The influence of political economy on registered nurses' post-registration development in the English NHS

Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy

December, 2024

Nicola Mercedes Fisher, RN, BSc (Hons), LLM, MSc

Nottingham University Business School, Faculty of Social Science

University of Nottingham

Dedication

To my 8-year-old self, who was told she may get GCSEs, probably not A levels, and would certainly never go to university. That she may make a good mother, and that would be it

This is for you.

I rise, I rise, I rise

Maya Angelou, And still I rise

Abstract

Registered nurses are the largest safety-critical profession in healthcare, and their post-registration development is essential for staff retention and high-quality patient care and safety. Despite this, nurses' post-registration is limited, fragmented, and lacking in transparency. With an increasing national drive and focus in policy on enhancing patient care, safety, quality, and staff retention, exploring why nurses' post-registration development is underdeveloped is essential for securing the future prospects of the health service.

This thesis is grounded in the sociology of the professions, focusing on considering nurses' market shelter strengthening through the lens of political economy. The theoretical core of this PhD uses Light's (1991, 1995, 2010) countervailing powers framework to consider the relationship between the state and the nursing profession. Consequently, the research question was: *'Why has nursing in England not established a stronger market shelter through post-registration development and career frameworks, despite post-Fordist reforms?'.* To enable the exploration of the research question, a qualitative research project was utilised, using a multi-method, multi-level research design incorporating NHS policy document analysis (n49) from 1989-2020, followed by semi-structured interviews over three levels. Macro (n9): individuals in national-level organisations that are influenced by or influence policy. Meso (n11): organisational leads, such as Chief Nurses. Micro (n27): registered nurses working in education, management, research and clinical areas.

The findings are presented in a chapter for each level of analysis. The policy document analysis highlights the role of clinical governance and the 'Agenda for Change' NHS workforce policy, workforce planning and data and the instability of healthcare governance and policy. The macro analysis considers the challenges with Agenda for Change, data and government, and the short termism and instability of politics and policy. The meso analysis considers the role of organisational governance, networks and partnership working and clinical governance and data. Finally, the micro analysis considers training and development as a 'luxury' item, the role of middle management and the overall impact of the lack of post-registration development on nurses.

The research question is answered through three core themes from the overall analysis, which are threaded throughout the different levels: first, the instability of healthcare policy; second, the lack of appropriate data and economic analysis; and finally, the juridification of practice. The overall implication from the analysis frames nurses' post-registration development as a 'wicked problem'.

The potential future research from this thesis includes exploring the view of healthcare as a safety-critical industry and implications for workforce development, system-wide considerations of labour economics and workforce planning, and finally the 'situated wickedness' of clinical governance in relation to nursing workforce policy and management.

Theoretically, this thesis provides an enhanced consideration of the state-profession relationship, including state actors and multi-level and multi-centric governance. Furthermore, it provides insight into the importance of stability in state projects, a focus on the economic within the 'market' and the increasing role of state-mandated legal mechanisms on professional practice. Critically, this PhD provides the development of a greater practice-theory perspective on professional development. Conceptually, this PhD indicates the importance and the role of workforce planning in relation to workforce development. Furthermore, how the healthcare industry is viewed as service or safety is explicitly linked to workforce development. Adjoining this is a greater emphasis on the role of data and economics, including how data is used to help a profession negotiate with various levels of power within a system.

Associated publications and conference presentations

Associated publications

From the Masers in Research component of the Economic and Social Research Council PhD scholarship that supported and funded this thesis:

Fisher, N. Bramley, L. Cooper, J. Field-Richards, S. Lymn, J. and Timmons, S. (2022) A qualitative study exploring the influence of a talent management initiative on registered nurses' retention intentions. *Journal of Nursing Management*, 30(8), pp. 4472-4479.

Forthcoming presentation and paper

Center for British Studies, University of California, Berkeley, 'Decentering the governance of public professionals: competing narratives, situated dilemmas, (re)making traditions', 7th November 2025. Invited speaker - 'The practice of nursing workforce planning – issues of situated wickedness and decentred governance'

Conference presentations

British Sociological Association Medical Sociology, London Study Group event 'Working at the intersection of medicine and social sciences', October 2024. Invited panel member and oral presentation – 'Researching and existing in the spaces in-between'

Post-crisis Professionalism Conference, University of Birmingham, June 2024. Oral presentation – 'Chronic policy change and nurses' market shelter development: a consideration of the Multiple Steams Approach and policy window sequencing'

University of Nottingham, University of Birmingham and Erasmus University 'Politics and Professionalism' workshop, University of Nottingham, April 2023. Oral presentation – 'Political economy and nurses' post-registration development in the English NHS: An exploration of Agenda for Change'

Nottingham University Business School Centre for Health Innovation, Leadership and Learning and the International Centre for Corporate of Social Responsibility 'Sustainable Healthcare Symposium', November 2022. Expert panel member - 'Sustainability, healthcare professions and work'

Royal College of Nursing International Research Conference, September 2021. Oral presentation – Workforce theme: 'NHS policy and nurses' post-registration development: considerations of data availability and generation'

AdvanceHE NET, September 2021. Theme paper presentation - Key challenge in healthcare education: 'NHS policy and nurses' post-registration development: considerations of data availability and generation'

British Sociological Association Work, Employment and Society Conference, August 2021. Oral presentation – Professions, occupations, skills, career and self-employment theme: 'Countervailing powers, the professions and development: a healthcare perspective'

University of Nottingham Taiwan Studies Programme and Taipei Medical University Joint Conference, June 2021. 'Public Policy in A Time of Crisis: Comparing British and Taiwanese government responses to Covid 19' Panel member presentation - 'Front-line workers researching front-line workers: Navigating the insider-outsider narrative in a pandemic. A nurse's experience'

Acknowledgements

No duty is more urgent than that of returning thanks

James Allen

I would like to take this opportunity to thank those who have helped me along the journey to completing this PhD. Without them, this would not have been possible.

