35

Further analysis revealed that similar proportions of respondents who had obtained NHS and non-NHS jobs had open-ended/permanent contracts.

5.3.3 Hours

Participants were asked whether their first job was full- or part-time, their preference for full- or part-time work and about the pattern of working hours the job entailed. As Table 5.6 shows, 94% (1258) had obtained a full-time job. Only 5% (61) of these respondents would have preferred to work part-time: of these 61 people 44% (27) did not take a part-time job because of financial reasons, 25% (15) stated that there were no part-time positions available, and 15% (9) thought that full-time work would better enable them to gain initial experience and consolidate their skills. (Ten did not give a reason.) Thirty-nine per cent (29) of the 76 respondents who had obtained a part-time job would have preferred to work full-time; nearly three-quarters of whom (21) took part-time work as full-time hours were not available.

Table 5.6 Full-time or part-time hours

Hours	No.	%
Full-time	1258	94
Part-time	76	6
No answer	6	*
Total	1340	100

The pattern of hours that people would work in their first job was asked using an open-ended question, and answers grouped into four broad categories (Table 5.7).

Table 5.7 Pattern of work hours

Pattern of work hours	No.	%
Rotation (e.g. days, nights, sleep-ins)	955	71
Day shifts	145	11
Fixed day-time hours (e.g. 9-5, 8:30-4:30)	31	2
Night duty	9	*
No answer/not classifiable	200	15
Total	1340	100

The most frequently mentioned pattern of hours was rotation between day and night shifts (71%, 955) followed by day shifts only (11%, 145). Only nine respondents would be working solely on night duty in their first job. It should be noted that the 'no answer/not classifiable' figure is fairly high because this category also includes respondents who stated only the number, rather than the pattern, of hours.

5.3.4 Rotation

For the purposes of this study, a rotational job is described as a job in which it is planned for the employee (respondent) to rotate between different clinical specialties (usually spending six months in each). These planned rotations have the benefit of enabling newly qualified nurses to gain a range of experience. Twenty-five per cent (330) of the 1340 respondents had obtained a rotational job.

5.3.5 Qualification required

It became apparent from pilot work that, for certain jobs, a number of qualifications aside from a Registered Nurse qualification were acceptable. Although the majority of adult branch nurses (96%, 1287) had obtained a first job for which a Registered Nurse qualification was a prerequisite, 3% (42) had obtained positions for which a number of different qualifications were acceptable. Eleven provided details as requested, the qualifications stated were enrolled nurse (6), operating department practitioner (4) and registered sick children's nurse (1).

5.4 SETTING

Participants were asked to ring, from a comprehensive list, the setting(s) within which they would be working during their first job. As could be anticipated, 97% (1299) stated that their first job would be in a hospital setting (Table 5.8). Two per cent (22) indicated

that their first job would be working in people's own homes. No respondents had obtained a first job in a school.

Table 5.8 Setting

Setting	(n=1340) No.	%
Hospital	1299	97
People's own home	22	2
Community services centre	17	1
Health centre	15	1
Nursing home	14	1
Day hospital	13	1
GP surgery	13	1
Residential home	11	1
Day centre	4	*
Hospice	3	*
Residential hostel	2	*
No answer	3	*

5.5 AGE GROUP AND CLINICAL SPECIALTY

5.5.1 Age group

As Table 5.9 shows, the majority (92%, 1231) of adult branch nurses would be working with adults in their first job. However, 30% (405) of respondents indicated that they would be looking after children and/or adolescents.

Table 5.9 Age group of patients

Age group	(n=1340) No.	%
Adults	1231	92
Elderly	665	50
Adolescents	264	20
Children	141	11

Table 5.10 shows the combinations of age groups ringed by respondents. Forty per cent (643) had a first job working with adults only. Working solely with children, adolescents, or elderly patients, or with a combination of age groups was less common.

Table 5.10 Age group of patients: combinations

Age group	No.		%	
Working with one age group only				
Adults only	643	739	40	55
Children only	5		*	
Elderly only	91		6	
Adolescents only	0		-	
Working with more than one age group				
Adults and elderly	323		20	
Children and adolescents	2	597	*	45
Children and adults	2		*	
Adolescents and adults	8		1	
Adolescents, adults and elderly	123		8	
Children, adolescents and adults	4		*	
Children, adults and elderly	1		*	
Children, adolescents, adults and elderly	127		8	
No answer	7		1	
Total	1340†		100	

† See note about weighting on p35

5.5.2 Clinical specialty

In relation to clinical specialty, participants were asked whether or not they would be caring for medical and/or surgical patients in their first job. Thirty-eight per cent (515) of respondents indicated that they would be caring solely for medical patients. Similarly, 36% (482) would be caring solely for surgical patients. Twenty-two per cent (292) of respondents indicated that they would be caring for both medical and surgical patients.

Table 5.11 Patient type

Patient type	No.	%
Medical patients	515	38
Surgical patients	482	36
Medical and surgical patients	292	22
Neither medical nor surgical patients	37	3
No answer	13	1
Total	1340†	100

† See note about weighting on p35

Clinical specialty was further explored by presenting participants with a list of specialties and asking them to indicate whether or not they would be working in each one in their first job. Opportunity was also provided for respondents to detail any clinical specialties not listed in which they would be working. As Table 5.12 Column 1 shows, some respondents would be working in more than one clinical specialty. The most frequently mentioned specialties were general medicine (33%, 439) and general surgery (22%, 291). Only 7% (92) stated that their clinical specialty was not listed. Respondents were asked to identify the main clinical specialty in which they would be working in their first job (Table 5.12 Column 2). Seventy-four per cent (992) identified just one clinical specialty as their main clinical specialty, 15% (200) mentioned two, 5% (67) mentioned three and 3% (35) mentioned four or more. As can be seen in Table 5.12 Column 2, the most frequently mentioned main clinical specialties were general medicine (24%, 322) and general surgery (15%, 196). The only other double figure percentage was for elderly care (10%, 132).

Table 5.12 Clinical specialty

	Column 1 Clinical specialty (n=1340)		Column 2 Main clinical specialty (n=1340)	
Clinical specialty	No.	%	No.	%
Accident and Emergency	79	6	55	4
Aids/HIV	45	3	10	1
Burns and plastics	23	2	19	1
Cardiac	166	12	103	8
Cardiothoracic	98	7	60	4
Community	20	1	16	1
Day surgery	65	5	17	1
Dermatology	34	3	15	1
Diabetes	12	1	9	1
District nursing	3	*	2	*
Ear, nose and throat	65	5	37	1
Elderly care	220	16	132	10
Endocrinology	68	5	28	2
Gastroenterology	123	9	69	5
General medicine	439	33	322	24
General surgery	291	22	196	15

...Continued...

Table 5.12 (Cont.) Clinical specialty

Clinical specialty	Column 1 Clinical specialty (n=1340)		Column 2 Main clinical specialty (n=1340)	
	No.	%	No.	%
Haematology	82	6	37	3
Hepatology/liver transplant	4	*	4	*
Infectious Diseases	49	4	12	1
Intensive care	78	6	48	4
Mental health - general	1	*	1	*
Mental health- elderly	2	*	2	*
Neurology (medical or surgical)	89	7	51	4
Ophthalmology	20	1	14	1
Oncology	110	8	44	3
Orthopaedics	133	10	95	7
Outpatients	25	2	8	1
Paediatrics	3	*	2	*
Palliative care	3	*	3	*
Practice nursing	3	*	1	*
Renal	81	6	35	3
Respiratory	42	3	31	2
Rheumatology	33	2	13	1
SCBU	3	*	3	*
Stroke/stroke rehabilitation	14	1	10	1
Theatres	79	6	61	5
Urology/genito-urinary	105	8	64	5
Vascular surgery	122	9	75	6
Women's health	1	*	0	-
Adult - unspecified	22	2	12	1
Other	13	*	8	1
No answer/not classifiable	6	*	45	3

5.5.3 Obtaining a first job in preferred clinical specialty

Participants were asked whether the clinical specialty(ies) of their first job was that in which they wanted to work. Table 5.13 shows that 76% (1017) of respondents obtained a job in their preferred clinical specialty. Eight per cent (113) obtained a job in a clinical specialty other than that which they wanted.

Table 5.13 First job based in preferred clinical specialty

Preference	No.	%
Yes	1017	76
No	113	8
Did not mind	182	14
No answer	27	2
Total	1340†	100

† See note about weighting on p35

Respondents whose first job was not in their preferred clinical specialty were asked in which clinical specialty they wanted their first job to be based. Twenty-four per cent (27) would have preferred their first job to have been in general surgery. General medicine, oncology and the community would each have been the preference for 11% (12) of respondents, accident and emergency the preference of 10% (11) and gynaecology the preference of 9% (10). The numbers of respondents stating each other clinical specialty are very small, no more than 6% (7) in each case.

5.6 TITLE AND GRADE

The majority of adult branch respondents (97%, 1301) described their job title as staff nurse; this includes titles such as associate nurse, RGN, team nurse.

Ninety-nine per cent of adult branch nurses (1320) were appointed at D grade or equivalent. Only one respondent had obtained an E/F grade, two respondents had obtained an F grade (or equivalent) and one respondent had obtained an H grade (or equivalent). (Sixteen respondents did not provide an answer.)

5.7 DIPLOMATES WHO HAD NOT OBTAINED A FIRST NURSING JOB

Sixteen per cent (256) of respondents had not obtained a first nursing job at the time they completed the questionnaire. They include three separate groups, each of which is considered in turn in this section, plus 38 people who had not obtained a job but provided insufficient information to be allocated to one of these three groups.

5.7.1 Diplomates who did not plan to obtain a nursing job immediately after qualification

Respondents who did not plan to obtain a nursing job immediately after qualification included 37 who did not plan to take up paid employment and four who planned to obtain a non-nursing job. Of the 37 respondents not planning to take up paid employment, 11 intended to go abroad, 11 intended to undertake full-time study (nine in midwifery and

two in nursing), six respondents were expecting a baby and five were simply planning to have a break. (Four did not provide an answer). Of the four respondents who planned to work in a non-nursing job, three had already obtained a job. These were as a member of an airline cabin crew, a stable groom and an estate agent. The fourth respondent was hoping to obtain a job as a primary school teacher.

These 41 respondents were asked whether they planned to obtain a nursing job in the UK at some stage in the future. As Table 5.14 shows, 70% (29) did plan to obtain such a job, 27% (8) of whom planned to do so six months or less after qualifying.

Table 5.14 Diplomates not planning to obtain a nursing job immediately after qualification: subsequent plans in relation to nursing

a) Plans to obtain a nursing job	No.	%
Yes	29	70
No	4	9
Not sure	7	17
Not stated	1	4
Total	41	100
b) When	**No.**	**%**
Six months or less	8	27
Longer than six months	14	48
Not sure	5	18
Not stated	2	7
Total	29	100

5.7.2 Diplomates who had obtained an agency/bank job

Of the 1385 respondents who had obtained a nursing job, 3% (43) would be working as an agency/bank nurse. These 43, 40 of whom had qualified from the diploma course, were asked their reasons for taking this type of work (Table 5.15); lack of full-time vacancies and needing flexibility featured most frequently.

Table 5.15 Reason for taking agency/bank nursing after qualification

Reasons	(n=43) No.
No full-time vacancies in area/hospitals/specialty in which wanted to work	13
Needed flexibility of agency work for personal reasons	10
Gain experience in wide range of specialties	6
Undertaking full-time study	3
Not yet qualified	3
Awaiting PIN number from UKCC	2
Awaiting start of degree course	3
Gain foothold in particular specialty	1
No answer	3

These 43 respondents were also asked about their plans to obtain a nursing job, which was not an agency/bank job at some stage in the future. As Table 5.16 shows, 40 intended to take such a job, with 30 indicating that they planned to do so six months or less after qualifying.

Table 5.16 Diplomates who had obtained an agency/bank job: subsequent plans in relation to obtaining a nursing job

a) Plans to obtain a nursing job	No.	%
Yes	40	93
No	1	3
Not sure	2	4
Total	43	100

b) When	No.	%
Six months or less	30	74
Longer than six months	6	15
Not sure	3	7
No answer	1	4
Total	40	100

5.7.3 Diplomates who planned to obtain a nursing job immediately after qualification but had not yet obtained one

The 134 respondents who had planned to obtain a first nursing job but had not done so were asked whether they had applied for such a job. The majority (65%, 88) had applied for a job; 22% (30) had not applied and 12% (17) did not answer. The 88 respondents

who had applied for a job were then presented with three closed options exploring why they had not yet obtained one. As Table 5.17 shows, the most frequently given reason was that respondents were waiting to hear the results of applications (52%, 46).

Table 5.17 Reasons for not yet obtaining a first nursing job despite having applied

	(n=88)	
Reasons	No.	%
Not heard result of application(s)	46	52
Not offered job(s) for which applied	24	27
Offered job(s) but not yet accepted	20	23
No answer	3	4

The 30 respondents who had not applied for a job were asked why this was so. As Table 5.18 shows, not having qualified was the reason given most often for not having applied for a job (13) followed by not wanting to commit to a permanent job immediately (9).

Table 5.18 Reasons for not having applied for a nursing job

	(n=30)
Reasons	No.
Not qualified	13
Not wanting to commit to a permanent job immediately	9
About to start a full-time degree	2
Taking a break to have a baby	2
No jobs available in specialty in which wanted to work	1
No jobs available in trust(s) in which did placements	1
Having a break	1
Just moved	1
No answer	1

Not having obtained a job was analysed by college to explore whether variation existed. The 134 respondents who had not obtained a job qualified from 30 of the 37 colleges where the adult branch was taught and thus were not all concentrated in a few colleges.

5.8 SUMMARY AND DISCUSSION OF KEY FINDINGS ON FIRST JOBS

Here we draw together the main findings about the first job obtained by this cohort of adult branch diplomates and, where data are available for those who completed the traditional course, compare the diplomate findings with these.

5.8.1 Plans to work in nursing

- **99% planned to take a nursing job immediately after qualifying**
- **Less than 1% did not plan to take a nursing job at some stage**

The findings demonstrate a commitment to staying in the profession in the first instance. There is no indication of attrition immediately following qualification. Other studies of adult branch diplomates do not report on plans immediately after qualifying. These studies do show, however, that the majority obtain a nursing job (see Section 5.8.2), and it seems a reasonable assumption that they planned to do so. Turning to those who took the traditional Registered General Nurse (RGN) course, Robinson *et al.* (1995) found that 95% planned to obtain a nursing post immediately after qualifying. Taken together, studies of both traditional and diploma course qualifiers for adult nursing indicate that a substantial majority plan to obtain jobs in adult nursing upon qualification.

5.8.2 Obtaining a first nursing job

- **91% of those planning to obtain a nursing job had done so (87% of the cohort as a whole)**
- **There were no colleges in which none of the adult diplomates had obtained a job**

There was little indication from this study of a lack of availability of jobs for adult branch nurses qualifying in 1997-8.

Other studies of adult branch diplomates have also shown that most obtain a job upon qualifying. Thus, the 54 who took part in the longitudinal study undertaken by Jowett *et al.* (1994) had all obtained jobs by this time, and May *et al.* (1997) report that for the six colleges participating in their study of the diploma course in Scotland, all or most of the adult diplomates obtained jobs. Turning to traditional course qualifiers, the study by Robinson *et al.* (1995) presents findings on the proportions who actually obtained a first job after qualification. Seventy-three per cent of those planning to obtain a nursing job had done so by, or shortly after, qualification (69% of the cohort as a whole). This is considerably lower than the figures of 92% and 87% reported above for the adult diplomate cohort, and may reflect the scarcity of jobs reported in the early 1990s for all newly qualified nurses (Cresswell 1992, Dickson 1993).

5.8.3 Employing organization and contractual conditions of first job

- **97% of those who had obtained a first job would be working in the NHS; 82% of the cohort as a whole**
- **69% of those with a first job in the NHS would be working in one of the trust(s) in which their course placements had been based**

- **Reasons for not taking an NHS job included lack of availability of jobs in preferred location and negative perceptions of working conditions**
- **61% had an open-ended/permanent contract; only 12% had a fixed-term contract of six months or less**
- **Nearly all (94%) would be working full-time; the most common pattern of work hours was rotation between day and night shifts**

The majority of the cohort began their post-qualification careers in an NHS job. It is not possible to compare this finding with those for adult branch diplomates in other studies. While Jowett *et al.* (1994) report that 88% (53/60) of students obtained an NHS job, details are not provided separately for the 54 adult diplomates. Similarly May *et al.* (1997) do not provide details of employing organization, other than to indicate that for one of the six colleges, diplomates did not experience difficulties in obtaining an NHS hospital job.

Turning to traditional course qualifiers, Robinson *et al.* (1995) found that all those who had obtained a first job would be working in the NHS. Robinson *et al.* (1995) also found that the proportion of traditional qualifiers who had obtained an NHS job in an authority other than the one in which they had trained was lower than that reported for this diplomate cohort: 16% vs. 29%. Other studies of adult diplomates have not provided details of the proportion obtaining a job outside the trust(s) in which placements were based, although May *et al.* (1997) report that this did occur in at least two of the six Scottish colleges included in their study. Diplomates who obtain an NHS job outside the trust(s) in which their course placements were based may do so either from choice or from necessity. If trust managers want, and are able, to offer jobs to their students, they may need to work actively to recruit them prior to qualification.

5.8.4 Setting of first job

- **97% had a first job based in a hospital**
- **2% had a first job which involved working in people's own home**

These findings reflect the prevailing trend for adult branch nurses to obtain their first job within an institutional setting. Community settings such as working in peoples own homes, community services centres, and health centres were, however, beginning to feature in the first job profile of the cohort. Comparisons with other studies of diplomates also indicate that a hospital is the most likely setting for a first job. Jowett *et al.* (1994) report this to be the case for 45 of the 54 adult diplomates in their study, and May *et al.* (1997) report that in four of the six colleges in their study a few of the adult diplomates obtained a community job, but in one college none did so. The latter authors also found

that students wanted to consolidate experience in acute settings before applying for community based jobs, and some trusts had unwritten policies that practitioners should serve a probationary period in an institutional setting prior to being employed in the community (May *et al.* 1997).

Findings for the cohort of traditional qualifiers (Robinson *et al.* 1995) show that all had obtained a first post in a hospital.