First and foremost, I am immensely grateful to Professor Stephen Timmons, Professor Joanne Lymn, and Dr Sarah Field-Richards. I could not have asked for or had a better supervisory team. Thank-you for your guidance, mentorship and unwavering forbearance with my Alice in Wonderland deep dives into copious varieties and amounts of ideas and arguments. You have enabled me to develop as a researcher, professionally and personally, and your supervision has given me the blueprint and benchmark for how supervision should be. Jo, thank-you for making me realise back in my undergraduate nurse training that a PhD was even an option for me. Your advice and support have been transformative and invaluable ever since.

Next, thank you to the Economic and Social Research Council (ESRC), Midlands Graduate School ESRC Doctoral Training Partnership (DTP), and the Nottingham ESRC DTP for the funding and incredible opportunity to undertake this PhD. It was a life-changing experience.

Fundamentally, thank you to all the participants who gave their time, insights, and opinions. This thesis would not have been possible without your willingness to talk openly and honestly with me. I will be forever in your debt, especially amid a global pandemic when health services and all those who worked in them were under immense and life-altering pressure.

I also want to extend my utmost gratitude to the following people, who gave their mentorship, time, and insights throughout this PhD, which helped me formulate my thinking, analysis and arguments. I will always be grateful for your willingness to say yes to cold call Twitter(X), LinkedIn and email messages seeking help and guidance. Some of these people also supported me during placements, offering insight into their professional experiences, which helped me succeed. The list is alphabetical by

surname: Professor Davina Allen, John Appleby, Professor Carol Atkinson, Professor Jane Ball, Dr Simon Bishop, Professor James Buchan, Professor Paul Cairney, Professor Anita Charlesworth, Professor John Coggon, Professor Charlotte Croft, Dr Amanda Crompton, Dame Professor Jane Dacre, Professor Robert Dingwall, Professor Mark Exworthy, Sir Robert Francis, Professor Alison Leary, Professor Shereen Hussein, Professor Jill Manthorpe, Derek Marshall, Dr Elaine Maxwell, Professor Stephen Peckham, Sharon Saunders, Yohanna Sallberg, Rob Smith, Professor Keith Syrett, and Professor Justin Waring.

To the B26 'cave' group and my peers within Nottingham University Business School and the Nottingham ESRC DTP cohort that I was a part of, you were an indispensable source of encouragement. While we were all on different timelines, with varying experiences, pandemic challenges, projects, and ambitions, being on this journey with you has made my PhD experience even richer.

Unusually, but essentially, to the Peak District National Park. My footprints are all over your hills, gritstone edges, fields and moors, which I utilised as a thinking ground and as an escape from my desk. I contrived numerous ideas and arguments and assimilated vast quantities of literature and data in your presence. Your ability to take me from confused, agitated and stressed to disentangled and at peace is second to none.

And finally, but cardinal to this entire feat, to my family and friends, who have stood by me and championed me throughout. There are no words to do justice to how much I value your support and patience. While I am aware that my level of reserve and quiet during this PhD was, at times, unnerving, you were always with me in times of solitude. I would like to express my sincerest gratitude for your unwavering belief in me, even at times when I could not fathom it for myself.

Contents page

Chapter 1: Introduction

1.1 Introduction

This chapter focuses on nurses' post-registration development in the English NHS.[1] The term post-registration considers the development in the period once a nurse has qualified as a registered member of the profession. This chapter first considers the nursing profession in numbers before providing an overview of the current situation with nurses' post-registration development and then the challenges associated with it. Subsequently, this section will then lay out the thesis aims and objectives. An overview of each chapter will then follow, covering the literature review, methodology, findings, discussion, implications of this research and the conclusion. Finally, this chapter will conclude with a reflection on why this topic was chosen.

1.2 Nursing – what the numbers tell us.

Within the UK, nurses are the largest registered healthcare profession and constitute approximately 44% of all registered healthcare staff (Karas, Sheen and North *et al,* 2020). According to the latest figures, 765,051 registered nurses are on the Nursing and Midwifery Council (NMC)[2] register in the UK; in England, there are 582,258 (NMC, 2024a, 2024b). If compared with medicine, there are 296,182 licensed doctors in the UK; in England, there are 242,908 (General Medical Council [GMC], 2023).[3] In relation to some of the allied health professions, the latest figures indicate that there are 74,551 physiotherapists, 39,362 paramedics and 47,897 radiographers (Health and Care Professions Council, 2024).[4]

The National Health Service (NHS) is the main provider of healthcare services in the UK. The latest figures state that 356,872 registered nurses work in the NHS in England

[1] For clarity, the title nurse is not protected under UK legislation, meaning anyone can call themselves a nurse and would not be breaking the law. However, throughout this thesis, when nurse, nurses, or nursing is mentioned, it refers to registered nurses. Registered nurse is a legally protected title under UK law and refers to the registered profession.

[2] The regulatory body for nurses in the UK

[3] The regulatory body for doctors in the UK

[4] The regulatory body for 15 allied health professions in the UK

(NHS England, 2024a).[5] While this thesis focuses on nurses within the NHS, it is important to highlight that in the UK and England, not all nurses work in the NHS. Registered nurses work across various sectors, including private healthcare, schools, prisons, other community settings, and the military. While some of these entities may include NHS services, for example, some prison healthcare is NHS-managed, not all nurses in England work in the NHS. Despite this, a significant proportion of nurses work in the NHS, and as the main healthcare system in England, it is thus the focus of this thesis.

Registered nurses are the largest safety-critical profession in healthcare. The association between the number of registered nurses and patient safety is well established. A higher ratio of registered nurses to patients reduces patient mortality (Aiken, Sloane and Bruyneel *et al*, 2014. Aiken, Sloane and Griffiths *et al*, 2017. Ball, Bruyneel and Aiken *et al*, 2018. Rafferty, Clarke and Coles *et al,* 2007). An additional patient per nurse is associated with a 5% increase in the odds of patient death (Cho, Sloane and Kim *et al,* 2015). Furthermore, Aiken, Cimiotti and Sloane *et al* (2011) found that 10% more degree-trained nurses in a clinical area decreased the odds of patient deaths by 4%.[6] Later research takes the percentage decrease in patient mortality to 9% (Cho *et al,* 2015). Minimum nurse-to-patient ratios have been shown to improve nurse staffing and patient outcomes, including reductions in readmissions and patient mortality, with a good return on investment (McHugh, Aiken and Sloane *et al,* 2021).