5.8.5 Age group/clinical specialty of first job

- **Over half of all respondents with a first job worked with more than one age group**
- **Clinical specialties listed most often were general medicine (33%); general surgery (22%), care of the elderly (16%) and cardiac (12%)**
- **Most respondents worked in one clinical specialty only**
- **25% had obtained jobs in which they would rotate between clinical specialties**
- **76% had obtained a job in their preferred clinical specialty. Respondents were more likely to say that they did not mind than that their preferences had not been fulfilled**

First jobs for adult branch diplomates are most likely to be based in general medicine or general surgery and therefore entail caring for a range of patient groups. Comparisons of these data with those from other studies of adult branch diplomates were not found to be possible, since these did not indicate the clinical specialty of respondents' first job (Jowett *et al.* 1994, May *et al.* 1997). Comparison with traditional qualifiers (Robinson *et al.* 1995) showed that the three specialties in which first jobs were most likely to be based were the same as for diplomates; namely general medicine, general surgery and care of the elderly.

5.8.6 Conclusion

In conclusion, the findings from this questionnaire indicate that the majority of the adult branch diplomate cohort wanted and had obtained a nursing job. Although there was very little evidence of constraints in obtaining a job *per se*, there was some in relation to obtaining a job in clinical area of preference and in the NHS. Subsequent questionnaires will demonstrate the extent to which these trends continue and whether those who had not obtained a job immediately were able to do so at a later date. Comparisons of diplomates with traditional qualifiers suggest the latter were more likely to have a job at, or shortly after, qualification and of the job being based in the NHS, in a hospital, and in an authority in which course experience was based.

CHAPTER 6: OBTAINING A FIRST JOB IN THE COMMUNITY

As noted at the beginning of chapter 5, the second aim of the research is to describe diplomates' career plans and pathways from qualification onwards. Policies for the delivery of care have laid increasing emphasis on its provision in the community (chapter 1 section 1.3.2); consequently the extent to which diplomates want and are able to obtain, jobs in community settings is investigated throughout the course of this research. While the UKCC had asserted that the diploma course should ensure those qualifying were capable of 'assessing, providing, monitoring and evaluating care in both hospital and community settings' (UKCC 1986, p40), this position was subsequently modified to the effect that newly qualified diplomates should work under the leadership of an experienced community nurse (UKCC 1991).

Given the foregoing, this first phase of the research sought to answer the following questions:

- Was diplomates' first job in a community setting? (Section 6.1)
- Did diplomates want their first job to be based in a community setting? (Section 6.2)
- Why did diplomates not obtain a first job in a community setting? (Section 6.3)
- Why did diplomates not want their first job to be in a community setting? Was it, for example, because they did not feel adequately prepared? (Section 6.4)

Pilot work revealed that 'the community' could be interpreted in many different ways. To ensure that findings are valid, therefore, it was necessary to develop an approach to asking about 'the community' that was relevant to, and interpreted in the same way by, all participants. Rather than using the word 'community', the questionnaire asked participants about working in three distinct, non-institutional, settings (Hickey and Hardyman 2000):

- visiting or providing care for people in their own homes - 'visiting people at home'

- settings in which care is provided to people who visit it but do not stay as inpatients - 'settings which people visit'
- settings in which people live together in the community - 'residential settings'

Asking about these three distinct settings, rather than about 'the community' *per se*, reduced the likelihood of participants applying their own interpretations of 'community' to questions. To clarify the questions, and the differences between the three settings, examples were included as follows:

- visiting people at home - district nursing, health visiting
- settings which people visit - GP's surgery, day hospital (A & E and outpatients were specifically excluded)
- residential settings - hostel, residential home

Since some jobs entail working in more than one community setting, each setting was asked about separately, and respondents gave answers in relation to each.

Ninety-five per cent of respondents (1512) were asked questions about obtaining a first job in a community setting. These respondents comprised two groups:

- those who had obtained a first job (n=1340)
- those who had not obtained a first job, but planned to do so in the six months after qualification (n=172)

Three per cent (46) did not plan to obtain a nursing job in the UK within six months of qualifying and were not asked about their plans to work in a community setting. The remaining 2% (38) provided insufficient information for categorization.

The first group - those who had obtained a job - were asked a set of questions about this job, in relation to each of the three community settings. The second group - those who had not obtained a job - were asked about the job they hoped to obtain, again in relation to each of the three community settings.

6.1 SETTING OF FIRST JOB

Of the 1340 adult branch nurses who had obtained a first job, just 3% (40) had a job based in one or more community settings (Table 6.1). Six respondents had a job the only community element of which was visiting people at home. Eight had a job only in a setting which people visit, and seven had a job in a residential setting. A further 19 respondents had a job which was based in more than one of the three settings.

Table 6.1 Setting(s) in which diplomates' first job would be based

Settings	No.	%
Visiting people at home only	6	*
Setting which people visit only	8	1
Residential setting only	7	*
Visiting people at home and setting which people visit	13	1
All three settings	6	*
None of the three settings	1266	95
Not classifiable (insufficient information provided)	34	3
Total	1340	100

For each setting, Table 6.2 shows the total number of respondents whose first job was based in the setting.

Table 6.2 Total number of diplomates with a first job in each of the three community settings

	(n=1340)	
Settings	No.	%
Total with first job visiting people at home	25	2
Total with first job in a setting which people visit	28†	2
Total with first job in a residential setting	13	1

† See note about weighting on p35

6.2 WANTING A FIRST JOB IN A COMMUNITY SETTING

Respondents who had obtained a job in a community setting (n=40) were asked whether they had wanted their first job to be in that setting. Those who had not obtained a job (n=172) were asked whether they wanted their first job to be based in each of the three settings. Data on these two groups are presented separately.

6.2.1 Those who had obtained a first job

Table 6.3 shows that, of the 25 respondents with a first job which entailed, solely or partly, visiting people at home, 82% (21) did want their first job to be in that setting. Similarly, ten of the 13 respondents who had obtained a job in a residential setting, wanted their first job to be in that setting. A lower proportion (70%, 19) of those with a job in a setting which people visit wanted their first job in that setting.

Table 6.3 Did diplomates want to work in the setting in which their first job would be based?

Views on wanting a job in setting	Visiting people at home No.	%	Settings which people visit No.	%	Residential setting No.
Wanted a first job in this setting	21	82	19	70	10
Did not want a first job in this setting	3	13	7	25	0
No answer	2	6	1	5	2
Total	25†	100	28†	100	13†

† See note about weighting on p35

6.2.2 Diplomates who had not obtained a first job

Table 6.4 shows that 9% (16) of the 172 respondents who had not yet obtained their first job wanted one which would involve visiting people at home, while 5% (8) wanted a job in a setting which people visit, and 4% (6) wanted their first job to be in a residential setting. Similar proportions of respondents did not want their first job to involve visiting people at home (49%, 84) and/or be in a setting which people visit (51%, 88). Seventy-one per cent (123), however, did not want their first job to be in a residential setting.

The combinations of settings in which respondents who had not obtained a job would like their first job to be based were also explored. Forty per cent (68) did not want their first job to be based in any of the three community settings; 8% (14) did not mind whether their first job was based in any of the community settings. One person wanted their first job to be based in all three settings.

Table 6.4 Settings in which diplomates who had not obtained a job would like their first job to be based

Views on wanting a job in setting	Visiting people at home No.	%	Settings which people visit No.	%	Residential settings No.	%
Wanted first job in this setting	16	9	8	5	6	4
Did not mind whether first job in this setting	45	26	52	30	18	11
Did not want first job in this setting	84	49	88	51	123	71
No answer	28	16	23	14	24	14
Total who had not obtained a job	172†	100	172†	100	172†	100

† See note about weighting on p35

6.3 REASONS WHY DIPLOMATES DID NOT OBTAIN A FIRST JOB IN A COMMUNITY SETTING

Pilot work showed that there were three main reasons why newly qualified diplomates did not obtain jobs in community settings:

- not wanting a job in the setting
- being unable to get a job in the setting
- ideally wanting a job in the setting but deciding to work elsewhere first

These reasons formed the basis of a question which asked participants why they had not obtained a job in each of the three community settings. Responses are shown in Table 6.5. It was thought that the reasons given by those who had obtained a job in a community setting other than the one being asked about, might differ from reasons given by those whose first job was based in an institutional setting. Analysis exploring this distinction, however, produced numbers too small for reliable interpretation. Findings are therefore presented together for all respondents who had obtained a first job.

Almost two-thirds of respondents stated that the reason their first job did not involve visiting people at home was, simply, that they did not want a job in this setting (64%, 818). (Reasons for not wanting a job in each setting are presented in Section 6.4.) Nearly one-third (32%, 416) did want a job in this setting, but decided to consolidate experience elsewhere first. Two per cent (26) wanted a job which involved visiting people at home but were unable to get one.

Table 6.5 Reasons for job not being in each of the three community settings

	Visiting people at home		Settings which people visit		Residential settings	
Reasons	No.	%	No.	%	No.	%
I did ***not*** want a job in this setting	818	64	1044	81	1259	97
I wanted a job in this setting, but could not get one	26	2	16	1	1	*
Ideally I wanted a job in this setting, but:						
• thought it best to consolidate experience elsewhere first	416	32	150	12	32	2
• was offered a job elsewhere first	16	1	6	*	1	*
No answer	14	1	78	6	11	1
Total	1290	100	1293†	100	1304	100

The main reason for jobs not being in a setting which people visit was also because respondents did not want a job in this setting (81%, 1044). Twelve per cent (150) ideally wanted a job in this setting but decided to consolidate their experience elsewhere first. Just 1% (16) wanted to work in this setting but had been unable to obtain a job.

Ninety-seven per cent (1259) of those who had not obtained a first job in a residential setting said that they did not want their first job to be in such a setting. Just 2% (32) ideally wanted a job in this setting but either decided to consolidate their experience, or were offered a job, elsewhere first. Only one respondent wanted a job in a residential setting but was unable to obtain one.

6.4 REASONS FOR NOT WANTING FIRST JOB TO BE BASED IN EACH COMMUNITY SETTING

All respondents who did not want a job in each particular setting were asked why this was the case. Four subgroups of the cohort were asked this question:

1. people who had obtained a job in that setting
2. people who had obtained a job in a different community setting(s)
3. people who had obtained a job not based in any of the community settings
4. people who had not obtained a job

Four closed responses plus an open 'other' option were provided for those who had obtained a job (groups 1 - 3 above), and five closed responses plus 'other' for those who had not (group 4). Respondents were asked to ring all responses which applied to them.

Each of the four subgroups described above was considered separately but no observable differences in the reasons they gave emerged. Reasons for not wanting a job in each of the three community settings are therefore presented for the four subgroups together (Table 6.6).

Table 6.6 Reasons for not wanting first job to be based in each community setting

Reasons	Visiting people at home (n=905)		Settings which people visit (n=1138)		Residential settings (n=1382)	
	No.	%	No.	%	No.	%
No interest in working in this setting	267	30	607	53	924	67
Disliked working in this setting while a student	98	11	59	5	159	12
In my view staffing levels in this setting mean that case loads are too high to provide good patient/client care	17	2	9	1	87	6
I do not feel adequately prepared at this stage to work in this setting	455	50	296	26	64	5
I want to consolidate experience elsewhere before working in this setting[1]	58[2]		31[2]		27[2]	
Other	137	15	72	6	88	6
No answer	44	5	146	13	168	12

[1] This option was only offered to those respondents who had not obtained their first job

[2] Percentages for these figures are not presented as only one of the four subgroups was given this option

6.4.1 Reasons for not wanting first job to involve visiting people at home

Nine hundred and five respondents stated that they did not want their first job to involve visiting people at home. One-half of these (50%, 455) did not feel adequately prepared to work in this setting, while almost one-third (30%, 267) were not interested in working in this setting. Of the 15% (137) who ringed 'other', 55% (76) wanted to gain experience in a hospital setting first and 22% (30) indicated that they may consider working in this setting in the future. Eight per cent (11) of respondents stated each of the following: that they wanted to work in a different setting or specialty, that they wanted the support offered by being part of a team, and/or that they were unable to drive.

6.4.2 Reasons for not wanting first job to be based in a setting which people visit

Of those who did not want their first job to be based in a setting which people visit (n=1138) over half (53%, 607) stated that they had no interest in working in this setting. Twenty-six per cent (296) did not feel adequately prepared to work in this setting. Six per cent (72) of those who did not want their first job to be based in a setting which people visit ringed the open 'other' option. Of these, 33% (24) indicated that they wanted to gain experience in a hospital setting first, and 18% (13) that they simply wanted to work in a different setting or specialty.

6.4.3 Reasons for not wanting first job to be based in a residential setting

Over two-thirds (67%, 924) of the 1382 respondents who did not want their first job to be in a residential setting stated that they had no interest in working in this setting. Twelve per cent (159) disliked working in this setting while a student. Among the 88 'other' answers were: wanting to gain experience in a hospital setting first (27%, 24), wanting to work in a different setting or specialty (22%, 19), and feeling that such settings were badly managed and/or provided a poor quality of care (14%, 12).

6.5 SUMMARY AND DISCUSSION OF KEY FINDINGS ON OBTAINING A FIRST JOB IN THE COMMUNITY

Given the emphasis on providing care in the community, the study explored the extent to which newly qualified diplomates had obtained jobs in three community settings, and their reasons for not doing so. The differences that emerged between findings for the three settings demonstrate the importance of researching 'the community' using this 'settings' approach.

6.5.1 Visiting people at home

Of those who had obtained a job (n=1340)

- **2% would be visiting people at home, 82% of whom wanted a job in this setting**

Of those who would not be working in this setting (n=1290)

- **2% had wanted but were unable to obtain such a job**
- **64% did not want a job in this setting**
- **32% wanted a job in this setting but thought it best to consolidate experience elsewhere first**

Of all respondents who did not want a first job based in this setting (n=905)

- **the most common reason given was not feeling adequately prepared (50%)**

6.5.2 Settings which people visit

Of those who had obtained a job (n=1340)

- **2% would be working in a setting which people visit, 70% of whom wanted a job in this setting**

Of those who would not be working in this setting (n=1293)

- **just 1% had wanted but were unable to obtain such a job**

- **81% did not want a job in this setting**
- **12% wanted a job in this setting but thought it best to consolidate experience elsewhere first**

Of all respondents who did not want a first job based in this setting (n=1138)

- **the most common reason given was no interest (53%)**
- **26% did not want their first job in this setting because they felt inadequately prepared**

6.5.3 Residential settings

Of those who had obtained a job (n=1340)

- **1% would be working in a residential setting, 77% of whom wanted a job in this setting**

Of those who would not be working in this setting (n=1304)

- **97% did not want a job in this setting**
- **2% wanted a job in the setting but thought it best to consolidate experience elsewhere first**

Of all respondents who did not want a first job based in this setting (n=1382)

- **the most common reason given was no interest (67%)**
- **12% did not want their first job in this setting because they disliked working in this setting while a student**

6.5.4 Community settings overall

Together these findings show that the majority of adult branch diplomates do not obtain their first job in community settings; this is in keeping with findings from other studies which have explored first job destinations of adult branch diplomates (Jowett *et al.* 1994, May *et al.* 1997). For traditional qualifiers, Robinson *et al.* (1995) found that none of the cohort had obtained a first job in a community setting.

Of note at this early stage of the diplomates' careers are the findings in relation to visiting people at home, in particular the relatively high proportion (compared with other settings) who did not want a job in the setting because they felt inadequately prepared, and who wanted a job in the setting but thought it best to consolidate experience elsewhere first. It seems that a perception exists that jobs visiting people at home require more post-qualification experience than does working in either of the other two community settings. Similarly May *et al.* (1997) report that adult branch diplomates wanted to consolidate experience in acute settings before applying for community based jobs, but did not

indicate whether this view differed by type of community setting. A comparable question was not asked in studies of traditional qualifiers (Robinson *et al.* 1995) and so a comparison of the two groups is not possible.

Subsequent questionnaires will explore diplomates' movements into, and between, the three community settings. As Chapter 8 shows, 18% (284) of this adult branch cohort plan to qualify as a district nurse and 2% (36) as a health visitor. In due course we will be able to ascertain how many of these diplomates do in fact qualify for, and work in, district nursing and health visiting, and whether those who do not do so changed their mind or were prevented from doing so. At qualification 97% of those not working in a residential setting did not want a job in such a setting. This may be a perception that residential settings relate primarily to nursing homes for the elderly, and are therefore not seen as a suitable destination for a first job. In due course the study will indicate the proportion of adult nurses who do at some stage opt to work in residential nursing homes.

CHAPTER 7: FUTURE PLANS - CERTAINTY AND CHOICE

Having focused on cohort members' immediate plans after qualification and details for their first job, the report now returns to their longer-term employment plans. These plans are considered in relation to the following: staying in or leaving nursing in the UK; moving between the NHS and other employing organizations, and working with particular clinical specialties. Anticipated outcomes for each of these levels are provided for different time-points after qualification. Information is also provided on whether diplomates plan to work full or part-time and the grades they hope to attain.

Research questions on plans for this phase of the research were as follows:

- **Nursing:** what proportion of diplomates planned to be working in nursing in the UK at specified time-points after qualification? (Section 7.1)
- **Employing organization:** what was the orientation overall towards working in the NHS, as opposed to non-NHS organizations, and what preferences were expressed for jobs in which diplomates hoped to be working at specified time-points? (Section 7.2)
- **Hours:** did diplomates plan to work full-time or part-time? (Section 7.3)
- **Clinical specialty:** was there an association between course experiences and clinical specialty of first job? In which clinical specialties did diplomates want subsequent jobs to be based and how did the clinical specialties of their first job relate to preferences expressed for subsequent time-points? (Section 7.4)
- **Grade:** what grades did diplomates hope to have reached by specified time-points? (Section 7.5)

Pilot work revealed considerable diversity in the extent to which diplomates had definite plans about directions to be pursued in the years after qualification. Some, for example,

had definite plans for several years ahead, whereas others had definite plans for the first year or two but were then uncertain although intending to remain in nursing. Some diplomates had clear ideas about particular aspects of jobs in which they hoped to be working, for example, the clinical specialty, but were less clear about other aspects, such as employing organization. Others were uncertain whether they would remain in the profession for more than a few months. While questions were designed to obtain as much information as possible about future directions, they also allowed for the expression of uncertainty in order to avoid the irritation which may be caused by forcing a choice.

In the early stages of pilot work, diplomates were asked about their plans in relation to staying in nursing. Our interest lay in ascertaining the proportion who planned to stay in nursing or in work which used nursing skills, for example bereavement counselling and health promotion. However, of those who had plans in relation to the latter, some did not regard this work as nursing and so said 'no' when asked about remaining in nursing. Consequently, in the two questions which asked about longer term plans, the phrase nursing, health and social care in the UK was used in order not to underestimate the proportion planning to remain in nursing and/or work which used nursing skills. For the sake of brevity, however, in the presentation of findings, only the term 'nursing' is used.