Despite the numerical size of the nursing profession compared to other professions, there are increasing concerns about the number of registered nurses in the UK and England (Buchan, Charlesworth and Gerslick, *et al,* 2019). According to recent figures from the NMC, of the 27,168 who had left the register in the last 12 months, 49% left earlier than planned and 14.2% left within 5 years of registering (NMC, 2024a). Current data indicates that the number of nurse vacancies is 7.5%, around 31,294 (NHS

[5] Health and healthcare are devolved to the respective UK country's parliaments and assemblies. This includes responsibilities for the healthcare system. While Scotland, Wales and Northern Ireland all have an NHS, they differ from England in their policies, legislation and structure. As this thesis is based in England, the focus is on the English NHS. The regulation of healthcare professionals, including nurses, is the only law in relation to health that is reserved. This means that the law applies to England, Scotland, Wales, and Northern Ireland despite devolution of powers on health to the respective governments and assemblies in those countries.

[6] The main outcome measure to ascertain this was 30-day inpatient mortality.

England, 2024b). Furthermore, recent employment survey data indicates that 45% of the nursing workforce is actively planning or considering leaving (Royal College of Nursing [RCN], 2024). Retention is a key issue for the NHS (Institute of Fiscal Studies, 2022), and concerns about the retention of nurses have been highlighted as limiting the ability of the government to meet workforce targets (Department of Health and Social Care [DHSC], 2022). Critically, it is acknowledged that *"The most cost-effective way to ensure the health and care system has the staff we need is to keep the people we already employ."* (Health Education England [HEE], [7] 2017a, p.7)

Globally, the retention of nurses is also a critical factor in the effectiveness of healthcare systems, and the International Council of Nurses (ICN) recently stated that the worldwide shortage of nurses should be treated as a global health emergency (ICN, 2023). In the *NHS Long Term Plan*, a step change increase in the international recruitment of nurses was highlighted as a core component of ensuring that the NHS had the staff it needed (NHS England, 2019a). In the last 12 months, 49.4% of new joiners to the register in the UK were internationally educated (NMC, 2024a). In England, 29.1% of all new joiners were internationally educated, which was 26.2% more than the same period in the previous year (NMC, 2024b). The top countries recruited from are the Philippines, India and Nigeria (NMC, 2024b). In England, there have been rises in first-time joiners from several 'red list' countries where active recruitment is not permitted (NMC, 2024b). Red list countries are indicated by the World Health Organisation (WHO) Workforce Support and Safeguard list as countries that have a Universal Health Coverage Index below 50 and whose workforce levels fall below the global mean (WHO, 2023).[8] Therefore, these countries have enhanced workforce needs and need support and safeguards targeted at them (WHO, 2023). However, this does not prevent individuals from those countries from applying independently to employers, including the NHS, without being targeted by a third

[7] HEE was created from the Health and Social Care Act 2012 as a non-departmental public body responsible for coordinating the education and training of the health and public health workforce in England. It merged with NHS England in 2023.

[8] The Universal Health Coverage (UHC) index measures on a scale from 0 (worst) to 100 (best) based on the average coverage of essential services, specifically 14 tracer indicators (such as reproductive and maternal health, infectious diseases and service capacity) of health service coverage. These are converged into a summary measure. The UHC is often used to measure the sustainability development goals indicator 3.8.1 (coverage of essential health services). The global mean for the density of doctors, nurses and midwives is 48.6. per 10,000 population

party, such as a recruitment agency or employer. However, memorandums of understanding between governments enable managed recruitment activities from red-list countries, such as Nepal (DHSC, 2024). The UK continues to emphasise international recruitment, bringing concerns about unethical and unsustainable recruitment practices (Health and Social Care Committee [HSCC], 2022). Consequently, improving the retention of nurses domestically is critical to ensure the future of the NHS.

Factors influencing retention are multifaceted; pay, working hours and patterns, cost of living pressures, poor workforce culture, work pressures and staffing levels all contribute to nurses leaving their jobs (RCN, 2024a. NMC, 2022a, 2024c). Critically, another core issue linked to retention is the lack of post-registration development, including career progression and opportunities (House of Commons Health Committee, 2018. Marufu, Collins and Vargas, 2021. NMC, 2022a. Kuijper, Felder and Clegg *et al,* 2024). Post-registration development opportunities have been shown to improve retention, alongside nurses feeling more valued and invested in (Mills, Chamberlin-Salaun, and Harrison *et al,* 2016. Aitken and Webb *et al,* 2019. van Schothorst-van Roekel, Weggelaar-Jansen and Hilders *et al,* 2021. Fisher, Bramley and Cooper *et al*, 2022). Therefore, an integral part of helping to address the retention challenge of nurses is to focus on their post-registration development.

1.3 Nurses' post-registration development

Nurses' post-registration development refers to the development that a nurse undertakes once they have qualified and entered onto the professional register. Development includes career pathways, frameworks, courses and additional qualifications. Qualifications and courses can be credit-bearing, for example, master's and PhD level education. They may also be short courses that are non-credit bearing but may be on a specialist subject such as advanced trauma nursing (e.g. Royal College of Surgeons of England [RCSE], 2024) or acute oncology (e.g. King's College London, 2024). Post-registration development is often referred to as continuing professional development (CPD).

The shape and point at which nurses' post-registration development occurs has shifted over time. The structure and direction of such development will also be country-dependent; thus, what is considered here is the structure, development and direction of nurses' post-registration development in the UK and England. Nurses' post-registration development has shifted with the broader developments of nursing as a profession. For example, post-registration as a term in relation to nurses only came into existence in the UK when nursing became a registered profession. The Nurses Registration Act 1919 was passed after a campaign to establish nursing as a recognised profession (Rafferty and Robinson, 1996). The Act was the first time a register was established for nurses nationally, and it subsequently standardised the point at which nurses qualified, and development could be termed post-registration (Rafferty, 1996). More recently, due to Project 2000,[9] and the move to make nursing a degree-entry profession in 2013, the landscape of nursing post-registration development has altered.