7.1 ORIENTATION TOWARDS NURSING

As Section 5.1 showed, the majority of the cohort (95%, 1522) planned to obtain a first job in nursing immediately after qualification, and 91% (1385) had done so. For 84% (1340) of the cohort, this was a permanent, as opposed to an agency or bank job. Moreover, the majority of those who had not obtained a permanent nursing job at the outset planned to do so within six months of qualifying (Section 5.7). Pilot work showed that some diplomates knew that they wanted to be working in nursing[1] at specific time-points in the future even though they were unable to specify a particular job. This was particularly marked for time-points beyond three years after qualification. All participants were therefore asked about the likelihood of working in nursing in the UK at the time-points shown in Table 7.1.

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1 See note about question wording above.

Table 7.1 Likelihood of working in nursing in the UK in the future

Likelihood	6 months No.	6 months %	18 months No.	18 months %	3 years No.	3 years %	5 years No.	5 years %	10 years No.	10 years %
Very likely	1457	91	1341	84	1076	67	804	50	604	38
Quite likely	18	1	114	7	277	17	414	26	458	29
Unlikely	10	1	21	1	65	4	62	4	59	4
Very unlikely	33	2	35	2	34	2	45	3	61	4
Unable to say at this stage	23	1	32	2	92	6	215	13	384	24
No answer	55	3	54	3	52	3	56	4	29	2
Total	1596	100	1596†	100	1596	100	1596	100	1596†	100

† See note about weighting on p35

For the first two time-points (six months and 18 months after qualifying) 92% and 91% respectively of respondents indicated that it was quite likely or very likely that they would be working in nursing in the UK. This proportion decreased to 85% (1352) at three years, to 76% (1218) at five years and to 67% (1062) at ten years. However, there is little change over time in the proportion of people suggesting that it is unlikely or very unlikely that they will be working in nursing; ten years after qualification just 8% (120) of respondents indicated that this might be the case, compared with 3% (43) at six months. Rather, the data show that there is an increase in the proportion who are uncertain. Indeed, for ten years after qualification, just under one-quarter of respondents (24%, 384) indicated that they were 'unable to say at this stage'.

A statistical modelling approach was used to ascertain whether sex, age-group, educational group and ethnicity were related to the anticipated likelihood of working in nursing in the UK in the future. As the proportion of respondents who thought it likely they would be in nursing in the UK at six months, 18 months and/or at three years after qualification was over 80% in each case, only the five year and ten year time-points were considered. As Table 7.1 shows, 76% of respondents thought it likely that they would be working in nursing in the UK five years after qualification. Three variables were significantly associated with this course of action. These were ethnicity ($\chi 2 = 27.67$, 3df. $p < 0.001$) and age group and educational group, in combination (interaction $\chi 2 = 22.29$, 11df, $p < 0.05$). Details of this analysis are in Appendix 7A1. The main points to emerge were that a combination of entry via an access course or DC test and belonging to the 23-24 age group is associated with the lowest likelihood of staying (53%) whereas a combination of the same qualification with an age of 22 and under (88%) and age of 30 or over (90%) is associated with the highest likelihood of staying.

Relationships between the four analysis variables and the likelihood of nursing 10 years after qualification was less complex than found for 5 year data. Ethnicity and age were both associated with the likelihood of nursing in the UK but not sex or educational group. Respondents aged 30 or over (77%) were more likely to stay than respondents' aged 29 and under (65%). Greater variation was evident for ethnicity with white-British the most likely (71%) and white-Irish (40%) least likely to be planning to nurse in the UK in ten years time. The statistical details of this analysis are in Appendix 7A.1.

That those who were older at qualification were those most likely to anticipate nursing in the UK at five and ten years after qualification is not surprising. People who enter a course later in life are likely to do so after having experienced and then rejected other occupations, or perhaps completed a period looking after young children. In either event they are perhaps more likely than those with less alternative experience to embark on a lengthy training with the intention of putting it to long term use. The association of entering nursing without formal academic qualifications with likelihood of staying at five years for the youngest and oldest entrants is of note. These diplomates may have perceived that the range of occupations which they can enter is restricted and that it is nursing, by offering the alternative entry routes of the DC test and Access courses, which offers them the chance of an occupational career. This may be of particular importance at the two time points indicated: as a school leaver without formal academic qualifications but wanting an occupation and as an older entrant without formal academic qualifications and seeking an alternative occupation. That nurses from the Republic of Ireland were less likely to anticipate nursing in the UK at ten years after qualification is consistent with a trend observed by Buchan (2000) of an increase in the proportion of these nurses returning to work in their home country after training in the UK. Nonetheless, findings reported here indicate that most intend to contribute to UK nursing in the short term.

In addition to the general question about the likelihood of working in nursing at specified time points, the project also explored the extent to which diplomates were able to give details of the jobs they hoped to hold at 18 months and three years after qualification. Diplomates were asked a two-part question; the format of the first part is shown in Table 7.2. The wording of the question did not specify that respondents had to answer in relation to a nursing job but rather to a job *per se*.

Table 7.2 Certainty about job plans for 18 months and three years after qualification

Degree of certainty	18 months No.	18 months %	3 years No.	3 years %
I am definite about the job/position in which I hope to be working	314	20	239	15
I have a reasonably clear idea about the job/position in which I hope to be working	592	37	401	25
I have a vague idea(s) about the job/position in which I hope to be working	365	23	329	21
	1272†	80	972†	61
I have no idea about the job/position in which I hope to be working	288	18	587	37
I do not plan to be in paid employment	23	1	10	1
No answer	13	1	31	2
Total	1596†	100	1596†	100

† See note about weighting on p35

Turning first to certainty about job plans at the 18 months point, Column 1 of Table 7.2 shows that the largest group of respondents (37%, 592) had a reasonably clear idea, followed by just under a quarter (23%, 365) who had a vague idea. The 1272 respondents who had some idea about the job/position in which they hoped to be working (i.e. definite, reasonable or vague) were then asked to provide as many details as possible (this included:- employing organization, clinical specialty, grade/pay-scale point, full- or part-time hours). From the answers provided it was possible to determine that 96% (1225) of these respondents hoped to be working in nursing; this accounts for 77% of the cohort as a whole[2].

Eighteen per cent (288) of respondents said that they had no idea about the job/position in which they hoped to be working at 18 months. In response to the 18 month point in the question shown in Table 7.1, nearly all these respondents (91%, 262) nonetheless anticipated that they would be working in nursing at this time.

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2 20 respondents were planning to work outside the UK, and 4 were planning to work in occupations outside nursing. 23 respondents provided insufficient information to determine whether they planned to hold a nursing job at the 18 month point.

The second column of Table 7.2 shows that in relation to the three-year time-point, the largest group (37%, 587) had no idea about the job/position in which they hoped to be working, 25% (402) had a reasonably clear idea, and a further 21% (329) had a vague idea. Just 15% (239) of the cohort were definite about the job in which they hoped to be working by this time. The 972 respondents who had some idea about the job in which they planned to be working (i.e. definite, reasonable or vague) were then asked to provide as many details as possible (employing organization, clinical specialty, grade/pay-scale point, full or part-time hours). From the answers provided it was possible to determine that 91% (882) planned to be working in nursing; this accounts for 55% of the cohort as a whole[3].

Thirty-seven per cent (587) of respondents said that they had no idea about the job/position in which they hoped to be working at three years. In response to the three year point shown in Table 7.1, the majority of these respondents (81%, 474) nonetheless anticipated that they would be working in nursing at this time.

The foregoing shows that at qualification this adult branch cohort indicated no sense of early attrition from the profession, but that there was considerable variation in the extent to which they were certain about the job which they hoped to be holding at 18 months and three years after qualification. The details of employing organization and clinical specialty which respondents were able to provide about the nursing job in which they hoped to be working at these two time-points are included in the next two sections of findings; base numbers are 1225 for 18 months and 882 for three years.

7.2 ORIENTATION TOWARDS WORKING IN THE NHS

As Section 5.3 (Table 5.3) showed, for 98% (1311) of the 1340 respondents who had obtained a first job, this was in the NHS or jointly funded by the NHS and a non-NHS organization. Just 23 respondents indicated that their first job was in a non-NHS organization; 14 would be working for a private healthcare company/employer, six for the Armed Forces, two for the Prison Service/Home Office and one for a charity. Questions on plans explored diplomates' orientation towards working in the NHS subsequently.

All participants (1596) were asked about their preference for working in or out of the NHS when holding jobs in nursing (Table 7.3).

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[3] 49 respondents were planning to work outside the UK, and two were planning to work in occupations outside nursing. 39 respondents provided insufficient information to determine whether they planned to hold a nursing job at the three year time-point.

Table 7.3 Preferred employing organization when holding jobs in nursing

Preference	No.	%
Only jobs funded wholly or partly by the NHS	744	47
Do not mind holding jobs in employing organizations other than the NHS	795	50
Only jobs that are not funded by NHS	21	1
Not planning to work in nursing	10	1
No answer	26	2
Total	1596	100

One-half (50%, 795) indicated that they would not mind working in employing organizations other than the NHS. A far greater proportion indicated that they would prefer jobs funded wholly or partly by the NHS, however, than would prefer jobs not funded by the NHS (47%, 744 vs. 1%, 21).

The extent to which the NHS featured in diplomates' plans was also indicated in the questions which asked for details of the job in which respondents hoped to be working at 18 months and three years after qualification. For those who had ideas about the job they hoped to hold, albeit with varying degrees of certainty, Table 7.4 shows the proportion able to specify the NHS for these two time-points.

Table 7.4 Employing organization of jobs in which hoped to be working at 18 months and three years

	18 months			3 years		
	Those hoping to be in a nursing job (n=1225)		Total cohort (n=1596)	Those hoping to be in a nursing job (n=882)		Total cohort (n=1596)
Employing organization	No.	%	%	No.	%	%
NHS	1089	89	68	753	85	47
Private sector	13	1	1	20	2	1
Armed Forces	12	1	1	12	1	1
Charity	9	1	1	13	1	1
GP fundholder	5	*	*	5	1	*
Trust - unspecified	3	*	*	4	*	*
Prison Service/Home Office	2	*	*	2	*	*
Educational	1	*	*	2	*	*
Other	3	*	*	1	*	*
Unclassifiable	9	1	1	10	1	1
Not stated	100	8	6	86	10	5

At both time-points the NHS was specified by the most respondents, albeit that there was a small decrease from 89% at 18 months to 85% at three years. At three years, 2% specified the private sector; at both time-points all other organizations were specified by 1% of respondents or less.

7.3 PREFERENCE FOR FULL- OR PART-TIME HOURS

As Table 5.6 (Section 5.3) showed, the majority (94%, 1258) of the 1340 respondents who had obtained a nursing job which was not agency/bank would be working full-time. All but 5% (61) said full-time was their preference at this stage. Table 7.5 shows, for the job in which respondents hoped to be working at 18 months and three years, the number who wanted to work full-time; this is expressed as a percentage of those planning to hold a job (Column 1) and as a percentage of the total cohort (Column 2). The cohort indicated a preference for full-time hours in the future with 90% wanting to work full-time 18 months after qualification and 88% at three years.

Table 7.5 Hours planned to work in future nursing jobs

Hours	Column 1 Those hoping to be working in a nursing job No.	% 	Column 2 Total cohort %
Job at 18 months	(n=1225)		(n=1596)
Full-time	1107	90	69
Part-time	62	5	4
Not stated	56	5	4
Job at 3 years	(n=882)		(n=1596)
Full-time	778	88	49
Part-time	51	6	3
Not stated	53	6	3

7.4 DIRECTIONS IN NURSING - WHICH CLINICAL SPECIALTY?

This section presents data on clinical specialties pertaining to different time-points. Analyses focus on links between experiences at one time-point and plans for subsequent time-points. The following are included:

- The influence of course experiences on wish to work in particular clinical specialties (Section 7.4.1)
- Links between experience during course and clinical specialties of first job (Section 7.4.2)
- Links between clinical specialties of first job with timing and choice of second job (Section 7.4.3)

- Clinical specialties of job planned for 18 months and three years (Section 7.4.4)

7.4.1 The influence of course experiences on wish to work in particular clinical specialties

All 1596 participants were asked whether experiences during the course had encouraged or discouraged them from wanting to work in certain clinical specialties. For each of a list of 28 specialties, participants were asked to ring one of four options shown in Table 7.6.

Three specialties stand out as ones in which over 50% of respondents felt encouraged to work: community (63%, 1010), general surgery (56%, 895) and general medicine (55%, 885). The four specialties in which course experiences had least effect in encouraging people to consider working were burns and plastics (5%, 82), dermatology (5%, 73), ophthalmology (5%, 81) and rheumatology (4%, 64). These low figures, however, are due at least in part to the fact that for each of these specialties over three-quarters of respondents had little or no experience during the course. Indeed, for 17 of the 28 specialties listed, over half of all respondents felt they did not have sufficient experience during their nurse diploma course to enable them to comment on how the course had affected their work plans.

Table 7.6 The influence of course experiences

Specialties[1]	Course experiences led me to consider working in this specialty		Course experiences did not affect my plans one way or the other		Course experiences put me off considering working in this specialty		Had little/no experience of this specialty so unable to comment	
	No.	%	No.	%	No.	%	No.	%
Accident and emergency	605	38	302	19	232	15	453	28
AIDS/HIV	178	11	293	18	14	1	1104	69
Burns and plastics	82	5	102	6	32	2	1370	86
Cardiology/coronary care	524	33	350	22	118	7	596	37
Cardiothoracic	233	15	209	13	53	3	1080	68
Community	1010	63	377	24	190	12	14	1
Day surgery	299	19	357	22	173	11	761	48
Dermatology	73	5	164	10	47	3	1302	82
Ear, nose and throat	120	8	238	15	95	6	1134	71
Elderly care	416	26	593	37	563	35	18	1
Endocrinology	118	7	249	16	28	2	1190	75
Gastroenterology	279	17	435	27	80	5	787	49
General medicine	885	55	410	26	254	16	35	2
General surgery	895	56	383	24	203	13	105	7
Gynaecology	396	25	179	11	102	6	911	57
Haematology	215	13	243	15	45	3	1086	68
Infectious diseases	110	7	256	16	39	2	1186	74
Intensive care	409	26	191	12	167	10	821	51
Neurology	186	12	241	15	58	4	1099	70
Oncology	452	28	273	17	60	4	804	50
Ophthalmology	81	5	154	10	82	5	1267	79
Orthopaedics	435	27	343	22	318	20	486	30
Outpatients	93	6	295	18	283	18	919	58
Renal	154	10	253	16	59	4	1122	70
Rheumatology	64	4	231	14	65	4	1225	77
Urology/genito-urinary	298	19	317	20	129	8	844	53
Theatres	354	22	419	26	522	33	296	19
Vascular surgery	261	16	348	22	114	7	865	54

1 Between four and 21 respondents did not provide an answer for each specialty

Table 7.7 shows the figures in Table 7.6 adjusted to exclude those respondents who had little or no experience in each specialty. Considering only those respondents who experienced each specialty during the course does little to alter the position of the three

most 'popular' specialties: general medicine, general surgery and community. It does, however, increase the proportion of respondents whom the course had encouraged to work in certain specialties. For example, whereas only 5% (82) of the total cohort stated that course experiences led them to consider working in burns and plastics, this rises to 38% when only those who gained experience in this specialty during the course are considered. Similarly, the 409 people whose course encouraged them to work in intensive care make up just 26% of the total cohort, but 53% of those who had some experience of this specialty.

Experiences during the nurse diploma course do not appear to have deterred respondents from working in most specialties. Specialties for which course experiences were most likely to have put respondents off were outpatients (42%, 283), theatres (40%, 522) and elderly care (36%, 563).

Table 7.7 The influence of course experiences - those who experienced each specialty during the nurse diploma course

Specialties[1]	Had some experience of this specialty - able to comment		Course experiences led me to consider working in this specialty		Course experiences did not affect my plans one way or the other		Course experiences put me off considering working in this specialty	
	No.	%	No.	%	No.	%	No.	%
Accident and emergency	1139	71	605	53	302	27	232	20
AIDS/HIV	485	30	178	37	293	60	14	3
Burns and plastics	216	14	82	38	102	47	32	15
Cardiology/coronary care	992	62	524	53	350	35	118	12
Cardiothoracic	495	31	233	47	209	42	53	11
Community	1577	99	1010	64	377	24	190	12
Day surgery	829	52	299	36	357	43	173	21
Dermatology	284	18	73	26	164	58	47	17
Ear, nose and throat	453	28	120	26	238	53	95	21
Elderly care	1572	98	416	26	593	38	563	36
Endocrinology	395	25	118	30	249	63	28	7
Gastroenterology	794	50	279	35	435	55	80	10
General medicine	1549	97	885	57	410	26	254	16
General surgery	1481	93	895	60	383	26	203	14
Gynaecology	677	42	396	58	179	26	102	15
Haematology	503	32	215	43	243	48	45	9
Infectious diseases	405	25	110	27	256	63	39	10
Intensive care	767	48	409	53	191	25	167	22
Neurology	485	30	186	38	241	50	58	12
Oncology	785	49	452	58	273	35	60	8
Ophthalmology	317	20	81	26	154	49	82	26
Orthopaedics	1096	69	435	40	343	31	318	29
Outpatients	671	42	93	14	295	44	283	42
Renal	466	29	154	33	253	54	59	13
Rheumatology	360	23	64	18	231	64	65	18
Urology/genito-urinary	744	47	298	40	317	43	129	17
Theatres	1295	81	354	27	419	32	522	40
Vascular surgery	723	45	261	36	348	48	114	16

1 Between four and 21 respondents did not provide an answer for each specialty

7.4.2 Links between experiences during course and clinical specialty of first job

Given that experiences during the course influenced some respondents to consider working in a certain specialty, it is important to ascertain whether there is any link between being encouraged or discouraged while undertaking the course, from working in a certain specialty, and the specialties in which subsequent jobs are based. If such links do exist, then these may have implications for specialties which are short-staffed. In this first phase of the project associations were explored between course experiences and specialty of first job.

Clinical specialties of respondents' first jobs were addressed in Section 5.5; these were most likely to be in general medicine, general surgery or care of the elderly. An analysis of whether those who said course experiences had led them to consider working in a specialty had obtained a first job in the specialty is shown in Appendix 7A.2. General medicine was the specialty in which the highest proportion (42%) of those who said course experiences had encouraged them to consider working in the specialty obtained a first job in the specialty. This was followed by elderly care (33%), general surgery (29%) and vascular surgery (29%). There were eight other specialties for which between a fifth and a quarter of those who had been encouraged by course experiences to consider working in the specialty had obtained a first job in the specialty (cardiology/coronary, cardiothoracic, endocrinology, gastroenterology, haematology, neurology (medical or surgical), orthopaedics and urology/genito-urinary.

The association between course encouragement to work in a specialty and obtaining a first job in that specialty was then analysed from the opposite perspective; i.e. identification for each specialty of the number of respondents who had obtained a job based within it, and then the proportion of these respondents for whom course experiences led them to consider working in this specialty, the proportion whom course experiences put off, and the proportion who had insufficient experience to comment (Appendix 7A.3). There was considerable variation across specialties. At one end of the scale 88% (258) of those who had obtained a first job in general surgery were encouraged to work in the specialty by their course experiences. In contrast, just 23% (8) of those with a first job in dermatology felt course experiences had encouraged them to work in this specialty. Seventy-seven per cent (61) of those with a first job in accident and emergency, 53% (41) of those with a first job in intensive care and 88% (18) of those whose first job was in the community, said course experiences had led them to consider working in that speciality.

The numbers who stated course experiences had put them off the specialty in which they had obtained their first job were small. No more than 5% had been put off working in each specialty. As Appendix 7A.3 also shows, some respondents obtained jobs in areas of which they had little or no experience during the nurse diploma course. Indeed, 66% (23) of those whose first job was in dermatology, 43% (29) in endocrinology, and 43% (28) of those in ear, nose and throat had little or no experience of these specialties during the course.

7.4.3 Links between clinical specialty of first job with plans for second job

Of the 1340 respondents who had obtained a first nursing job, 91% (1291) planned to leave this job at some stage. When asked whether they intended to take a second such job, 85% (1097) of these respondents indicated that they did (Table 7.8).

Table 7.8 Plans for taking a second nursing job in UK

Plans	No.	%
Plan to take a second job	1097	85
Do not plan to take a second job	41	3
Unsure whether to take a second job	145	11
No answer	8	1
Total	1291	100

Two aspects of links between first job and plans to take a second job were explored:

i) Time-scale for second job by whether first job was in preferred clinical specialty
ii) Clinical specialty of second job and relationship to that of first job

i) Time-scale for second job by whether first job was in preferred clinical specialty

Of the 1097 respondents who planned to obtain a second nursing job, just 1% (16) planned to do so within six months of qualifying, 14% (150) planned to do so at six months after qualification, and the largest group (53%, 581) planned to obtain a second job longer than six months after qualifying (Table 7.9). Thirty-one per cent (336) were not sure when they would take a second job. These data conceal differences, however, between respondents whose first job was not in their preferred clinical specialty, and those for whom their first job was their preference (see Section 5.5).

Table 7.9 shows that 25% (26) of respondents whose first job was not in their preferred clinical specialty planned to take a second job six months or less after qualifying. The

comparable figure for those whose first job was in their preferred specialty is 14% (113). These figures suggest that nurses who do not obtain a first job in their preferred specialty are likely to take a second job sooner than are those who obtain their preferred job: subsequent questionnaires will reveal the extent to which these plans transpire.

Table 7.9 Time-scale for second job, by whether clinical specialty of first job was respondent's preference

Planned time-scale for taking second job	First job based in preferred specialty		Did not mind in which specialty first job based		First job not based in preferred specialty		All respondents[1]	
	No.	%	No.	%	No.	%	No.	%
Less than six months after qualifying	10	1	2	2	4	4	16	1
Six months after qualifying	103	13	24	16	22	21	150	14
Longer than six months after qualifying	465	57	73	48	38	36	581	53
Not sure	236	29	49	32	37	36	336	31
No answer	6	1	4	3	3	2	13	1
Total	820	100	152	100	104	100	1097†	100

1 Includes 22 people who did not state whether first job was their preference

† See note about weighting on p35

ii) Clinical specialty of second job

The 1097 respondents who planned to obtain a second nursing job were asked about their preference for the clinical specialty of this job. They were offered four options: the same specialty as their first job; a different specialty from their first job; don't know; don't mind. Table 7.10 shows the relationship between the specialty(ies) in which respondents planned to work in their second job and the specialty(ies) of their first job.

Overall, 21% (229) of respondents planned for their second job to be in the same specialty(ies) as their first. Twenty-sex per cent (289) did not know, and 10% (115) did not mind, in which specialty(ies they would work in their second job. Thirty-seven per cent (403) wanted to work in a different specialty in their second job.

Table 7.10 Clinical specialty of second job, in relation to that of first job

Relationship of specialty of second job to that of first job	First job based in preferred specialty		Did not mind in which specialty first job based		First job not based in preferred specialty		All respondents	
	No.	%	No.	%	No.	%	No.	%
Same	203	25	16	10	6	6	229	21
Different	261	32	69	46	69	66	403	37
Don't know	218	27	46	30	21	20	289	26
Don't mind	93	11	11	7	7	7	115	10
No answer	45	4	10	7	1	1	62	6
Total	820	100	152	100	104	100	1097†	100

[1] Includes 22 people who did not state whether first job was their preference

† See note about weighting on p35

Table 7.10 also presents the data by whether respondents' first job was based in their preferred specialty. Comparing responses given by those whose first job was, and was not, in their preferred specialty sheds light on the figures. Only 6% (6) of those whose first job was not in their preferred specialty wanted to work in the same specialty in their second job, compared with 25% (203) of those who obtained a first job in their preferred specialty. Likewise, 66% (69) of those whose first job was not in their preferred specialty wanted their second job to be based in a different specialty, compared with 32% (261) of those whose first job was in their preferred specialty.

7.4.4 Clinical specialty of job in which hope to be working at 18 months and three years after qualification

As Section 7.1 shows, 1225 respondents planned to be working in nursing 18 months after qualifying and 882 planned to do so at 3 years after qualification. At both time-points, respondents were asked to provide details of the clinical specialty in which they hoped to be working, if able to do so at this stage. Some 40 specialties were specified in the question about plans for 18 months (see Appendix 7, Table 7A.4) and 37 in the question about plans for three years (see Appendix 7, Table 7A.5). The main points to emerge are summarized here.

At 18 months the largest proportion of respondents hoped to be working in general medicine (14%, 175); 11% of the cohort as a whole. This was followed by general surgery (13%, 165); 10% of the cohort as a whole. Eleven per cent (129) stated that they wished to work in accident and emergency (8% of the cohort) and 9% (104) in intensive

care (7% of the cohort). Sixteen per cent (190) of those hoping to be in a nursing job at 18 months did not provide details of the specialty in which they hoped to be working.

At three years the specialty most frequently mentioned was community (12%, 107) 7% of the cohort. Accident and emergency was mentioned by 11% (99), and 10% (84) stated that they hoped to be working in intensive care; these figures account for 6% and 5% of the cohort respectively. Twenty-one per cent (189) of those hoping to be in a nursing job at three years did not provide details of the specialty in which they hoped to be working.

Our initial intention was to explore the extent to which the specialty of a job held at one time-point featured in plans for specialties of jobs in which respondents hoped to be working at subsequent time points. Given the diversity of specialties in which first jobs were held, 28 separate analyses would have been required to pursue this. We therefore focused on respondents' plans to work in those specialties, other than general medicine or surgery, mentioned most often in plans for 18 months and three years: accident and emergency and intensive care. We also had intended to explore whether respondents who had obtained a first job in their preferred clinical specialty planned to remain with their initial preference over time. As observed in Section 5.5 however, for respondents whose first job was based in more than one clinical specialty, it was not possible to identify which were their preference and which not. Moreover, very few respondents said that their first job was not with their preferred specialty. Consequently the analysis was pursued for all respondents with a first job. Details of this analysis are in Appendix 7, Table 7A.6. The findings showed that there was a link over time. Thus those for whom the specialty was the main (or one of the main) specialty(ies) of their first job were more likely to specify the specialty as the one in which they hoped to be working at 18 months and 3 years than those whose first job was not based in the specialty, or those whose first job included the specialty but not as a main specialty.

7.5 GRADE

As described in Section 5.6 the majority of the 1340 respondents with a first nursing job were appointed at a D grade (99%, 1320). One person was appointed at E/F grade, two at F grade, and one at H grade. Those who had ideas about the nursing job they hoped to hold at 18 months (n=1225) and at three years (n=882) were asked to give details if known, of the grade/pay-scale point[4] which they hoped to have reached, by these time-points.

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[4] Hereafter, for readability, the term 'grade' is used to refer to 'grade/pay-scale point'

Table 7.11 Grade of job in which hoped to be working at 18 months and three years after qualification

	18 months						3 years					
	Those hoping to be in a nursing job (n=1225)				Total cohort (n=1596)		Those hoping to be in a nursing job (n=882)				Total cohort (n=1596)	
Grade	No.		%		%		No.		%		%	
D grade	480		39		30		88		10		6	
D/E grade	239		20		15		71		8		4	
E grade	393		32		25		383		43		24	
E/F grade	20		2		1		99		11		6	
F grade	5		*		*		81		9		5	
F/G grade	6				*		15		2		1	
G grade	2	13		1	*	1	33	133	4	15	2	8
G/H grade							3		*		*	
H/I grade							1		*		*	
Points on other scales	2		*		*		4		*		*	
Not stated	78		6		5		104		12		7	

As Table 7.11 shows, of the 1225 respondents hoping to be in a nursing job at 18 months, 39% (480) of those who gave a grade (30% of the cohort), hoped to be a D grade 18 months after qualifying. Thirty-two per cent (393) hoped to have obtained an E grade by that stage. This accounts for 25% of the total cohort. One per cent (13) of respondents hoped to have obtained an F grade or above 18 months after qualifying. Of the 882 respondents able to give some details of the nursing job which they hoped to be holding at three years, just 10% (88) planned to be working as a D grade at that stage (Table 7.11). This accounts for only 6% of the total cohort. Fifty-five per cent (482) (30% of the cohort) planned to be either an E grade or an E/F grade by this stage. Fifteen per cent (133) hoped to have reached an F grade or higher.

Analysis by sex showed differences between women and men in relation to the grade in which they hoped to be working at 18 months and three years after qualification (see details in Appendix 7, Tables 7A.7 and 7A.8). Similar proportions of each sex thought that they would have obtained an E grade within 18 months of qualifying (32%, 358 of women vs. 33%, 35 of men). A higher proportion of women than men thought that they would be a D grade at this stage (40%, 446 vs. 32%, 34). Men, however, were significantly more likely than women not to state the grade at which they hoped to be working 18 months after qualification (15%, 16 vs. 6%, 63 $p<0.001$).

By three years after qualifications, the largest proportion of both sexes hoped that they would be an E grade, although women were significantly more likely to hope for an E grade than men (45%, 363 vs. 26%, 20 p<0.001). The difference in the proportions of women and men who thought they would be an F grade or above three years after qualification was not significant (15%, 120 vs. 14%, 11). Again, men were significantly more likely than women not to state the grade at which they hoped to be working (25%, 19 vs. 11%, 87 p<0.001).

7.6 SUMMARY AND DISCUSSION OF KEY FINDINGS ON FUTURE PLANS

Here we draw together the key findings on future plans. Comparison with findings from other studies proved problematic. Although Jowett *et al.* (1994) provided information on plans, findings were not presented separately for each branch. In the study of traditional qualifiers (Robinson *et al.* 1995) questions were asked in a format which precluded detailed comparison with the diplomate cohort.

7.6.1 Orientation towards nursing

- **95% planned to obtain a first nursing job**
- **The majority of the cohort thought it likely that they would be working in nursing at subsequent time-points: 6 months (92%); 18 months (91%), 3 years (85%); 5 years (76%) and 10 years (67%)**

At the time of qualification, this adult branch cohort indicates no sense of early attrition from the profession. Data from subsequent questionnaires will identify whether cohort members do in fact hold a nursing job at each of the specified time-points. These data will be compared with their earlier plans, and reasons for differences explored. Moreover, questions about plans to stay in nursing are repeated in post-qualification questionnaires and will indicate whether plans change over time.

7.6.2 Orientation towards working in the NHS

- **98% of those with a first job said it was funded (wholly or partly) by the NHS**
- **47% said that their preference was only to hold jobs funded by the NHS (wholly or partly). One-half (50%), however, did not mind holding jobs in organizations other than the NHS**
- **The NHS was the employing organization most likely to be specified by those who had some idea of the job in which they hoped to be working at 18 months (89%) and/or at three years (85%)**

The early orientation towards the NHS is perhaps not surprising, given that it is the organization in which diplomates were most likely to gain experience and with which

they were most likely to be familiar. The inclusion of a wide range of organizations, other than the NHS, however, may well reflect diplomates' awareness that an increasing number of other employers are now involved in the provision of care.

Subsequent questionnaires will provide information on the organizations in which cohort members obtain jobs, and whether difficulties are experienced in gaining employment in organizations of choice.

7.6.3 Hours

- **At each time-point the majority of the cohort planned to be working full-time; there was little evidence of a move towards part-time employment**

7.6.4 Clinical specialty

i) Influence of course experiences

- **For 17 of the 28 specialties, over half of respondents had little or no experience during the course**
- **For those who had experience, this was more likely to encourage than discourage them from considering working in the specialty (the only exceptions were elderly care, outpatients and theatres)**
- **For each specialty only a minority said course experiences had put them off considering working in the area (1%-35%)**

The findings do suggest that experience in an area during the course is more likely to lead to adult nurses to consider working in a specialty than to be put off. Consequently, it is suggested that ways are found to include placements in those specialties over which there is concern about the number of adult nurses wishing to work in them.

ii) Specialties of jobs - held and planned

- **First jobs were spread across a total of 28 specialties, job planned for 18 months across 40 and for 3 years across 37. While general medicine and general surgery featured most often in first jobs and job planned for 18 months, by 3 years community, accident and emergency, and intensive care did so**
- **Those who did not obtain a first job in their preferred specialty were more likely than those who did, to want to leave the job 6 months or less after qualifying and to plan to obtain a second job in a different specialty**

Many were uncertain about the clinical specialty of jobs in which they hoped to be working in the future. This uncertainty may reflect lack of sufficient experience, and the knowledge upon which to be able to base a decision about choosing to work in particular specialties, combined with a desire to consolidate experience before embarking on a specialist career. Career pathways, desired and achieved,

within specialties should emerge more clearly from subsequent questionnaires.

7.6.5 Grade

- **Nearly all started work at a D grade**

- **There was some degree of uncertainty about the grade hoped for by subsequent time-points. Some diplomates, however, had a clear promotion path planned with 15% hoping to have reached an F grade or higher three years after qualification**

7.6.6 Uncertainty

The majority of diplomates thought it likely that they would be working in nursing in the future. There was, however, a considerable degree of both flexibility and uncertainty about the specific direction which they wished to pursue in terms of employing organization and clinical specialty. A similar degree of flexibility and uncertainty about these directions was also found for those qualifying from traditional courses (Robinson et al. 1995).

7.6.7 Conclusion

At qualification this adult branch cohort indicated no sense of early attrition from nursing. While first jobs were most likely to be in the NHS, there was not, however, a unanimous commitment to remaining in the NHS in the longer term. A wide range of specialties featured in first jobs and in jobs diplomates hoped to hold in the future; there was some indication of links between experience at one time-point with plans for future time-points.

CHAPTER 8: PRECEPTORSHIP AND CONTINUING EDUCATION

The third aim of the research is to investigate five subjects relevant to diplomates' careers: continuing professional development, career guidance combining work and family, quality of working life and some aspects of developments in nursing roles. Aspects of the first three subjects were included in the questionnaire sent to diplomates at qualification. This chapter focuses on continuing professional development.

The importance of continuing professional development was strongly emphasized in the Project 2000 proposals; in particular the provision of a period of support for the newly qualified nurse and a planned programme of continuing education in the years after qualification (UKCC 1986). As detailed in chapter 1 (section 1.3.3), the importance of these and other aspects of continuing professional development were stressed in subsequent policy documents produced by professional and statutory bodies and by central government. Recognition was accorded to the role of continuing professional development in individual job satisfaction, career progress and retention, as well as enhancing the quality of patient care and meeting service needs.

In this research, the following aspects of continuing professional development are being investigated: preceptorship, supervision, meeting PREP requirements, and taking courses and obtaining further qualifications. In the 'at qualification' questionnaire, diplomates were asked about preceptorship and plans to take courses and findings are reported in this chapter. Pilot work indicated that it was too soon in diplomates' careers to ask questions about PREP and clinical supervision, since many respondents lacked an understanding of the former and a familiarity with the latter. Consequently, these topics were deferred to subsequent questionnaires.

The UKCC (1993) described preceptorship as a distinct period of support for the newly qualified nurse and suggested an average period of preceptorship of four months, depending on the preceptee's ability and experience. Preceptorship was identified as an essential part of ensuring a smooth transition from student to professional practitioner; in addition it was argued that the care and protection of patients would be enhanced by

supporting and developing newly qualified nurses in this way (UKCC 1993). This project investigated newly qualified diplomates' expectations of preceptorship, and how satisfied they were with what they subsequently received. Research questions for the first phase of the project were as follows:

- Of those who planned to obtain a first nursing job (six months or less after qualifying) what proportion wanted a preceptor? (Section 8.1.1)
- How important were each of 11 different aspects of preceptorship to newly qualified diplomates? (Section 8.1.2)
- For how long did diplomates want to receive preceptorship? (Section 8.1.3)
- Did women and men have different expectations of preceptorship (Section 8.1.4)

Turning to continuing education, pilot interviews indicated that given the increasing numbers of degree qualified nurses, many members of the pilot cohort believed that they needed a degree in order to compete in the labour market and that many colleges were encouraging students to build on their diploma and gain a degree. Investigating reasons for planning to obtain a degree indicated whether these related to enhancing a career in nursing or perhaps to pursuing a career outside nursing instead. Furthermore, it was important to ascertain whether diplomates felt pressured to obtain a degree, since if this was the case it might adversely affect their morale. Pilot work also showed that some planned to qualify for other parts of the register. Those specified included the following: taking the mental health branch in order to specialize in the care of children with mental health problems; likewise the learning disability branch. Other members of the pilot cohort planned to work as health visitors, district nurses or midwives. Intentions to take a variety of other courses, including those offered by the National Boards, were also indicated by pilot work.

In summary, diplomates may want, or be required, to take specific courses in order to pursue particular directions in nursing, to obtain skills and knowledge necessary for certain roles, to obtain promotion, and as a means of meeting PREP requirements. In this project, therefore, it was important to ascertain whether diplomates had opportunities, such as obtaining study leave and funding, to facilitate the undertaking of courses, since this may determine whether diplomates start and/or continue with further study.

Given the foregoing, research questions on continuing education for this first phase of the project were as follows:.