The revised NHS constitution highlights that the NHS commits to providing staff with professional development (Department of Health [DoH], 2015a). Currently, in the UK and England, a nurse's employer determines their development, whether they are an NHS Trust or an organisation such as the British Army. This is in sharp contrast to medicine, which has a national training programme across the UK (The Gold Guide, 2022). Foundation programmes[10] and speciality training all have GMC-approved standards, and there is a separate part of the GMC register for speciality registration, which a doctor must enter to practice within that speciality (GMC, 2024). Each speciality has its own curriculum and training pathway devised by that speciality's Royal College (and approved by the GMC). For example, for oncology (cancer), see Fig.1 (Royal College of Radiologists (RCR), 2021. GMC, 2024).

[9] Project 2000 was a reorganisation of nurse undergraduate education training, which commenced in 1989. Nurse education transferred into higher education institutions, made student nurses supernumerary, created four branches of nursing (adult, child, mental health and learning disability), created a minimum award of diploma status to the exit qualification and established a common foundation programme within the training.

[10] A two-year rotation programme undertaken on completion of medical undergraduate training

Fig.1 Training pathway for clinical and medical oncology in the UK, RCR (2021)[11]

Nurses do not have their own royal colleges for specialities, and there are no formalised and regulated training pathways for career progression. The NMC regulates some post-registration standards for nurses; specialist community public health nursing and community nursing specialist practice qualifications do exist.[12] However, these specialist practice qualifications do not have a protected title or function (NMC, 2022b, 2024d). Government-level policies have focused on trying to create national nursing post-registration career frameworks and development, including *Modernising Nursing Careers* (DoH, 2006) and the *Shape of Caring Review* (HEE, 2015). Both of these examples were produced in light of healthcare service reforms, changing health needs of the population, and in the case of the *Shape of Caring Review*, national and patient safety concern reports including Willis (2012), the DoH *Berwick Report* (2013a), Francis (2013), the DoH *Keogh Report* (2013b) and the NHS England *Bubb Report* (2014a), all of which highlighted recommendations for improving education and training of registered nurses (HEE, 2015). HEE was also mandated to provide leadership to ensure that professional development continued beyond the end of pre-registration training (DoH, 2014). However, they were not responsible for developing any national career frameworks.

Alongside the number of nurses being important for patient safety, nurses' post-registration development is essential to enable safe, effective, high-quality patient care across healthcare settings (Rafferty, Xyrichis and Caldwell, 2015). Higher levels of

[11] Regarding the diagram, ARCP stands for Annual Review of Competency Progression, and CCT means Certificate of Completion of Training

[12] A review recently decided to no longer apply standards for specialist education and practice to public health nursing, health visiting, occupational health nursing and school nursing (NMC, 2024d). Thereby reducing some aspects of regulation for nurse' post-registration development

education among nurses are associated with lower risks of failure to rescue[13] and patient mortality (Audet, Bourgault, and Rochefort, 2018). Additionally, recent research has indicated a significant association between registered nurses' intent to leave their job and patient mortality (Catania, Zanini and Cremona *et al*, 2024). Furthermore, a good work environment, which supports retention and includes professional development, has been shown to reduce the odds of death by 15% and 16% lower odds of being admitted to intensive care for surgical patients (Krupp, Lasater and McHugh, 2021). As highlighted earlier, the retention of nurses is critical to the future of the NHS, and post-registration career frameworks and development are crucial to staff retention. To enable appropriate and effective ratios of nurses to patients, high-quality patient care and safety, and workforce policy must focus on retention as well as recruitment.

Furthermore, safety concerns in NHS are rising, and protocols and systems are being implemented in an attempt to address them (NHS England and NHS Improvement [NHSEI], 2019). Thus, it can be argued that nurses and their post-registration development are safety interventions. Any safety protocol or system intervention requires a person to understand and carry them out efficiently. Otherwise, the intervention is redundant (Carayon, Wetterneck and Rivera-Rodriquez *et al,* 2014). Staff development, patient safety, and subsequent interventions are not separate entities; they are intertwined.

1.4 Challenges associated with nurses' post-registration development

Despite previous attempts at national-level career and development frameworks, including the examples highlighted earlier, none have been fully implemented, and nurses struggle to build a career (Wallenburg, Friebel and Winblad *et al,* 2023). For example, while there has been the introduction of Advanced Clinical Practitioners

[13] Failure to rescue means a failure or delay in recognising, preventing and responding to patient deterioration from a complication of medical care or underlying illness. The impact of this can be patient death.

(ACPs),[14] which, in policy, has been placed as central to helping to transform service delivery (NHS England, 2019a), pathways and roles are locally determined rather than nationally standardised. Concerns over meeting service healthcare service demands and needs and workforce recruitment and retention challenges prompted the introduction of a multi-disciplinary role, and a framework has been developed to help bring a greater level of standardisation to the ACP role (HEE, 2017b). However, educational standards for ACP training are not formalised, and employers are responsible for developing and deploying ACPs (HEE, 2017b). Additionally, there are wide variations in roles and scope of practice of other nursing roles, for example, within clinical nurse specialists, which confuses patients, employers and those commissioning services (Leary, Maclaine and Trevatt *et al,* 2017). Additionally, the variety and scope of nursing roles defy the assumption that advanced practice labels are associated with career progression and, subsequently, should be addressed by a regulator (Leary *et al,* 2017).

While clinical career frameworks have struggled to become established, this is also the case for other areas of nursing, including education, research and hybrid roles. For example, clinical academic careers, despite being foregrounded as essential in policy to improving patient care have unclear career pathways, limited long-term career progression, no standardisation of employment contracts and an absence of employment terms and conditions (Kent, Plugaru and Page *et al,* 2022. Council of Deans of Health, 2018, 2020a, 2024). Additionally, the nursing education workforce, which is central to training nurses to assist with securing a future workforce and meeting service demands, is facing a recruitment and retention crisis (Council of Deans of Health, 2020b, 2024). Underpinning issues to this crisis include absent entry requirements, no defined career progression framework or pathway, and unclear definitions of responsibilities (Oaten and Plotkin, 2024).