- What proportion of diplomates planned to obtain a degree? Why, when and how do they plan to obtain the degree, and why did some diplomates not plan to obtain a degree? (Section 8.2)
- Did diplomates plan to qualify for other branches of nursing? (Section 8.3)
- What proportion of diplomates planned to apply for other courses (including ENB courses) during the first six months after qualifying? When and why did they plan to start them? (Section 8.4)

8.1 PRECEPTORSHIP

Five hundred and ninety seven respondents, who had obtained, or planned to obtain, a nursing job six months or less after qualifying, were asked questions about their expectations of preceptorship in their first job. Although several definitions of preceptorship exist in the literature (e.g. Chickerella and Lutz 1981) no definition was provided in the questionnaire, since pilot work indicated that this caused confusion if expectations and the definition did not match.

8.1.1 Wanting to have a preceptor

As shown in Table 8.1, the majority of respondents (97%, 1462) wanted a preceptor in their first job, 2% (29) did not mind whether they had a preceptor, and 1% (13) did not want one. This latter group was not asked any further questions about preceptorship.

Table 8.1 Wanting to have a preceptor in first job

Wanting to have a preceptor	No.	%
Want to have a preceptor	1462	97
Did not mind	29	2
Do not want to have a preceptor	13	1
No answer	8	1
Total	1512	100

8.1.2 Expectations of preceptorship

The 1491 respondents who wanted or did not mind whether they had a preceptor were asked about their expectations of preceptorship. Eleven aspects of preceptorship were presented, and respondents asked to rate, on a scale of 'very important' to 'not at all important', how important each was to them. The aspects were developed and refined through existing literature on preceptorship and work with the pilot cohort.

Table 8.2 presents the aspects in decreasing order according to the number of respondents who ringed 'very important'. All 11 aspects of preceptorship were rated by the majority

of respondents as either 'very important' or 'quite important'. Clinical skills, both feedback on and the teaching of, were the aspects most frequently rated as 'very important', and were both considered as important by 99% of respondents when the figures for 'very important' and 'quite important' are combined. Confidence building also featured strongly, with 63% (944) rating this aspect as 'very important' to them. At the opposite end of the scale, discussing career plans was rated as 'very important' by less than one-fifth of respondents; 19% (288). However, when 'very important' and 'quite important' are combined this aspect was seen as important by nearly two-thirds (63%, 935) of respondents. Discussing career plans was the only aspect which was regarded by more than one-quarter of respondents as 'not very important'. Very few people regarded aspects of preceptorship as 'not at all important', and for some aspects no respondents ringed this option.

Table 8.2 Expectations of preceptorship

	Very important		Quite important		Not very important		Not at all important	
Aspects of preceptorship	No.	%	No.	%	No.	%	No.	%
Constructive feedback on my clinical skills[1]	1361	91	121	8	7	*	0	-
Teaching new clinical skills	1239	83	240	16	11	1	0	-
Confidence building[1]	944	63	474	32	64	4	8	1
Help me to settle into the work environment	891	60	504	34	87	6	9	1
Advising on professional issues[1]	859	58	578	39	50	3	2	*
Assisting in setting learning objectives	759	51	645	43	77	5	9	1
Emotional support[1]	747	50	623	42	113	8	5	*
Someone to work alongside[1]	463	31	719	48	270	18	37	2
Someone to confide in[1]	436	29	683	46	323	22	47	3
Someone to meet with on a regular basis	434	29	734	49	270	18	53	4
Discussing career plans[1]	288	19	647	43	486	33	67	4

1 Between one and three respondents did not provide an answer for this item

8.1.3 Length of time for which preceptorship wanted

The same 1491 respondents were asked for how long they would like to receive preceptorship. As Table 8.3 shows, just over three-quarters (76%, 1135) wanted a preceptorship period of four to six months, the most frequently mentioned time-scale

being six months (51%, 767). Just 7% (99) of respondents wanted a longer preceptorship period.

Table 8.3 Length of time for which respondents would like preceptorship: women and men

	All respondents	
Length of preceptorship	No.	%
3 months or less	251	17
4 or 5 months	368	25
6 months	767	51
Longer than 6 months	99	7
No answer	6	*
Total	1491	100

8.1.4 Differences between women and men

When questions on preceptorship were analysed by sex only one significant difference emerged. Women were significantly more likely to rate emotional support as important (52%, 710 vs. 33%, 37 of men $p<0.001$).

8.2 PLANS TO TAKE DEGREES

One thousand five hundred and fifty of the 1596 people who returned this first questionnaire were asked about their plans to take a degree. The 46 people not asked were those who had not yet taken a nursing job in the UK and were unsure or did not plan to do so within six months of qualifying (n=11) plus those people who failed to answer an earlier question and were routed past this section of the questionnaire (n=35). These 1550 respondents were first asked whether they had obtained a degree before starting the nurse diploma course. Four per cent (64) had a degree, 95% (1474) did not, and 12 people did not answer[1]. Those with and without a degree were then routed to questions asking them about their plans to undertake a/another degree.

[1] Table 3.3 showed that 69 people had a degree; 64 of these confirmed this having been routed to the above specific question on the subject. Table 3.3 also indicated that 1526 people did not include a degree in their pre-course qualifications; of these 1474 confirmed this having been specifically asked as above.

8.2.1 Plans to obtain a degree

Table 8.4 Column 1 shows that, of the 67 people who had already obtained a degree, over a half (54%, 36) intended to obtain another degree[2]. Of the 1471 respondents who did not have a degree, over two-thirds (67%, 989) planned to obtain one (Table 8.4 Column 2). The 1025 respondents who planned to take a degree account for 64% of the total cohort.

Table 8.4 Plans to obtain a degree

	Column 1 Respondents with a degree		Column 2 Respondents without a degree		All respondents	
Plans to obtain a degree	No.	%	No.	%	No.	%
Plan to obtain a degree	36	54	989	67	1025	67
Unsure about obtaining a degree	16	25	423	29	439	29
Do not plan to obtain a degree	11	17	58	4	69	4
No answer	3	4	2	*	5	*
Total	67†	100	1471†	100	1538	100

† See note about weighting on p35

Plans to take a degree were analysed by sex (Appendix 8A.1). Women and men who already had a degree did not differ significantly in their plans to take another. For women and men without a degree, however, men were significantly more likely than women to plan to obtain one (79%, 89 vs. 66%, 901 $p<0.01$). Women were significantly more likely than men to be unsure about obtaining a degree (29%, 400 vs. 20%, 221 $p<0.05$).

Further analysis focused on whether plans to obtain a degree differed by highest academic qualification before starting the diploma course (Appendix 8A.2). In 11 of the 13 qualification groups more than half the respondents planned to take a degree; the exceptions were those with a Diploma in HE and 1-4 O' levels but no DC test/access course. For 8 of the 11 groups, the proportion planning to take a degree varied between 64% and 69%.

The 990 respondents who did not have a degree and who planned to obtain one, were asked to provide details about the degree subject. The majority (72%, 710) indicated that

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[2] Respondents who already had a degree (n=67) were asked whether they planned to obtain a degree in another subject towards which they would be able to use their nurse diploma as credits, and not just whether they planned to pursue any degree. It is possible, therefore, that people who already had a degree and who indicated that they did not, or were unsure, could be planning to pursue a degree in another non-nursing subject. It is unlikely, however, that people who already have a non-nursing degree would plan to obtain another non-nursing degree.

this degree would be in nursing, 17% (169) planned to pursue a degree in a subject other than nursing but for which they would be able to use their nurse diploma qualification as credits, and just seven people planned to pursue a degree for which they would not be able to use their nurse diploma qualification as credits. Ten per cent of respondents (101) were unsure about the degree they would obtain.

Of all 1025 respondents who were planning to obtain a degree, 58% (590) planned to study part-time, 20% (203) by credit accumulation and just 12% (122) planned to study full-time. Eight per cent (85) stated that they did not know by which of these methods they would undertake their degree.

8.2.2 Reasons for planning to obtain a degree

As Table 8.5 shows, respondents were most likely to be planning to pursue a degree to develop their career in nursing (76%, 775). Just 7% (69) planned to take a degree to pursue a career other than nursing. Respondents were much more likely to want to take a degree course for personal fulfilment (58%, 591) than because they felt pressured to do so (10%, 106). Analysis by sex showed no significant differences in the reasons given by women and men.

Table 8.5 Reasons for planning to obtain a degree

	Respondents with a degree (n=35)	Respondents without a degree (n=990)		All respondents (n=1025)	
Reasons	No.	No.	%	No.	%
To develop my career in nursing	32	743	75	775	76
Personal fulfilment	17	574	58	591	58
Feel pressured to obtain a degree	3	103	10	106	10
To pursue a career other than nursing	0	69	7	69	7
Other	1	30	3	31	3
No answer	2	83	8	85	8

8.2.3 Time-scales for starting degree

Table 8.6 shows when respondents planned to start a degree. Given that they had only just qualified from a three-year course and were likely to be concerned with consolidating their skills and experience, it is unsurprising that nearly three-quarters (73%, 753) either planned to start a degree more than six months after qualifying or were unsure when they

would do so. Analysis by sex showed no significant differences between women's and men's time-scales for starting a degree.

Table 8.6 Time-scale for starting a degree

Time-scale	Respondents with a degree No.	Respondents without a degree No.	%	All respondents No.	%
Six months or less after qualifying	8	179	18	187	18
Longer than six months after qualifying	20	553	56	573	56
Not sure	7	174	18	180†	18
No answer	0	84	9	84	8
Total	35	990	100	1025†	100

† See note about weighting on p35

8.2.4 Study leave and funding for degree

The 187 respondents who planned to start a degree six months or less after qualifying were asked about their study leave and funding arrangements (it was unlikely that those who intended to start a degree after this point, or who were unsure about when they would start it, would be certain of such details). As Table 8.7 shows, the most frequent responses were 'attend in own time while also in paid employment' (35%, 66) and 'combination of study leave and own time' (22%, 42).

Table 8.7 Study leave arrangements for degree

Study leave arrangements	No.	%
Attend in own time while also in paid employment	66	35
Combination of study leave and own time	42	22
Given study leave by employer	16	9
Don't know	35	19
Not applicable - will not be in paid employment	19	10
No answer	9	5
Total	187	100

Table 8.8 shows respondents’ planned funding arrangements. Over one-third (36%, 67) planned to fund the degree themselves.

Table 8.8 Funding arrangements for degree

Funding arrangements	No.	%
Self-funded	67	36
Funded by employer	24	13
Grant/bursary	18	10
Combination of employer and self-funding	18	10
Don't know	44	23
No answer	15	8
Total	187†	100

† See note about weighting on p35

8.2.5 Reasons for not planning to obtain a degree

The 59 respondents who did not have a degree and who indicated that they did not plan to obtain a degree, were asked to give their reasons. The options provided in the questionnaire include those that reflect 'organizational constraints', (i.e. 'unlikely that I will be able to obtain adequate funding' and 'unlikely that I will be able to secure adequate study leave'), and those reflecting personal constraints, such as the perceived value of a degree and concerns about their ability to obtain one. As Table 8.9 shows, the most three frequently cited reasons all related to personal constraints. In particular, 45% (27) were not interested in studying for a degree.

Table 8.9 Reasons for not planning to obtain a degree

	(n=59)	
Reasons	No.	%
Not interested in studying for a degree	27	45
Not confident of my academic ability to obtain a degree	20	33
Do not think a degree is necessary to further my career in nursing	12	21
Unlikely that I will be able to obtain adequate funding	8	13
Unlikely that I will be able to secure adequate study leave	2	3
Other	3	5

8.3 PLANS TO QUALIFY FOR OTHER PARTS OF THE REGISTER

The same 1550 respondents who were asked about degrees were asked whether they intended to qualify for other parts of the register. First they were asked about plans to qualify for other branches included in the Project 2000 diploma course (child, learning disability and mental health). A second question then explored intentions to qualify as a health visitor, district nurse or midwife.

Beginning with other branches, just 4% (62) indicated that they did intend to take a second branch and just under a fifth (23%, 362) were unsure. The majority (71%, 1108) stated that they did not plan to qualify for any of the other branches. (Eighteen people did not provide an answer.) Table 8.10 shows the other branches for which respondents planned to qualify, as well as the proposed time-scale. The most frequently mentioned branch was child (33), with 23 people indicating the mental health branch, just one person the learning disability branch, and one person who did not state a branch. For each branch, the majority planned to start the course longer than 6 months after qualifying (Table 8.10). Just under one-third (32%) of those who had wanted to change branch during the course but had not been able to do so planned to qualify for another branch.

Table 8.10 Planned time-scale for starting other branches

Time-scale	Child No.	Mental Health No.	Learning Disability No.
Six months or less after qualifying	2	1	0
Longer than six months after qualifying	21	17	1
Not sure	11	5	0
Total	33	23	1

Turning to other parts of the register, 18% (284) of respondents planned to qualify as a district nurse, 10% (152) as a midwife and 2% (36) as a health visitor. In terms of time-scales, just 34 respondents intended to start a course six months or less after qualifying. For each of these qualifications, the majority planned to start these courses longer than six months after qualifying (Table 8.11).

Table 8.11 Planned time scale for other parts of the register

	District Nurse		Midwife		Health Visitor	
Time-scale	No.	%	No.	%	No.	%
Six months or less after qualifying	6	2	27	18	1	4
Longer than six months after qualifying	196	69	110	73	20	58
Not sure	55	20	14	9	11	31
No answer	26	9	0	-	3	8
Total	284	100	152	100	36	100

8.4 PLANS TO APPLY FOR OTHER COURSES IN THE FIRST SIX MONTHS AFTER QUALIFYING

The 1550 respondents were asked whether there were any other courses that they had applied for, or planned to apply for, during the first six months after qualification. Instructions were given to include National Board courses and other healthcare related courses; examples relevant to adult nurses were provided. Participants were asked not to include workshops and training days. Fifteen per cent (260) of respondents had applied, or planned to apply for one or more courses during the first six months (16% of the cohort as a whole). A larger proportion (62%, 996) reported that they had neither applied for a course, nor intended to do so within six months; 17% (267) were unsure whether they would apply to take any courses.

The 260 respondents who had applied or planned to apply for one or more courses were then asked to give the course title(s); space was provided for two since pilot work indicated that this would be sufficient. Sixty-four per cent (165) gave details of one course and 34% (89) gave details of two (344 courses in total). The ENB 998 Teaching and Assessing in Clinical Practice was mentioned most often; 68% (177) of respondents had applied for this course or planned to do so shortly (11% of the cohort as a whole). Thirty-four other ENB courses were mentioned; the most frequent was ENB 100 Intensive Care Nursing (16), followed by ENB 199 Accident and Emergency Nursing (6).

Twenty-nine 'other' courses (i.e. not National Board) were detailed by respondents. Most frequently mentioned were a variety of counselling courses, (11), aromatherapy and massage (7), sign language (5), care of the dying (4), palliative care (3), and wound care (3).

Respondents were asked their reasons for wanting to attend each course, and when they wanted to start it. Table 8.12 shows the list of reasons offered to respondents, grouped according to whether these relate to one of two categories (career progress and professional development, and developing/improving skills and knowledge) or to the two reasons shown under 'other'. Figures presented refer to the number of courses (n=344) not the number of respondents.

Table 8.12 Reasons for taking courses

Reasons	No. (n=344)	%
Career progress and professional development		
Enhance future career options	240	70
Meet requirements of PREP for re-registration	195	57
Improve chances of promotion	194	56
Gain credits towards degree	119	35
Pursue a career other than nursing	22	6
Developing/improving skills and knowledge		
Develop/take on new role(s) within job	220	64
Develop knowledge/skills relevant to clinical specialty with which working	191	56
Improve the quality of patient care which I provide	175	51
Other		
Personal interest	249	73
Required to attend by employer	22	6
No answer	6	2

The reasons ringed most frequently were 'personal interest' (71%, 249), to enhance future career options (69%, 240) and to 'develop/take on new role(s) within job' (63%, 220).

The main reasons given for taking the ENB 998, the course cited most often, were to 'develop/take on new role(s) within this job' (71%, 125 people), to 'enhance future career options' (71%, 125) and 'personal interest' (67%, 118).

Time-scales for starting these courses are shown in Table 8.13. The option ringed most often was 'longer than six months after qualifying' (40%, 136). For just under a fifth of the courses 18% (62) of respondents were unsure when they wanted to start.

Table 8.13 Time-scale for starting other courses

Time-scale	No.	%
Six months or less after qualifying	130	38
Longer than six months after qualifying	136	40
Not sure	62	18
No answer	16	5
Total	344	100

8.5 SUMMARY AND DISCUSSION OF KEY FINDINGS ON PRECEPTORSHIP AND CONTINUING EDUCATION

Here we summarize the key findings to emerge from these two aspects of continuing professional development - preceptorship and taking further courses and consider their implications. Most of the other studies which have included adult branch diplomates (e.g. Jowett *et al.* 1994, White *et al.* 1994) have not reported plans to take courses separately for each branch. Some comparisons with traditional qualifiers are available from the study by Robinson *et al.* (1995).

8.5.1 Preceptorship

- **97% of respondents wanted a preceptor in their first job**
- **All aspects of preceptorship were rated as important by more than 50% of respondents**
- **The two aspects relating to clinical skills were those most frequently rated as very important**
- **Just over three-quarters (76%) wanted a preceptorship period of four to six months**

These findings suggest overwhelming support for a period of preceptorship from this cohort of newly qualified adult branch diplomates. The emphasis on aspects relating to clinical skills may support views that diplomates qualify with a deficit of practical clinical skills (Department of Health 1999). Conversely, it could be argued that newly qualified diplomates are keen to consolidate their clinical skills as indeed were traditionally trained nurses. Respondents anticipated that a preceptorship period of up to six months would be adequate but this may be a reflection of their understanding of the UKCC guidelines (1993) and common working practices.

Having ascertained newly qualified diplomates' expectations of preceptorship, it is important to find out about their experiences of, and satisfaction with, the preceptorship which they subsequently received. The second questionnaire, sent to participants six months after qualification, therefore includes questions that will enable assessment of whether expectations are fulfilled. Dissatisfaction with preceptorship may lead to people changing jobs and/or leaving nursing. Good experiences of preceptorship may facilitate the transition from student to qualified nurse and encourage diplomates to want to become preceptors themselves.

These recommendations have time implications for clinical staff, both in providing preceptorship and attending courses on being a preceptor. Clinical staff, however, are already heavily committed with service delivery and supporting pre-registration students

on clinical placements. Provision of preceptorship may well, as hoped, prove important for quality of care and retention of staff. Consequently workforce planners need to ensure that sufficient staff are available so that workloads can encompass provision of preceptorship. While this may increase costs in the short-term, these may be outweighed by longer term benefits.

8.5.2 Plans to obtain a degree

- **4% had obtained a degree prior to starting the nurse diploma course; 55% of these planned to obtain another degree (n=35)**
- **Of those who did not have a degree, 67% planned to obtain one and 29% were unsure at this stage**
- **Of those who did not have a degree and who planned to obtain one (n=990), 72% indicated that this would be a degree in nursing, 17% a different subject for which they could use their nurse diploma as credits and 10% were uncertain**

Of the 1025 respondents planning to take a/another degree (64% of the total cohort)

- **Pursuing a career in nursing was cited much more frequently as a reason for taking a degree than a career outside nursing: 76% vs. 7%. Personal fulfilment was cited much more frequently than feeling pressured to take a degree (58% vs. 10%)**
- **For over half (56%), the planned start date was longer than six months after qualifying, 18% were uncertain, 18% said six months or less after qualifying**
- **Not interested in studying for a degree was the reason cited most often for not planning to start a degree**

The growing emphasis on nurses having a degree has not been reflected unequivocally in the plans of these adult branch diplomates at the time of qualification. Moreover, of those who do plan to obtain a degree, many were uncertain about the subject and about when to start. The potential value of a degree to future career options was however reflected, in that 'enhance future career options' was the reason was cited more frequently than any other. In the 'six months' questionnaire respondents are reminded of their plans at qualification and asked how they have fared in the intervening period. Those who have not started a degree are asked about their current plans in this respect thus enabling an assessment of any changes in plans.

Questions about taking degrees asked of traditional qualifiers (Robinson *et al.* 1995) were not directly comparable with those asked of diplomates. The findings showed, however,

that fewer of the former had plans to take a degree at this early stage; 42% expressed an interest in doing so, compared with 64% of diplomates.

8.5.3 Plans to qualify for other parts of the register

- **18% planned to qualify as a district nurse, 10% as a midwife and 2% as a health visitor**
- **4% (62) planned to qualify for another branch; child was most frequently mentioned (33)**
- **71% did not plan to qualify for other branches, 23% were unsure at this stage**

Subsequent questionnaires will indicate whether those who planned to qualify for other parts of the register did in fact do so. If not, is this due to a change of plan or not being able to obtain a place on, or funding for, such a course? Will those who qualify for other branches pursue a career in the specialism concerned or continue as an adult nurse but apply the knowledge and skills gained to the care of specific patient groups?

Comparable findings for traditional qualifiers plans to qualify for other parts of the register are available in Robinson *et al.* (1995). Twenty-three per cent planned to qualify as a midwife compared with 10% of diplomates. This reflects the fact that when the traditional cohort qualified, the post-registration route was the main route to midwifery whereas direct entry courses are now available. Similar proportions of traditional qualifiers and diplomates planned to qualify as district nurses: 21% vs. 18%, but the former were more likely than the latter to plan qualifying as a health visitor: 13% vs. 2%. Twenty per cent of traditional qualifiers planned to qualify as children's nurses compared with 2% of diplomates. As with midwifery, this difference no doubt reflects the fact that a post-registration course was the main route to children's nursing when the traditional cohort qualified. Some interest in mental health nursing was evidenced in both groups: 10% of traditional qualifiers vs. 1% of diplomates, but little in learning disability nursing.

8.5.4 Plans to apply for other courses in the first six months after qualifying

- **15% had applied, or planned to apply, for other course(s) in the first six months after qualifying**
- **Reasons cited most often for attending were: personal interest (73%), to enhance future career options (70%); and to develop/take on new roles within job (66%)**
- **ENB 998 (Teaching and Assessing in Clinical Practice) was mentioned most often (68% of those applying for courses, 11% of the cohort as a whole). Reasons for**

attendance cited most often were to take on new roles within job (71%) and to enhance future career options (71%)

- **62% did not plan to apply for other courses during the first six months after qualifying; 17% were unsure at this stage**

The perceived importance of gaining the ENB 998 qualification as a means of enhancing promotion chances was a key point to emerge from these data. Many E grade jobs require applicants to hold the ENB 998 certificate; subsequent questionnaires will show how soon after qualification these respondents were able to obtain a place on the course and the effect, if any, of obtaining the qualification. The role of continuing professional development in individual career development and enhanced quality of patient care were evenly reflected in the reasons given by diplomates for wanting to attend courses. The traditional qualifiers (Robinson *et al.* 1995) were asked a specific question about plans to take ENB courses. As with diplomates, ENB 998 was mentioned most often, followed by ENB courses in intensive care nursing and in accident and emergency nursing.

CHAPTER 9: CAREER GUIDANCE AND CAREER PLANNING

Investigating career guidance is included in the third aim of the research – investigating subjects relevant to diplomates' careers. Career guidance has a potential contribution to make to the effective management of nurses' careers at both the organizational and individual level. At an organizational level, maintaining sufficient numbers, an effective skill mix and the management of inter-and intra-organizational mobility is essential for the maintenance of quality care (Cole 1993), while for many individuals, career progress is central to personal morale and job satisfaction (Mercer *et al*. 1976, Mackay 1998, 1989).

As indicated in Chapter 1 (Section 1.3.4), while recommendations for the provision of career guidance for nurses have a long history, there has been increasing emphasis within the profession in recent years on career planning. With regard to student nurses, the integration of nurse education with higher education means that they now have access to university based careers information and advisory services. It is not known, however, whether these services have the capacity and specialist knowledge to provide guidance to the influx of large cohorts of nurse diploma students.

Given the foregoing, research questions for this first phase of the project were as follows:

- Did diplomates receive information and advice, during the diploma course, about topics relating to career planning? (Section 9.1)
- Did diplomates feel they had sufficient information and advice? (Section 9.2)

- Did diplomates have discussions during the diploma course about planning their future career, and with whom were such discussions held? (Section 9.3)
- Were diplomates aware of the strategies to inform career planning recommended by the Department of Health (1995)? (Section 9.4)
- Did differences exist between women and men's experiences of career guidance? (Section 9.5)

Although other studies have explored guidance available to diploma course students (e.g. O'Neill *et al.* 1993, Jowett *et al.* 1994), findings are not reported by branch and so do not afford a direct comparison with this adult diplomate cohort. Research into career guidance for student nurses on traditional RGN courses has, however, been undertaken by Crofts (1992) and Robinson *et al.* (1995). Findings from the latter study have some measure of comparability with those from the current study in that the research undertaken was a large-scale survey by questionnaire, sent to participants at, or near, the end of their course; reference is made to published articles (Marsland 1996) and to a PhD thesis (Marsland 1997).

Previous chapters of this report have compared findings for the diplomate cohort with those from other studies in the discussion section at the end of the chapter. The detailed nature of the career guidance questions, however, indicated that such comparison would be better placed after the corresponding diplomate data in each section of the chapter.

9.1 INFORMATION AND ADVICE RECEIVED DURING THE NURSE DIPLOMA COURSE

Pilot work undertaken by the research team for the study of traditionally qualified RGNs revealed that interviewees had widely differing interpretations of the term 'career guidance' (Marsland *et al.* 1993, Robinson *et al* 1995). Consequently this term was not used in questions. Instead, participants were asked about *information and advice* received about 16 topics of career planning. For brevity and readability, however, the term 'guidance' is used in this chapter. Some of the topics had been developed for previous projects (Robinson *et al.* 1995, Robinson *et al.* 1996), whereas others (e.g. information and advice about degrees) were new. The topics related to three main areas: applying for a first job, continuing education, and career pathways. Findings for each area are presented separately.

9.1.1 Applying for first job

Four topics related to applying for a first job (Table 9.1). For each of these, more than 70% of all respondents had received guidance during the nurse diploma course.

Table 9.1 Guidance received about applying for first job:

Topics	No. (n=1596)	%
Completing job application forms	1317	83
Performing at job interviews	1269	80
Writing a CV	1256	79
Job availability	1134	71

Analysis by college (Appendix 9A.1) revealed considerable variation in the proportion of diplomates who had received guidance about each of the topics concerned with applying for first job.

Traditional qualifiers (Marsland 1996) were asked about two of these topics in a format which allows a measure of comparability with that asked of the diplomates. First, they were asked if they had received guidance about 'how to apply for first post'. Seventy-nine per cent said that they had; this is similar to the proportion of diplomates who said that they had received guidance about 'completing job application forms (83%) and 'writing a CV' (79%). Second, the traditional qualifiers were asked if they had received guidance about 'vacancies'. Just over one-half (54%) said that they had, a figure considerably lower than the 71% shown for diplomates in relation to receiving guidance about job availability.

9.1.2 Continuing education

Four topics focused on continuing education (Table 9.2). In previous NRU studies these topics focused on clinical courses offered by the National Boards, since these were viewed as the main way in which nurses could develop a career in a particular clinical area. As noted in Section 8.3, recent years have, however, seen increasing emphasis on nurses obtaining degrees. Moreover, pilot work revealed that staff at some colleges were encouraging students to build on their diploma to gain a degree. Consequently, it was important to explore whether diplomates received information and advice about obtaining a degree, in addition to that about taking National Board courses.

Table 9.2 Guidance received about continuing education

Topics	No. (n=1596)	%
Obtaining a degree	1052	66
Types of clinical courses offered by the National Boards (e.g. ENB 998 teaching and assessing)	835	52
Clinical courses offered by the National Boards relevant to your particular ideas about the future	636	40
Procedures for applying for clinical courses offered by the National Boards	419	26

As Table 9.2 shows, more respondents had received guidance about obtaining a degree (66%, 1052) than about any of the three topics relating to National Board courses. Although just over half of respondents had received guidance about clinical courses offered by the National Boards (52%, 835), it would appear that much of this was general in nature, since only 40% (636) received guidance about courses relevant to their particular ideas for the future, and just over one-quarter (26%, 419) received guidance about procedures for applying for National Board courses. Considerable variation existed in the proportion of diplomates from each college who had received guidance about each of the topics concerned with continuing education (Appendix 9A.1).

Traditional qualifiers (Marsland 1996) were asked about two of these topics in a format which allows some degree of comparability with those asked of the diplomates. First, they were asked if they had received guidance about the 'various clinical courses offered by the National Boards, e.g. ENB 216 stoma care'. Thirty-seven per cent said that they had; this compares with 52% of diplomates who said that they had received guidance about 'the types of clinical courses offered by the National Boards e.g. ENB 998 teaching and assessing'. Second, the traditional qualifiers were asked if they had received guidance about 'post-basic courses relevant to your particular ideas about your future'. Just 17% said that they had had such guidance, a figure considerably lower than the 40% of diplomates who received guidance about clinical courses offered by the National Boards relevant to their particular ideas about the future. The higher figures for the diplomates for these topics may reflect an increasing awareness of the importance of guidance for career planning.

9.1.3 Career pathways

Eight topics focused on career pathways (Table 9.3). These included general topics, for example 'career pathways for people with a nurse diploma from the adult branch', and more specific pathways such as those in clinical practice, education and research.

Table 9.3 Guidance received about career pathways

Topics	(n=1596) No.	%
Career pathways for people with a nurse diploma from the adult branch	850	53
Developing a career in clinical practice	742	47
Jobs for which your particular skills might be most suitable	636	40
Opportunities for working abroad	422	26
Developing a career in management in the NHS	418	26
Developing a career in nursing research	412	26
Opportunities for working outside the NHS	400	25
Developing a career in nurse education	279	18

The topic about which respondents were most likely to have received guidance was pathways for people qualifying from the adult branch (53%, 850). Fewer respondents received guidance about specific career pathways. Although 47% (742) had received guidance about developing a career in clinical practice, just over one-quarter had guidance about careers in management in the NHS (26%, 418) and nursing research (26%, 412), and only 18% (279) received guidance about pursuing a career in nurse education. Once more considerable variation existed across the colleges in the proportion of diplomates who had received guidance about each of the career pathways topics (Appendix 9A.1). Least variation existed for guidance received about developing a career in nurse education; in no college did more than one-third of respondents receive guidance about this topic.

In the Marsland (1996) study, questions were asked which offer some degree of comparability with the first two topics 'career pathways for people with a nurse diploma from the adult branch' and 'jobs for which your particular skills might be most suitable' albeit that they referred more specifically to the NHS. First, traditional qualifiers were asked if they received guidance on 'the range of careers available in the NHS to people who have qualified as nurses' and second, whether they received guidance on 'areas of work within the NHS for which your skills might be most suited'. In response to these two questions, Marsland (1996) reports that just 25% and 15% of respondents respectively received guidance. This compares with figures of 53% and 40% in the current study. Data also exist for the traditional qualifiers on guidance received about the six specific career pathways. Data for some topics (e.g. how to develop a career in clinical practice, nursing education and nursing research are directly comparable since the same question wording was used. Slightly different formulations for the other topics mean that the comparisons should be treated with some caution. The overwhelming finding, however, is that for all topics, a smaller proportion of traditional qualifiers

recorded having received guidance than is the case for diplomates in the current study: developing a career in clinical practice (12% vs. 47%); opportunities for working abroad (12% vs. 26%); developing a career in management (9% vs. 26%); developing a career in nursing research (8% vs. 26%); opportunities for working outside the NHS (8% vs. 25%), and developing a career in nurse education (16% vs. 18%).

9.2 VIEWS ABOUT THE AMOUNT OF GUIDANCE RECEIVED

Tables 9.1 to 9.3 show that, for nearly all topics explored, one-quarter or more of respondents did not receive guidance during their nurse diploma course. It is possible that those who did not receive guidance considered the period prior to qualification to be too early for career guidance, and that the main concern at that time was obtaining a first job. In order to ascertain respondents' views about the amount of guidance received, for each topic, those who had received guidance were asked if they would have liked more, and those who had not received guidance were asked if they would have liked some.

Findings on applying for first job (Table 9.4) show that for all four topics, over 50% of respondents wanted more guidance (Column 1). Interpreting these figures further is difficult, however, since it is not known how much guidance respondents received. The findings in Column 2 are less ambiguous; these respondents had not received guidance, and in this sense were all in the same position. For each topic, over 60% of those who had not had guidance said they had wanted some, and in the case of job availability, this figure is over three-quarters (77%, 340). It is illuminating to consider these responses as a proportion of the total cohort (Column 3). Just over one-fifth of all respondents did not receive guidance about job availability and wanted some. A picture of overall demand can be obtained by combining the figures from Column 1 and Column 2. As Column 4 shows, irrespective of whether respondents had received guidance, for each of the four topics over half of all respondents wanted some/more.

In the study of traditional qualifiers (Marsland 1996), comparable data were obtained in that those who had received guidance about topics were asked if they would have liked more, and those who had not received guidance were asked if they had wanted some. Seventy-nine per cent of traditional qualifiers wanted more guidance about 'how to apply for first post', compared with 51% of diplomates who wanted more guidance on completing application forms and 57% who wanted more about writing a CV. Eighty-one per cent of traditional qualifiers who had not received guidance about how to apply for first post wanted some, compared with 67% of diplomates who wanted some on completing application forms and 63% who wanted some about writing a CV. Turning to guidance about job availability, a slightly smaller proportion of traditional qualifiers than

diplomates wanted more guidance (49% vs. 54%), but a greater proportion of traditional qualifiers who had not received guidance wanted some (88% traditional qualifiers vs. 77% diplomates).

Figures relating to topics of continuing education are presented in Table 9.5. Sixty-four per cent of those who received guidance about obtaining a degree said they wanted more, and this figure is higher for those who received guidance about each of the three topics relating to National Board courses (Column 1). Furthermore, 90% or more of those who did not receive guidance about these three topics said that they had wanted some (Column 2). The figures for the total cohort (Column 3) show that for 'clinical courses offered by the National Boards relevant to your particular ideas about the future', over half of all respondents had not received guidance and had wanted some. The corresponding figure for 'procedures for applying for clinical courses offered by the National Boards' is 65%. Moreover, Column 4 shows that over 80% of all respondents wanted some or more guidance about the three topics relating to National Board courses.

In the study of traditional qualifiers (Marsland 1996), 67% of respondents wanted more guidance about clinical courses offered by the National Boards, a smaller proportion than of diplomates in the current study (78%). Similar proportions of respondents in each study who did not receive guidance on this topic wanted some (93% traditional qualifiers vs. 92% diplomates). Turning to clinical courses relevant to the respondent's ideas for the future, a similar pattern emerged in that a smaller proportion of traditional qualifiers than diplomates who had received guidance wanted more (60% vs. 81%), but the proportions of those in each study who had not received guidance and wanted some were similar (88% traditional qualifiers vs. 90% diplomates). This comparison of diplomates with traditional qualifiers indicates that the demand for guidance on continuing education remains high. Moreover, of those who received guidance, diplomates were more likely to want more than was the case for traditional qualifiers.

Table 9.6 shows the equivalent information for topics relating to career pathways. For all topics, over 60% of those who received guidance said they wanted more (Column 1). Over half of those who did not receive guidance about each topic said they had wanted some (Column 2), and for 'career pathways for people with a nurse diploma from the adult branch' this figure was 94%. The figures in Column 3 show that the proportion of the total cohort who had not received guidance and wanted some ranged from 38% to 51%. Moreover, Column 4 shows that around 80% of all respondents wanted some or more guidance about career pathways for people with a nurse diploma from the adult branch, developing a career in clinical practice, and jobs for which their skills might be most suitable.

A comparison of the data for those who received guidance and wanted more with findings from traditional qualifiers (Marsland 1996), shows, for all topics, a greater demand from the diplomate cohort. For some topics this difference is only slight (e.g. jobs for which your skills might be most suitable: 67% traditional qualifiers vs. 71% diplomates). For others, however, there is a marked difference: career pathways for people qualifying as nurses (from the adult branch) (25% traditional qualifiers vs. 79% diplomates); developing a career in clinical practice (51% vs. 75%); developing a career in nurse education (44% vs. 69%), and developing a career in nursing research (37% vs. 61%). These findings suggest that although a higher proportion of diplomates than traditional qualifiers received guidance on these topics (see Section 9.1.3), fewer of this group feel the guidance they received was adequate. The proportions of traditional qualifiers and diplomates who received no guidance about each topic and wanted some were similar, although for all topics except career pathways for people qualifying as nurses (from the adult branch), a higher proportion of traditional qualifiers than diplomates wanted guidance.

9.3 DISCUSSIONS ABOUT CAREER PLANNING

Participants were asked whether, during their nurse diploma course, they had any discussions about how they might plan their career. In particular, given the integration of nurse education with higher education, it was important to determine whether diplomates had used university based information/advisory services during the course. If respondents had had a discussion about career planning they were asked with whom; seven closed responses were offered plus an open 'other' option. If they had not had such a discussion they were asked whether they would have liked one.