The lack of structure for nurse's post-registration development remains despite changes in patient demographics and the increasing demands upon the NHS. These

[14] ACPs are healthcare professionals educated to masters level or equivalent and come from various professional backgrounds, including nursing. Advanced clinical practice is a level of practice, crossing traditional professional boundaries, with an increase in scope, including aspects such as prescribing, diagnosis and treatment planning. ACPs work across a variety of settings, including emergency medicine, acute medicine and primary care.

require nurses to care for patients with a higher level of co-morbidities in a range of settings with an increasing level of autonomy and accountability but also in increasing scarcity resulting in bedside rationing of care (NHS England, 2019a. Felder, Schuurmans and van Pijkeren *et al,* 2024). For example, in England in the decade before the COVID-19 pandemic, there was a 25% rise in the number of people with a major illness, such as dementia, cancer or a combination of illnesses (The Health Foundation, 2023a). Furthermore, analysis has projected that by 2040, nearly 1 in 5 adults in England will be living with a major illness, an increase of 2.5 million (37%) since 2019 (The Health Foundation, 2023b). Additionally, since 2016, after recommendations from the Francis (2013) report into patient safety failings, CPD has been a required part of revalidation for nurses to enable them to stay on the professional register (NMC, 2013, 2021).

Despite government-level policies focusing on nurses' post-registration development, they remain limited, fragmented, and lacking in transparency. The policies and strategies mentioned previously have not been met with adequate implementation, and there remains a gap in understanding why nursing post-registration development and career frameworks have struggled to become established (Rafferty *et al,* 2015).

A way to explore the challenges that nursing post-registration development and frameworks have faced is to consider the wider healthcare governance changes that have occurred in response to the alterations in patient demographics and service demands. The alterations have meant changes to working practices, requirements, accountability and the scope of nursing practice, and these have been the reasons that previous attempts to implement stronger post-registration development for nurses have been formed. It is important to consider the broader system nurses work in, as a 'whole system' approach has been identified as key to meeting the demands placed on the NHS (NHS England, 2019b). However, at the time of writing, there has been no direct research and analysis on the influences of healthcare governance on nurse's post-registration development. This will be explored in more detail in the literature review.

The changes through which healthcare governance in the NHS can be considered are through political economy (PE). The nature of PE and its relation to the welfare state,

policy, and government will also be explored in detail in the literature review. However, broadly, PE can be considered an interdependence of political and ideological issues of power and the allocation of resources within economic considerations such as welfare, including health care and the provision and organisation of services (Greener, 2004. Folbre, 2012. Reich, 2019).

1.5 Research aim and objectives

Consequently, the research aim and objectives of this thesis are presented below.

The research aim is:

To explore the influence of political economy on nurses' post-registration development in the English NHS.

The research objectives are:

1. *Undertake a multi-method and multi-level qualitative study using policy document analysis and semi-structured interviews to explore the impact of PE, through policy and governance, at a national (macro), organisational (meso) and individual (micro) level on nurses' post-registration development*
2. *Explore the impact and implications of healthcare policy and governance at each level of analysis on nurses' post-registration development*
3. *Consider the threads that run throughout the different levels of analysis, from national policy to the individual level, impacting nurses' post-registration development*

1.6 Outline of each chapter

Chapter two is the literature review. In this chapter, the first section explores PE and its relationship to healthcare and the nursing profession. This section will consider what PE is, how it is used in this thesis, how it relates to a welfare state and the central role that policy plays in enacting the position of the welfare state. Framing PE through the lenses of Fordism, post-Fordism, and neo-Fordism will then be presented, as well

as how this relates to the NHS, the nursing profession, and its post-registration development. The second section considers this thesis's theoretical base: sociology of the professions and the concept focus: a profession's market shelter. An overview of this theoretical base will be given alongside the specific theoretical focus used in this thesis: Light's (1991, 1995, 2010) countervailing powers framework. Finally, the last section will explore the research gap and present the research question. The research question considers why nurses in England do not have a stronger market shelter through post-registration development and career frameworks despite post-Fordist reforms.

Chapter three is the methodology. This chapter is structured into three core sections. First, the philosophical underpinnings of this research are addressed, including the ontological, epistemological, and methodological foundations. Second, the methods section considers the research design, methods, data collection and sampling, data analysis, and ethics. Finally, this chapter presents a reflexive account of this research and a statement on how the COVID-19 pandemic impacted and changed its course.

Chapter four consists of four sub-chapters of data findings. Each sub-chapter presents the data from a level of analysis. Chapter 4a covers the policy document analysis through three themes. Chapter 4b considers the macro-level semi-structured interviews through three themes. Chapter 4c explores the meso-level semi-structured interviews in three themes. Finally, chapter 4d considers the micro-level semi-structured interviews through three themes.

Chapter five is the discussion. This chapter is structured into three main themes through which all the levels of analysis findings are interwoven. Each theme is based on considering the findings from each data chapter and exploring a thread that ran through all of them. These three themes will be discussed in relation to their impact on nurses' post-registration development. Subsequently, these core themes will be augmented by considering how they have impacted the development of nurses' market shelter and how Light's (1991, 1995, 2010) countervailing powers framework is associated with this. The augmentation of each theme with Light's framework is utilised to present an answer to the research question from each theme.

Chapter six concerns the thesis's implications, future research, and policy impact. In this chapter, the implications of this thesis are presented first. The focus is placed on considering nurses' post-registration development as a wicked problem. This includes considerations of possible solutions and mechanisms through which nurses' post-registration development could navigate. Consequently, avenues for future research will follow. Finally, a broader consideration of the policy implications of this research will be stated.

Chapter 7 is the conclusion. This chapter will first restate the research question and summarise how this thesis has answered it. Then, the contributions to knowledge will be stated, followed by the strengths and limitations of this thesis. Finally, a reflection on the PhD process is presented, and concluding remarks on the importance of this research and nurses' post-registration development will be stated.

1.7 How this topic was chosen

I conducted my initial nurse training, BSc (Hons) Adult Nursing, from 2012 to 2015. Upon graduating, I entered the British Army as a Nursing Officer, having been sponsored by the Army through my nurse training. As a registered nurse, one of the first things that struck me was how the development opportunities and career structures fell away once I had graduated. Despite being in the Army and not employed by the NHS, I experienced a profound sense of absence in direction and structure that would allow me to channel my ability and ambition to provide high-quality patient care. Alongside this, I had numerous conversations with the NHS staff I worked with. I began to appreciate that this situation was not unique to my position in the Army. I realised that the Army mirrors the NHS in terms of narrow and unclear pathways. From this point, through personal conversations and professional experience, I correlated the lack of post-registration development with concerns about staff retention, wellbeing and patient safety. These conversations were exceptionally influential. Despite my efforts to carve my own path, this was insufficient in stopping my theorising about why this situation existed. I recognised a profound disconnect between the promises of policy and employers and what was being enabled in practice.

On leaving the Army, I undertook an LLM in Health, Law and Society at the University of Bristol. In this master's, I was taught about the broader healthcare system, including governance processes and the influences of politics on policy directions and mandates. The LLM was a profoundly influencing factor in my understanding of my own experiences. From this, I began to place the broader consideration of PE onto nurses' post-registration development and my own experiences. Subsequently, I decided to pursue this consideration formally and applied to the Economic and Social Research Council for a PhD studentship. I succeeded, and this thesis results from the profound loss I experienced as a registered nurse regarding post-registration development.

Chapter two: Literature review

2.1 Introduction

This chapter is structured into three main sections. The first explores PE and its relationship to healthcare and the nursing profession. This section will consider what PE is, how it is used here, how this relates to a welfare state and the central role that policy plays in enacting the position of the welfare state. Framing PE through the lenses of Fordism, post-Fordism, and neo-Fordism will then be presented, as well as how this relates to the NHS, the nursing profession, and its post-registration development. The second section considers this thesis's theoretical base: sociology of the professions. An overview of this theoretical base will be given alongside the theoretical focus used in this thesis. Finally, the last section will explore the research gap and present the research question.

2.2 Part one: Political economy and the healthcare professions

2.2.1 Political economy: An overview

PE has a variety of meanings, which can be contradictory. Broadly, it considers the relationship between politics and economics, the interdependence of political and ideological issues of power, the allocation of resources within economic considerations such as welfare, including health care and the provision and organisation of services (Greener, 2004. Folbre, 2012. Reich, 2019). PE can be considered an area of study, for example, the interrelationship between politics and economics and viewed as a methodological approach (Weingast and Wittman, 2008). The methodological approach is often broken down into the economic, including public choice and the individual, or the sociological, which can explore power dynamics often at the level of analysis of the institution, including the state and its influence (Weingast and Wittman, 2008). PE is thus not a single approach, but a group of approaches, which can be considered as a form of 'open system'- one that is open and evolving (Dow, 2023). Recently, there has been greater awareness of the interconnections of the governance, social, and economic dimensions of policy making

(Dow, 2023). Correspondingly, an open system methodology of PE encourages considering a range of theories, influences and disciplines to focus on the interconnectedness of the economy, society and politics (Dow, 2023). Therefore, this open-system approach can employ multiple forms of analysis, including drawing on other disciplines, combined with judgment to address the complex and interconnected nature of the phenomenon under consideration. For clarity, there is a difference between theory and methodology. A theory can be viewed as an explanation, and a methodology as a framework for exploration and how research should proceed, which can include how the structure of theory can be applied in research areas (Harding, 1987).

When PE is used as a methodology, various theoretical and conceptual approaches can be combined and drawn upon. If used solely as a theoretical or conceptual approach, the PE perspective would be limited to one framing. Due to the complexity inherent in this research, a more dynamic and flexible approach is needed, which is afforded by PE used as an open-system methodology. In this study, this is of paramount concern, as the complexity of the politics, political landscape, and economic considerations affecting health and healthcare in England impacts nurses' post-registration development. Additionally, nurses are a heterogeneous profession, not a homogeneous one, which necessitates flexibility and an open-systems perspective to be considered holistically.

Thus, PE is not employed as a theoretical or conceptual approach in this context, as it would restrict and constrain the consideration of PE and nurses' post-registration development to a designated body of economic or political thought. This would inhibit flexibility and freedom to consider changes over time in PE and, henceforth, the impact and implications on nurses' post-registration development.

In this thesis, an open-system methodological approach (Dow, 2023) is utilised by considering the changes in the PE landscape and what this has meant for the organisation of healthcare in the UK. Specifically, what these changes have brought about for the workforce, their organisation and, critically, nursing post-registration development. In utilising a methodological variant of PE, this thesis does not discount the role of the relationship between politics and economics as an area of study. The

relationship between the economic and the political frames the methodological approach, despite it not being a focused area of study in this instance. Nursing is an interesting case study as large amounts of PE flux have changed the work landscape, driven by State relations with professional groups. Healthcare governance has changed dramatically, which has altered working patterns and practices, and nursing as a core professional group has been greatly affected by this.

The quote below is dated, but none of the things being considered analytically have changed.

> *"…health work has been at the cutting edge of a politically inspired attempt to restructure working practices in Britain over the past decade. Attempts at creating markets, giving priority to 'consumers' over producers, introducing new forms of management and cost containment, have turned the health service into a laboratory of experiment in changing working practices."* (Walby, Greenwell, Mackay *et al,* 1994)

The processes noted above are arguably more widespread, making this quote and the arguments still relevant today. The pace of change in working practices in the NHS has increased, and the State has reprimanded the professions, including nursing, for perceived failings and shortcomings (Francis, 2013). Consequently, the state has introduced various policies to exert more control and influence over the professions, reducing self-regulation and increasing accountability to patients and the public.

Subsequently, healthcare professionals who work in the NHS do so in a highly politicised setting (Traynor, 2013). Thus, it is prudent to suggest that nurses do not work and develop in isolation from PE. The professions are not protected from PE influence, just as the NHS is not immune to political influence. This is not confined to the NHS. Other European countries additionally experience the political impact on healthcare and the professions, including nursing (Wallenburg *et al,* 2023). Even in the United States of America (USA), which has a privately funded healthcare system, healthcare remains a highly politicised area (Dingwall and Allen, 2001). This is because a country's healthcare system is central to its welfare state organisation (Dent, 2003) and, thus, has broader implications for the distributional organisation of the state,

which ignites political debate, whether being a perceived market system in the US or state dominated in the UK (Waddan, 2011).