Forty per cent (644) of respondents had had some discussion, during the nurse diploma course, about planning their career. The people with whom discussions were most likely to have been held were personal tutor (67%, 429) and clinical staff met during placements (59%, 383) (Table 9.7). Just 12% (76) of respondents had had a discussion with staff of a university careers information/advisory service; this accounts for 5% of the total cohort. Seventy-four respondents cited sources under the open 'other' option. These were primarily other nursing students and friends or relatives.

Table 9.7 With whom discussion had about career planning

	(n=644)	
Personnel	No.	%
Personal tutor	429	67
Clinical staff met during placements	383	59
College staff other than personal tutor and careers personnel	269	42
Staff of university careers information/advisory service	76	12
Staff of careers information/advisory service within college of nursing	64	10
Staff of trust careers information/advisory service	41	6
Staff of ENB careers advisory service	7	1
Other	74	11
Not stated	1	*

Information about the combination of sources with which diploma course students had discussions is important to determine whether particular groups of staff were providing, or being targeted by diploma course students for, guidance. For 70% (438) of those who had had a discussion about planning their career, this was with one or more of the three most frequently cited sources. All other combinations of sources (comprising 30% (196) in total) were each cited by 2% or less of respondents. Most diplomates therefore had discussions about career planning with people with whom they were in close contact

during the diploma course; i.e. college and clinical staff. Few appear to have accessed careers services run by the university, college of nursing, or trust.

Of the 923 respondents who did not have discussion about planning their career, 80% (736) wanted some (Table 9.8); this accounts for 46% of the total cohort.

Table 9.8 Discussion wanted about planning a career

Discussion wanted	No.	%
Wanted some discussion	736	80
Did not mind whether had discussion	0	-
Did not want discussion	157	17
No answer	30	3
Total	923	100

The cohort of traditional qualifiers were not asked whether they had had discussions about career planning in a format comparable to that asked of the diplomate cohort.

9.4 AWARENESS OF STRATEGIES TO INFORM CAREER PLANNING

The 1995 Department of Health publication 'Career pathways' identified three strategies which can be used by individual nurses to inform career planning: the recording of professional development activities for PREP, work shadowing, and networking. It was our original intention to ask participants whether they had used these strategies for career planning during their nurse diploma course. Pilot work indicated, however, that because many participants were not aware of the strategies, it was meaningless to pursue this exploration. The question was therefore simplified to ask participants, using three closed responses, to indicate their awareness of each of these strategies. As Table 9.9 shows, just over three-quarters of respondents (76%, 1218) thought they knew what was meant by using the record of their continuing professional development activities they maintain for PREP to inform their career planning; just 6% (89) had not heard of this strategy. Over one-third (38%, 612) had not heard of work shadowing, however, and an even greater proportion (51%, 822) had not heard of networking.

Table 9.9 Awareness of strategies for career planning

	I have heard about this strategy and think I know what it means		I have heard of this strategy but am not sure what it means		I have not heard of this strategy		No answer	
Strategies	No.	%	No.	%	No.	%	No.	%
Strategy 1 - Using the record of continuing professional development activities you maintain for PREP to inform your career planning	1218	76	272	17	89	6	18	1
Strategy 2 - Work shadowing to increase your awareness of career opportunities	624	39	339	21	612	38	22	1
Strategy 3 - Networking to broaden your career horizons and market your skills	327	20	425	27	822	51	22	1

This question on awareness of strategies for career planning was not asked of the traditional qualifiers; the 1995 Department of Health document was published after they had qualified.

9.5 CAREER GUIDANCE AND CAREER PLANNING: DIFFERENCES BETWEEN WOMEN AND MEN

Other research has suggested that men are more likely than women to have mentors generally (Jackson 1990) and in nursing specifically (Winson 1992). Analyses were therefore undertaken by sex to explore whether similar patterns exist in career guidance. For this adult branch cohort, however, no statistical difference emerged in the proportions of women and men who received guidance about any topic. Furthermore, no significant difference existed between the proportions of women and men who received guidance and wanted more. For three topics, a significantly higher proportion of women who had not received guidance wanted some than was the case for men (Appendix 9A.2). Two of these topics, 'job availability' and 'career pathways for people with a nurse diploma from the adult branch', reached significance at the level of $p<0.001$. No significant differences emerged between the proportion of men and women who recorded that they had heard of each strategy and thought they knew what it meant.

Turning to the cohort of traditional qualifiers, analysis by sex was undertaken only in relation to guidance received. Marsland (1997) reports that few differences existed between women and men in this respect. For all topics which are comparable with those

asked of diplomates, and are thus reported in this chapter, none of the differences between women and men were significant.

9.6 SUMMARY AND DISCUSSION OF KEY FINDINGS ON CAREER GUIDANCE AND PLANNING

This final section draws together the key findings on the three aspects of career guidance explored in the study: guidance received; discussions, and awareness of career planning strategies.

9.6.1. Guidance received during the diploma course

Topics relating to applying for first job

- **For all four topics on applying for a first job, the majority of respondents had received guidance**
- **Greatest overall unmet demand emerged for guidance about performing at job interviews; 62% wanted some or more**

Topics relating to continuing education

- **Whereas 66% of respondents had guidance about degrees, figures were lower for all three topics relating to National Board courses**
- **Figures both for those who had guidance and wanted more, and for those who had none and wanted some, revealed a greater unmet demand for guidance about National Board courses than about obtaining a degree**

Topics relating to career pathways

- **The proportion of respondents who received guidance varied across topics, from 53% who had guidance about career pathways for people with a nurse diploma from the adult branch, to 18% who had guidance about developing a career in nurse education**
- **Greatest overall unmet demand emerged for guidance about career pathways for people with a nurse diploma from the adult branch (84%), developing a career in clinical practice (81%), and jobs for which their particular skills might be most suitable (79%)**

The findings indicate that a substantial proportion of diplomates did not receive guidance about many aspects of career planning during their nurse diploma course. The relatively large proportion who had received guidance about obtaining a degree is indicative of the

increasing emphasis on degree level qualifications within the profession. The paucity of guidance about taking National Board courses is of concern, however, since it means that many diplomates are embarking upon their post-qualification careers without the knowledge necessary to make constructive decisions about their continuing education.

A comparison with traditional qualifiers revealed that for each topic for which comparable data was available, a slightly larger proportion of diplomates than of traditional qualifiers had received guidance. This may reflect increased awareness of the need for guidance on the part of diplomates and/or the various staff with whom they come into contact. For each topic, however, of those who had received guidance, a higher proportion of diplomates than of traditional qualifiers said that they wanted more. It appears, therefore, that although a higher proportion of diplomates than traditional qualifiers are receiving guidance, the demands of many are still largely unmet.

There is a considerable unmet demand for career guidance; lack of guidance about career planning is a concern to many diplomates, even at this early stage of their careers. The question emerges, however, of who should be responsible for career guidance. Whilst students may have an expectation that guidance should be provided for them, recent years have seen increasing emphasis on the self-direction of, and individual responsibility for, career development. It is therefore essential that, by qualification, diplomates are equipped with the knowledge, skills and attitudes necessary to enable them to manage their careers proactively. The response to the lack of guidance revealed by this research should, therefore, not necessarily be increased provision of information and advice about the topics identified, but the introduction of career development programmes enabling students to identify, access and utilize the information and advice they require. Further research into the guidance received by women and men would provide important information about the differential foci of such programmes.

9.6.2 Discussions about career planning

- **40% of respondents had had some discussion about planning their career**
- **70% of discussions were with a personal tutor, and/or other college staff and/or clinical staff**
- **Just 12% of respondents (5% of the total cohort) had had a discussion with staff of a university careers information/advisory service**
- **80% of those who did not have a discussion about career planning wanted one**

Again, these findings demonstrate a substantial unmet demand for guidance. Furthermore, the discussions which did take place were primarily with staff with whom

students routinely had contact during the course. Whilst some such staff may provide accurate guidance there is a danger that, without relevant training, information and advice provided by others may be narrow and out of date, being based on their own past experiences rather than on current healthcare developments. If such staff are to be involved in providing career guidance, strategies are necessary to ensure that the information and advice they provide is accurate and up-to-date.

It is noteworthy that so few students had discussions with university careers services. It may be that such services do not advertise themselves to nurse diploma students for fear of being unable to cope with the demand. Alternatively, students may feel that university services are unable to provide the specialist information they require and therefore prefer to discuss career issues with those more closely connected with the profession. A further factor may be the accessibility of such services. The amalgamation of colleges of nursing and integration of nurse education with higher education means that nursing students may not be based on the campus where such services are located.

9.6.3 Strategies for informing career planning

Of the three strategies identified by the Department of Health (1995)

- **Respondents were most likely to be aware of using their record of continuing professional development activities maintained for PREP (76%)**
- **Over one-third of respondents had not heard of shadowing and over a half had not heard of networking**

Given the emphasis placed on proactivity in career management in the Department of Health publication 'Career pathways', it is surprising that so few diplomates had been introduced to the three main strategies during their diploma course. This finding supports the need described in Section 9.6.1 for greater emphasis to be placed on career development programmes during the nurse diploma course.

CHAPTER 10:
SPOUSE/PARTNER AND CHILDREN: EFFECT ON DIPLOMATES' WORK AND CAREER PLANS

For many nurses combining work and family may be an important aspect of career decisions and experiences; the third aim of this research includes investigating this in the context of diplomates' careers. The potential impact of family life on work and career has two main elements: first the work and career plans of a spouse/partner and second combining work with caring for children. As discussed in Chapter 1 (Section 1.3.7), recent years have witnessed increased recognition of the impact of caring for children on working lives, and a series of documents have been produced by the Department of Health which set out policies on structuring working arrangements and career development opportunities in a way which better accommodate NHS staff with family commitments (e.g DH 1999a).

Although diplomates completed the first questionnaire before their post-qualification careers had got underway, it was important to ascertain both the proportion of diplomates who began their career with family circumstances which had the potential to affect their decisions and their views on whether this was already the case. The subject is explored in greater detail in subsequent questionnaires. Moreover, 18 months after qualification a separate questionnaire is sent to those who are taking a break for maternity leave/childcare and to all diplomates who have responsibilities for children, exploring their experiences and views about combining family life with work.

At this stage of the research, questions were as follows:

- How were priorities accorded to diplomates' own work/career plans and those of their spouse/partner? (Section 10.1)
- Were the hours diplomates chose to work influenced by their spouse/partner's level of income? (Section 10.2)
- Did a spouse/partner's work influence where diplomates lived and were their career plans affected by this location? (Section 10.3)

- How were diplomates' work/career plans affected by their own and/or their spouse/partner's children? (Section 10.4)

10.1 PRIORITIES ACCORDED TO WORK/CAREER PLANS OF SELF AND SPOUSE/PARTNER

As presented in Section 3.6, 60% (954) of respondents indicated that they had a spouse/partner[1]. These respondents were asked about the relative priorities which they and their partner gave to their respective work and career plans; Table 10.1 shows the proportion ringing each of the options offered.

Table 10.1 Priorities given to own and partner's work/career plans: women and men

	Women		Men		All respondents	
Allocation of priorities	No.	%	No.	%	No.	%
We give equal priority to our own and each other's work/career plans	641	73	46	65	687	72
We have decided that his/her work/career plans take priority over mine	30	3	1	1	31	3
We have decided that my work/career plans take priority over his/hers	36	4	11	16	47	5
We consider our work/career plans independently from each other	171	19	13	18	184	19
No answer	5	1	0	-	5	1
Total	884†	100	70†	100	954	100

† See note about weighting on p35

Giving equal priority to each other's work/career plans was the most frequent response for both women and men and the difference was not significant. Men were significantly more likely than women to indicate that their own work/career plans took priority over their partner's (16% vs. 4% $p<0.001$).

10.2 EFFECT OF PARTNER'S INCOME ON HOURS DIPLOMATES WILL WORK

Table 10.2 shows the effect of partner's income on the hours respondents chose to work.

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[1] Hereafter, for readability the term 'partner' is used to refer to spouse/partner.

Table 10.2 Effect of partner's income on hours diplomates chose to work: women and men

Effect on hours chose to work		Women		Men		All respondents	
		No.	%	No.	%	No.	%
1	His/her level of income means I could choose not to work	54	6	0	-	54	6
2	His/her level of income means I could choose to work part-time rather than full-time	192	22	15	21	207	22
3	His/her level of income (or lack of income) means I have to work full-time	181	21	22	31	203	21
4	His/her level of income (or lack of income) means I have to work at least part-time	74	8	5	7	79	8
5	His/her level of income has no effect on the number of hours I work	375	42	28	39	403	42
No answer		8	1	1	1	9	1
Total		884	100	70†	100	954†	100

† See note about weighting on p35

The most frequent response was 'his/her level of income has no effect on the number of hours I work' (42%, 403). A total of 27% (261) of respondents had a partner of sufficient means that they could choose either to work part-time or not at all (options 1 and 2). Men were significantly more likely than women to state that their partner's level of income meant that they had to work full-time (31% vs. 21% $p<0.05$) whereas women were more likely to say that their partner's income meant that they could chose not to work (6% vs. 0% $p<0.05$).

10.3 INFLUENCE OF LOCATION OF PARTNER'S WORK

Respondents were asked whether the decision to live in their current location was influenced by the location of their partner's work; the majority said it was not (Table 10.3). Women and men did not differ significantly in this respect.

Table 10.3 Influence of partner's location of work on decision where to live: women and men

	Women		Men		All respondents	
Influence	No.	%	No.	%	No.	%
Location did influence decision	332	38	24	35	357	37
Location did not influence decision	545	62	43	62	588	62
No answer	8	1	2	3	10	1
Total	854†	100	70†	100	954†	100

† See note about weighting on p35

The 357 respondents shown in Table 10.3 who indicated that their geographical location was influenced by their partner's work were then asked whether living in this location affected their own work/career plans. Just over two-thirds (67%, 240) said that their plans were not affected; women and men did not differ significantly in this respect. Those who said that their plans were affected (109 women and 7 men) were asked in which of the ways listed in Table 10.4 the effect was manifest. 'Limits choice of job' was the effect indicated most frequently (69%, 80).

Table 10.4 Effects of living in current location on work/career plans: women and men

	Women (n=109)		Men (n=7)	All respondents (n=116)	
Effect of location	No.	%	No.	No.	%
Limits choice of job	75	69	5	80	69
Can't have a job in specialty of choice	10	9	0	10	9
Not able to take course I want to	4	4	0	4	3
Delay in starting course	2	2	0	2	2
Other	29	27	2	31	27

10.4 EFFECT OF CHILDREN ON WORK/CAREER PLANS

As detailed in Section 3.7, 23% (374) of respondents had children (either their own and/or those of a partner) living with them.

These 374 respondents were asked whether these children had any effect on their work/career plans. Forty-five per cent (170) indicated that this was the case. A higher proportion of women than men indicated that their work/career plans were affected by children living with them (46%, 162 vs. 29%, 8) although this difference was not

significant. These respondents were then asked to indicate what the effects were by ringing the options shown in Table 10.5.

Table 10.5 Effects on work/career plans of children living with respondent: women and men

Effects on work/career plans	Women (n=162)		Men (n=8)	All respondents (n=170)	
	No.	%	No.	No.	%
My geographical mobility is limited because I do not want child(ren) to have to move	81	50	5	86	51
My income needs to be sufficient to pay for childcare costs	55	34	2	58	34
I need work patterns which are compatible with my childcare arrangements	47	29	2	49	29
Will only work part-time until child(ren) are of a certain age	31	19	0	31	18
Will not work at all until child(ren) are of a certain age	4	2	0	4	2
I need a job that has crèche facilities	2	1	0	2	1
Other	29	18	4	32	19

The effect cited most frequently was that their geographical mobility was limited because they did not want child(ren) to have to move (51%, 86).

Eight per cent (130) of respondents had children (or children of a partner) who did not live with them. These respondents were asked whether or not these children affected their work/career plans and, if so, how. Just 16 women and five men indicated that these children did affect their work/career plans; Table 10.6 shows the options which they ringed.

Table 10.6 Effects on work/career plans of children not living with respondent: women and men

Effects on work/career plans	Women (n=16) No.	Men (n=5) No.	All respondents (n=21) No.
Geographical mobility limited - I want to remain near child(ren)	7	4	11
My income needs to be sufficient to pay maintenance	5	4	9
Geographical mobility limited - partner wants to remain near children	4	0	4
Other	4	1	5

10.5 SUMMARY AND DISCUSSION OF KEY FINDINGS ON PARTNER AND CHILDREN

Here the main findings are summarized and compared with those for traditional qualifiers.

Partner

- **The majority (73%) said that they and their partner gave equal priority to each other's work/career plans**
- **42% said their partner's income had no effect on the number of hours they worked, but 22% said that their partner's income meant that they could choose to work part-time rather than full-time, and 6% that it meant that they could choose not to work at all**
- **62% said the decision to live in their current location was not influenced by the location of their partner's work. Of those who said this decision was thus influenced, the majority (67%) said it did not affect their own plans. Of those whose plans were affected, limiting job choice was cited most frequently**

Children

- **Just under half (45%) of the 23% who had children living with them said they had an effect on their plans; this was most likely a limit on geographical mobility, followed by needing sufficient income to pay for childcare costs**
- **16% of the 8% who had children (or children of partner) who did not live with them, said these children had an effect on their plans; these included restrictions on geographical mobility and needing sufficient income to pay maintenance**

Differences between women and men

- **Men were more likely than women to indicate that their career plans took priority over those of their partner. Men were more likely than women to say that they had to work full-time because of partner's level (or lack of income), whereas women were more likely than men to say their partner's income meant that they could chose not to work**

At this early stage, the majority of the diplomates said that they and their partner gave equal priority to each other's plans. Some constraints caused by partner's work emerged, however, these related to restricted geographical mobility, restricted job choice and the need for a certain level of income. A greater proportion of those with children living with them than those with a partner indicated that this affected their work/career plans. Similar findings on the effect of partner reported here for diplomates, emerged for traditional qualifiers (Robinson *et al*. 1995). Traditional qualifiers were most likely to say that their partner's work or future plans had little or no effect on them (46%) and/or that mutual support was offered so that both could attain their goals (11%). Restricted geographical mobility was the constraint on work or future plans most likely to be cited by traditional qualifiers. The traditional qualifiers were not asked at qualification about the effect of children on their plans.

While potential familial constraints are, at qualification, only relevant to a small number of diplomates, it is likely that this number will increase. Subsequent questionnaires will document whether, and how, these potential constraints affect careers over time, and the extent to which differences emerge between women and men in these respects.