2.2.2 The welfare state: An overview

As highlighted above, central to the influence of PE is a country's welfare state. A welfare state, in general, is a term used to describe the concept in which the state plays a key role in the promotion and protection of the economic and social well-being of its citizens, including health (Castles, Leibried and Lewis *et al,* 2010). Therefore, the welfare state is central to modern democracy, where PE is grounded. Subsequently, a welfare state can be considered an expression of certain ethical ideals and is often defended in the name of social justice, but also contested on the premise of individual liberty (Hill and Varone, 2021). The emergence and development described here is that of the Western welfare state. The shift in viewing problems such as poverty, as social problems, and thus needing collective solutions, started in the sixteenth century (Castles*, et al* 2010). What followed were progressive shifts in attitudes towards public intervention rather than such issues only being of local or individual concern (Greve, 2012). With the evolution of industrialisation, an altered understanding of unemployment and the operation of the business cycle brought a new focus to the idea of welfare on a grander scale (Castles *et al,* 2010). The 'social question' concept was developing, and ideas around social rights gained greater attention. Consequently, the emerging role of the state included aligning the state with the role of social protection (Ackers and Abbott, 1996). Prior to this, the role of the state was centred on protecting citizens from invasion and violence, and building infrastructure, such as transport, for improved economic development (Castles, *et al* 2010).

However, there is no one way to view the welfare state; different welfare state typologies exist (Greve, 2012). This thesis does not have enough scope to identify and explain the causes of welfare-state differences across countries. However, giving a brief overview of the differences does help to provide context to the focus of PE in this thesis. An influential typology from Esping-Anderson (1990) delineates between liberal, conservative and socially democratic welfare states and debates on need,

equality and liberty centre on the level of state involvement. This typology is not without criticism (Bambra, 2007. Arts and Gelissen, 2002), but it does present a way to frame differences. These different typologies determine the welfare regime, the politics attached to them, and thus, the action or inaction of the state. A liberal regime ascribes a lower level of state intervention, with a greater focus on means-tested assistance and demonstrable need, self-help, and promotes the role of the market (Esping-Anderson, 1990). Examples include Australia, the USA and the UK. The conservative regime considers an increasing level of state intervention; benefits in welfare programmes are often earnings-related, geared towards maintaining existing social patterns, and the redistributive impact is minimal (Esping-Anderson, 1990). Examples include France, Germany and Italy. Finally, the social democracy regime has the highest level of state intervention in welfare. In this approach, universalism and decommodification of social rights are foregrounded, with generous benefit levels and comprehensive risk cover (Esping-Anderson, 1990). Examples include the Nordic countries, such as Denmark and Norway. These typologies should not be viewed as absolute and rigid. Different political parties within a country can have different views on the welfare state due to differences in political ideology. Thus, variations in views can change the welfare state's course, size and influence. Therefore, the view of the 'state' can be different, depending on the political party and their aims. Examples may be changes in tax rates on income or benefit allowances. In the UK, changes from labour, conservative and coalition government administrations have adjusted the size and shape of the welfare state, including in relation to healthcare. Subsequently, who or what the state is and what it does or does not do will change over time.

In relation to health and healthcare, the emergence of health systems and those systems as 'public', recognising the role of the state in health, are attached to the creation and development of the welfare state. Moran (1992, p.79) refers to the 'health care state' as *"...part of any state concerned with regulating access to, financing and organising the delivery of health care to the population".* Healthcare state typologies tend to be based on differences in sources of financing and public vs private ownership (Castles, *et al* 2010). A classic distinction is between the NHS, social insurance systems (common in Europe, including Germany) and private systems (such

as the USA). Even though the UK has a broadly conceived liberal welfare state regime, it has a universal health service. It thus does not follow that if a country has a liberal welfare state, private health care will dominate (though in the USA, it does). While ways to classify health systems have focused on finance and public vs private ownership, another is on regulation patterns, distinguishing broadly between markets, hierarchies, and networks (Knill and Tosun, 2020). The central place of health in relation to the welfare state is summarised in the quote below:

"*The health of the people is really the foundation upon which all their happiness and their powers as a state depend.*" (Disraeli, 1877, in Timmins, 1995, p. 63)

2.2.3 Policy as a vessel for the welfare state

Alongside the different politics attached to various views and regimes of a given welfare state, the resulting differences in, for example, healthcare governance can be distributed through policy. State directives and mandates are within policy and can thus be a way PE can be viewed.

According to Dye (2014, p.11) policy is *"whatever governments choose to do or not do".* Policy can be understood in different ways, but it can be a field of study, an expression of intent, specific proposals, decisions of governments and formal authorisation of decisions, a process package of legislation, staffing and funding, including outputs and outcomes, and a process and series of decisions (Cairney, 2020). Consequently, Cairney (2020) states that it is a challenge to define policy and thus provide certainty on the meaning of policymaking.

However, there are ways through which it is possible to examine policy, such as policy tools and more specific instruments. These are devices which turn broad policy aims into specific actions. Lowi (1972) distinguishes between regulatory, distributive, redistributive, and constituent policies for policy tools. John (2011) expands this to include psychological techniques to influence behaviour, including the nudge method of informing choices (Thaler and Sunstein, 2008). Instruments can consist of different ways of conducting public expenditure, including taxation, where to raise money, and

in which policy areas (including health) and spending (Cairney, 2020). Other instruments include providing state services for free, charging or expecting the market to deliver, and providing services directly or through non-governmental organisations or networks of public and private actors (Cairney, 2020). The nature of the policy tool chosen is related to the perceived nature of the problem and its political cost (Knill and Tosun, 2020). Consequently, 'policies determine politics' (Smith, 2002). For example, redistribution presents debates about how far the state should be allowed to regulate and tax its citizens (Cairney, 2020). Therefore, differences in problem definition present no objective or apolitical definition of policy problems (Bacchi, 1999). Thus, politics is also policy. The selection of policy tools can vary by sector, including health and criminal justice. However, the boundaries between policy tools are not definitive, and policy measures can include elements of different ones (Smith and Larimer, 2009).

Policy agenda setting and formulation, which frame the policy problems and what is to be done about them, can be placed within a policy cycle alongside legitimisation, implementation, evaluation and policy maintenance, succession and termination (Cairney, 2020). However, caution is raised in assuming that this orderly cycle represents reality. Consequently, the policy process is messy and complex. While some proponents would support viewing each 'stage' as a key function of government (Knill and Tousan, 2020), others suggest that the idea of the policy cycle is a starting point for prescriptive and descriptive analysis (Wu, Howlett and Ramesh *et al,* 2017). However, policy agenda setting and formulation are acknowledged to pave the way for how policy tools and instruments will be used (Cairney, 2020).