CHAPTER 11: POLICY IMPLICATIONS OF KEY FINDINGS

For each of the aims of the research, this last chapter brings together the key findings and discusses their policy implications. These policy implications are considered in terms of those which have immediate relevance i.e. for adult branch diplomates up to the point of qualification and those which are relevant to later stages of their careers. Chapter sections are as follows:

Diversity of diplomates (Section 11.1)
Career plans and pathways (Section 11.2)
Continuing professional development (Section 11.3)
Career guidance (Section 11.4)
Aspects of nurses' roles in the delivery of care (Section 11.5)
Combining work and family (Section 11.6)
Associations with anticipated retention (Section 11.7)
Choice and constraint (Section 11.8)

11.1 DIVERSITY OF DIPLOMATES

The first aim of the research is to ascertain the diversity within the diploma qualified adult nursing workforce in terms of demographic characteristics, previous education and work experience, and routes into nursing and the adult branch.

11.1.1 Policy relevance of researching diversity

Policies to increase diversity in nursing had been advocated by the UKCC in its 1986 Project 2000 proposals and this was subsequently re-affirmed by the UKCC and the Department of Health (UKCC 1999a, DH 1999a). These policies had referred to nursing as a whole, however, and not to its separate branches. This first phase of the research demonstrated the diversity which existed within the adult diploma qualified nursing workforce at qualification and the extent to which this differed in some aspects from traditional qualifiers.

11.1.2 Key findings on diversity at qualification

The adult cohort encompassed a diversity of demographic characteristics, personal circumstances, previous educational and work history, and routes into nursing. Comparisons with those qualifying from traditional courses (Robinson *et al* 1995) indicated the following: no change in the proportion of men, a small increase in the proportion of those from the Black and Asian communities, an increase in the proportion of those aged 30 or over, a slight decrease in the proportion of those entering with two or more A' levels, a slight increase in the proportion entering with a degree and an increase in those entering without formal academic qualifications.

Diversity also emerged in the cohort's decision making routes to nursing and to the adult branch. At the time they were completing secondary education, a nursing course was first choice for one half, but 23% opted for something different and 25% were unsure about nursing at that time. Some had made the decision while at school, others while working in another occupation or studying for another subject, and others while raising a family. While 74% had selected the adult branch prior to the CFP and had not wanted to change, 13% had wanted to do so, but most subsequently decided not to do so. Four percent had selected another branch prior to the CFP but had subsequently changed to the adult branch.

11.1.3 Immediate policy implications of findings on diversity

Recruitment strategies need to be targeted widely and not just at those nearing completion of secondary education, if the diversity of background which currently exists in the adult nursing workforce at qualification is to be maintained and perhaps increased.

While findings reported here relate to course qualifiers and not course entrants, it is suggested that to further increase diversity, greater emphasis needs to be placed on recruitment of men and members of ethnic minority groups. Careers services should play an increased role in bringing nursing to the attention of these groups. As many such potential recruits may not be in a position to access careers services, however, national and local advertising campaigns should also be regularly deployed. It is also important to ascertain whether members of these groups who do start the course are as likely as others to complete it, since if not, the potential for diversity will not be realized.

11.1.4 Policy implications of findings on diversity for later career stages

This first phase of the research demonstrated the diversity of the cohort at qualification. These findings provide a baseline for:

i) Demonstrating the extent to which the diversity which existed at qualification is maintained among those who remain in the adult nursing workforce as a whole and profiling the workforce in different employing organizations, settings and clinical specialties.

ii) Indicating the subgroups at which retention strategies should be targeted if diversity is to be retained in the workforce as a whole and in the organizations, settings and clinical specialties in which it is deployed.

In due course, the findings from this research will provide a baseline for comparing the diversity amongst the qualifiers from the adult branch of the revised diploma course which started in autumn 2000.

11.2 CAREER PATHWAYS

The second aim of the research is to describe diplomates' career plans and pathways from qualification onwards in relation to: retention in nursing; directions pursued within nursing, and career progression.

11.2.1 Policy relevance of researching career pathways

The need to improve retention of qualified nursing staff was highlighted by the UKCC in its 1986 Project 2000 proposals and is a major objective of the current administration's plans for the health service (DH 1997a, 1999a, 2000c). Concern exists, however, not only about retention overall but also about shortages of staff in certain services. This research demonstrates plans and pathways of adult branch diplomates in relation to remaining in nursing overall and directions pursued in terms of employing organizations, hospital and community settings and clinical specialties. This first phase describes plans at qualification and immediate pathways pursued.

11.2.2 Key findings from the at qualification phase on career plans and pathways

Nursing in the UK

At qualification the majority (95%) of adult branch nurses planned to obtain a nursing job, 91% of whom had already done so. Less than 1% of the cohort did not plan to obtain a nursing job at any stage. Future plans of the cohort revealed an orientation to continue working in nursing in the UK and there was no sense of early attrition from the profession.

Employing organizations

There was an early orientation towards the NHS in that the majority (98%) had obtained their first job in the NHS and it was the organization most likely to be specified for jobs diplomates hoped to hold at 18 months and three years after qualification. The increasing involvement of other organisations in the provision of care was, however, reflected in the plans and early pathways of some members of the cohort. Thus half said that they would not mind working in organizations other than the NHS. The private sector was the non-NHS sector most likely to feature in diplomates' first job, the private sector, charities and the Armed Forces in jobs diplomates hoped to hold at subsequent time-points.

Setting

Although most diplomates (97%) had obtained a first job in hospital, the increasing provision of care in the community was reflected in the small proportion who had a first job in one or more community settings. Views about feeling inadequately prepared to work in the community and/or preferring to consolidate experience elsewhere first, were much more marked in relation to visiting people at home than to either residential settings or settings which people visit such as GP's surgeries..

Clinical specialties

For each clinical specialty of which diplomates had experience during the course, then with the exception of, outpatients, theatres and care of elderly people, these experiences were more likely to have encouraged, than discouraged, diplomates from considering working in the area in the future. Although diplomates' first jobs encompassed a wide range of clinical specialties, the clinical specialty was most likely to be general medicine (33%), followed by general surgery (22%), care of elderly people (16%) and cardiac (12%). Diplomates who had not been able to obtain their first job in their preferred clinical specialty; were more likely than those who had been able to do so to plan moving onto a second job in a different clinical specialty in six months or less. Looking ahead to 18 months and three years after qualification, the main point to emerge was lack of certainty about the clinical specialty in which diplomates hoped to be working.

11.2.3 Immediate policy implications of findings on career pathways

With regard to working in community settings in the early post qualification period, then it is visiting people at home for which diplomates are most likely to need the support of an experienced community practitioner. The other findings on career pathways provide a context for the interpretation of findings for later career stages (11.2.4).

11.2.4 Policy implications of findings on career pathways for later career stages

Later phases of the research each describe diplomates' pathways in relation to staying in nursing, working in different employing organisations, settings, clinical specialties, and their reasons for the particular directions which they pursue. Over time, therefore, the research is building up a much more comprehensive picture of the adult nursing workforce than has existed hitherto. The importance of the at qualification findings is in providing a baseline against which subsequent events can be compared. Little sense of likely attrition from nursing was evident from plans diplomates expressed at qualification. Later phases will show whether those diplomates who planned to stay in nursing do in fact do so, and if not what caused a change of mind. Pathways which diplomates wanted to follow but are unable to do so will be identified; investigation of reasons for this occurring may contribute to the development of strategies to improve staffing levels in services which have staffing problems. It will also show whether there are clinical specialties in which few diplomates wish to work, and whether diplomates wish to obtain jobs in certain areas but find them difficult to obtain.

11.3. CONTINUING PROFESSIONAL DEVELOPMENT

The third aim of the project is to investigate subjects relevant to diplomates' careers: continuing professional development; career guidance; aspects of nurses' roles; combining work and family, and quality of working life. Aspects of the first four were included in this first phase of the research.

11.3.1 Policy relevance of researching continuing professional development

The importance of continuing professional development for nurses featured strongly in the Project 2000 proposals and this view has been reiterated in subsequent policy documents produced by the statutory and professional bodies for nursing and by central government (chapter 1 section 1.3.3). These documents have identified, with varying degrees of emphasis, the role of CPD in individual career progress and retention, enhancing the quality of patient care, and meeting service needs. While aware of debates about whether CPD does enhance the quality of patient care, this research investigated

diplomates' satisfaction with some aspects of CPD and its relevance to their career plans and pathways. The first phase focused on expectations of preceptorship, heralded as a means of supporting newly qualified nurses in the transition from student to practitioner. Plans to take courses were also investigated in order to assess how much demand, and for which courses, there was likely to be at this early stage and the way in which courses featured in diplomates' career plans.

11.3.2 Key findings on expectations of preceptorship and plans to take courses

There was a very substantial demand for a period of preceptorship after qualification, with 97% of adult branch diplomates wanting to have a preceptor in their first job. This research advanced what is known about preceptorship by investigating the subject in terms of its constituent elements rather than as an undifferentiated whole. Aspects of preceptorship most frequently rated as very important were those concerned with feedback on clinical skills (91%), teaching of new clinical skills (83%) and confidence building (63%).

Sixty seven per cent planned to obtain a degree, 76% of whom saw this as a means of improving their career in nursing. Just under a fifth (18%) planned to start a degree six months or less after qualifying. Only 4% planned to qualify for another branch, most likely child, although as with degrees the planned start date was likely to be longer than six months after qualifying. Eighteen per cent planned to qualify as a district nurse, 10% as a midwife and 2% as a health visitor. Sixteen per cent had applied, or planned to apply, during the first six months for courses other than degrees or other branches. ENB Course 998 (Teaching and assessing in clinical practice) was mentioned most often; by 11% of the cohort as a whole. Reasons for wanting to attend courses reflected individual career development and improving the quality of patient care.

11.3.3 Immediate policy implications of findings on continuing professional development

Employers should ensure that all newly qualified adult nurses are allocated a preceptor, given the demand which exists for having this form of support in the early post-qualification period. This in turn will need supporting by the provision of training programmes to equip sufficient numbers of staff for the role of preceptor. Such programmes should include consideration of the separate elements of preceptorship identified for this research. Preceptors should ascertain the expectations held by their preceptees in order to appropriately focus the preceptorship which they provide. These recommendations have time implications for clinical staff, both in providing preceptorship and attending courses on being a preceptor. Clinical staff, however, are

already heavily committed with service delivery and supporting pre-registration students on clinical placements. Provision of preceptorship may well, as hoped, prove important for quality of care and retention of staff. Consequently workforce planners need to ensure that sufficient staff are available so that workloads can encompass provision of preceptorship. While this may increase costs in the short term, these may be outweighed by longer term benefits.

11.3.4 Policy implications of findings on continuing professional development for later career stages

The findings on preceptorship provide a baseline of expectations against which subsequent experiences during the first six months can be compared.

The next phase of the research investigates whether plans expressed at qualification to start degrees, other branches, and other courses in six months or less have been realised. Reasons given for not having started courses within this time scale indicate whether this was due to a change of plan on the part of the diplomate or to barriers such as lack of places, funding and study leave and lack of support by the diplomate's manager for attending the course in question.

11.4 CAREER GUIDANCE

The third aim of the research includes investigating career guidance

11.4.1 Policy relevance of researching career guidance

Although not specifically mentioned in the Project 2000 proposals, it has been maintained in various policy documents that career guidance facilitates career development and planning, and thereby contributes to improved retention (chapter 1 section 1.3.4). Career guidance is investigated throughout the course of the research; this first phase focused on guidance during the nurse diploma course.

11.4.2 Key findings on career guidance during the nurse diploma course

In relation to eleven aspects of guidance, information was obtained on whether diplomates had received information and advice; if so had they wanted more, and if not had they wanted some. In relation to continuing education, there was much greater unmet demand for information about National Board Courses than for degrees. For career pathways, unmet demand was greatest for information about career pathways for people who had qualified from the adult branch, jobs for which the individual's particular skills might be most suited, and developing a career in clinical practice. Less than half (44%) had had a discussion about planning their career, most likely with a personal tutor and/ or

clinical staff met during placements. The majority (80%) of those who had not had a discussion would have liked one. Findings on knowledge about strategies to inform career planning, showed that while 76% thought they knew about using PREP in this context, fewer thought they knew about work shadowing (39%) and networking (20%).

11.4.3 Immediate policy implications of findings on career guidance

Even at this early stage of their careers, students are wanting career guidance and many had unmet demands in this respect at the point of qualification. While students may have an expectation that guidance should be provided for them, recent years have seen increasing emphasis on the self-direction of, and individual responsibility for, career development. It is suggested, therefore, that by qualification students should be becoming equipped with the knowledge, skills and attitudes necessary to help them manage their careers proactively. Consideration needs to be given as to how, and by whom, career development programmes are introduced into the diploma course.

11.4.4 Policy implications of findings on career guidance for later career stages

The relationship of guidance received during the course to subsequent plans and events is complex and not uni-directional (Murrells and Robinson 1997) and we would not maintain that guidance received during the course necessarily has an influence on subsequent careers followed and patterns of retention. Career guidance is investigated at each later phase of the research.

11.5 ASPECTS OF NURSES' ROLES IN THE DELIVERY OF CARE

The third aim of the research includes investigating aspects of nurses' roles in the delivery of care which may be relevant to their career decisions.

11.5.1 Policy relevance of researching aspects of nurses' roles in the delivery of care

The Project 2000 proposals had envisaged that the practitioner of the future would be someone who gives as well as supervises care and would be willing to change practice (UKCC 1986). As noted in chapter 1 (section 1.3.5), there was much subsequent discussion, in the context of the skill-mix debate, about the role of the registered nurse in relation to that of the healthcare assistant. The amount of time spent in giving direct care, and willingness and ability to change practice, is likely to vary at different stages in diplomates' careers and may be related to decisions about staying in particular jobs and opting for certain pathways.

11.5.2 Key findings from the at qualification phase on nurses' roles in the delivery of care

This first phase of the research showed that wanting an occupation which involved caring for people was cited by 71% of diplomates as very important in their decision to start the course, with a further 25% stating that this was quite important.

11.5.3 Policy relevance of findings for later career stages

Subsequent stages of the research investigate the proportion of time which diplomates spend on direct patient care, whether they perceive themselves to be spending too little or too much time on aspects of direct patient care, and if so why this is. For each job held diplomates are asked whether dissatisfaction with the amount of time spent on direct patient care led to a decision to leave the job. Later stages of the research also investigate the extent to which diplomates are able to fulfil the other Project 2000 objective concerning their role in care-giving; namely acting as an agent of change.

11.6 COMBINING WORK AND FAMILY

The third aim of the project includes investigating diplomates' experiences of combining work and family.

11.6.1 Policy relevance of researching combining work and family.

In its Project 2000 proposals, the UKCC had emphasized the importance of support facilities for those with family commitments as a means of improving rates of retention in, and return to, nursing. As noted in chapter 1 section 1.3.7, the provision of family-friendly policies is high on the current policy agenda as a means of improving the quality of working lives of the workforce and as an aid to retention. By investigating diplomates experiences' in these respects from qualification onwards, this research will be able to demonstrate the extent to which plans about combining work and family are facilitated, thwarted or changed.

11.6.2 Key findings from the 'at qualification' phase on combining work and family

This first phase of the research indicated the extent to which some diplomates' career/work plans were affected by family circumstances. Thus 11% said that they had children living with them who had an effect on their work/career plans and 1% said that this was the case in relation to children who did not live with them (either their own or those of a spouse/partner). For both groups, restricted geographical mobility and the need for a certain level of income were the main effects described. 28% had a partner whose level of income meant that they could chose to work part-time or not at all, whereas 29 %

said that their partner's level, or lack, of income meant that they had to work full-time or at least part-time. 5% said that having to live in a particular location because of their partner's job meant that their own choice of job was limited.

11.6.3 Policy implications of findings on combining work and family

These findings indicate that when employers are considering ways of supporting those with family commitments, they should not overlook that this may be needed by some of those at the very start of their career.

11.7 ASSOCIATION OF PROFILE VARIABLES WITH ANTICIPATED LIKELIHOOD OF STAYING IN NURSING

The fourth aim of the project is to identify relationships between career plans, careers followed, and profile and experience variables.

11.7.1 Policy relevance of researching association with retention

Increasing diversity of entrants, improving the quality of working life, and providing opportunities for continuing professional development and career progress have all been advocated as strategies to improve retention in nursing. This research investigates these associations for nurses qualifying from the diploma course in order to identify those strategies most likely to improve retention. This first phase investigated the relationship between profile variables and anticipated likelihood of remaining in nursing.

11.7.2 Key findings on association with retention

Anticipated likelihood of working in nursing was investigated for five and ten years after qualification. At both time-points those who older at qualification were the most likely to anticipate being in UK nursing. At the five year time-point there was an association for the youngest and oldest age groups between anticipating being in nursing and having entered without formal academic qualifications. At the ten year time-point nurses from the Republic of Ireland were less likely to anticipate being in nursing than those from other ethnic groups.

11.7.3 Policy implications of findings on association with retention

Later phases of the research will show whether these early predictors are borne out in practice.

11.8 CHOICE AND CONSTRAINT

Considering the findings as a whole, this section considers the extent to which choice and constraint emerged at this first stage of adult diplomates' careers. The majority of those

who planned to obtain a nursing job had done so and obtained one in their first choice of clinical specialty. Choice of career direction was often not finalised at this early stage and many diplomates answered 'do not know' or 'unable to say at this stage' to a range of questions about career plans: e.g. grade, clinical specialty and taking courses. At the point of qualification it cannot be assumed that adult branch diplomates will have had the necessary exposure or indeed experience to make decisions about planning/constructing a career. It is probable at this early stage diplomates are more concerned with settling into the work environment and consolidating skills acquired during the course and that career plans develop over time. Later phases of the research investigate whether plans become more certain, but also allow for the expression of uncertainty.

As shown in section 11.6, choice and constraint also emerged in relation to aspects of family circumstances: some diplomates said work and career plans were affected by children; some had a partner whose level of income meant that they had a choice over the hours they themselves would have to work, whereas for others the reverse was the case.

11.9 CONCLUSION

This first phase of the research has provided a range of information about adult nurses. As this chapter has shown, the findings have a number of immediate policy implications relating to diplomates up to the point of qualification and also provide a baseline against which subsequent events can be compared. The value of a longitudinal design in the investigation of diplomates' careers is that their plans have been obtained near the time when formulated, rather than being subject to subsequent recall. Later phases of the research demonstrate how adult branch diplomates' careers progress, the changes and developments in their employment and continuing education plans, and their experiences of, and satisfaction with, working in nursing/healthcare.