Different healthcare systems are created through differences in policy tools and instruments. Timmins (1995) aligns the clinical and organisational development in the NHS with the broader development of the welfare state. The NHS was formed in 1948 and was the first Western country to offer healthcare services free for all at the point of delivery. It was the first system not based on insurance and entitlement following contributions but on the national provision of services (Klein, 1983). The health service in the UK did not begin with the NHS, and its creation was a rationalisation and restructuring of what existed. Brought about by the end of World War II, the UK was

rebuilding, and actions of the state included nationalising state industries, including steel and the railways. Alongside this, the NHS was formed. As a nationalised service, governing healthcare consumption within the NHS is a core proponent of the state, including the conditions under which populations have access to healthcare goods and services, and the total cost of consumption in healthcare (Moran, 1999). Connected with this, Moran (1999) identifies that governing the professions in the healthcare service is essential. Professions are central to the life of the modern state and thus, the central state is central to the life of professions (Moran, 1999). Moran (1999) goes on to reflect that a reason why doctors, rather than nurses, have had a focus within the study of governments and professions is because of their role in allocating healthcare resources, which is perceived as more significant than nursing. While the perception that allocation from medicine is more significant, nurses are involved in the consumption and rationing of resources, as well as allocation, for care (Felder *et al,* 2024. Scott, Harvey and Felzmann *et al*, 2019. Parishani, Mehraban and Naesh, 2021). The allocation of resources is a core consideration of governing consumption, which subsequently receives a core focus within policy. Consequently, practices governing the healthcare state will impact the professions, including nursing.

The governance of healthcare professions and the healthcare system can be viewed within policy agenda setting. Within policy, the agenda-setting process is synonymous with the role of power and ideas (Cairney 2020). Therefore, Bacchi (2009) states that policy problems do not exist naturally. Subsequently, agenda setting is an avenue to exercise power to define a policy problem and establish its severity and cause. This paves the way for what can be considered public problems, thus relevant to government intervention and policy action, and private issues, which are not. Evidence on which policymaking is founded, including agenda setting, is therefore aligned with the power to determine what knowledge counts (Cairney, 2020). The power associated with policy is presented by Jones (2014) to mean that the narrative aligned to policy is socially constructed. Subsequently, Knill and Tousan (2020) argue that problem definition, in the path to agenda setting, is not a neutral realisation of problems and that a 'problem' may only exist because someone decides it does. Politics is an exercise of power, and policy is a means to implement it.

Through the welfare state, PE has a role in policy that is intertwined with power and the social construction of problems. This will alter how states address challenges, such as the provision and governance of healthcare. Conversely, how healthcare professionals, including nurses, will be situated. There are lenses through which it is possible to view PE changes and development, including their implied impacts, which will now be considered. Due to devolution in the UK, there are now four NHS systems.[15] As a result, the focus within the lens framing PE post-devolution will focus on the English NHS as this thesis research is based in England.

2.2.4 Political economy, the NHS and nursing in the context of Fordism, post-Fordism, neo-Fordism

Within PE, there are lenses through which to view the changes healthcare governance has undergone. This enables an analysis of the impact on work organisation, working practices and nursing professional development. This review considers the lenses of Fordism, post-Fordism, and neo-Fordism, including how each of these relates to hierarchies, markets and networks. The delineation between Fordism, post-Fordism and neo-Fordism acts as a way of illustrating a greater dominance of particular working practices or patterns and their subsequent effects. Conceiving PE through the lens of Fordism, post-Fordism, and neo-Fordism enables an open-system approach to consider various dynamics and concepts within the boundedness of changes and impacts hitherto on healthcare governance and working practices. Therefore, perhaps more familiar conceptualisations, such as framings of a welfare and neoliberal state (Kus, 2006) and related changes, such as the shift from public administration to New Public Management (Dunleavy and Hood, 1994) and from personnel administration to Human Resource Management (Storey, 2014), can be placed within a wider system of influence including economic and the political that the lens of Fordism, post-Fordism and neo-Fordism enable. Thus, this approach does not discount other ways of

[15] As highlighted previously, devolution is decentralising government power to other nations and regions in the UK. The Scotland Act 1998, the Government of Wales Act 1998 and the Northern Ireland Act 1998 all enable the three legislatures to pass primary and secondary laws in devolved areas, of which health is one. As health is a devolved matter, health and healthcare policy and governance are the mandates of that particular country. Thus, policy and laws on health and healthcare in England, only apply to England, not, for example, Scotland and vice versa.

conceiving changes and contrasting analyses of PE but rather incorporates and gives space to their consideration through an open system methodological perspective of PE. Subsequently, a holistic, open-system analysis of PE and the nursing profession can be conceived.

This account of PE is given in a specific UK and English context because, as Dent (2003) highlights, providing sweeping accounts of the healthcare professions across countries is inappropriate. This is due to the variations in State approaches to and influence upon welfare regimes, labour markets, management of nurses in healthcare and the number of doctors in the health system (Dent, 2003). These elements have been further developed by Pavolini and Kuhlmann (2016) and Gunn, Muntaner and Villeneuve *et al* (2019) and are argued to impact the development trajectory of nurses and other professions in general.

2.2.5 Fordism

Fordism has three interrelated meanings: first, as a labour process relating to mass production; second, as an economic system of accumulation through consumption; and third, as a socio-political mode of regulation (including institutions and policies) that supports mass production and consumption (Lipietz, 1994). Rather than being separate, these meanings and actions interact with each other. The term arose from elements of the production system developed in the early 20th century by Henry Ford, which saw work shifting primarily from the home and the land into factories and 'places of work' (Engell, 2012). There are no definitive boundaries regarding when Fordism started or finished; however, Fordist working practices can be viewed as dominant from the post-World War II period to the early 1980s (Halford, Savage and Witz, 1997).

Fordism and the NHS

A critical part of the Fordist ideal was the creation of the 'Fordist welfare state', which involved improving the health and productivity of workers to reduce turnover and absenteeism (Engell, 2012). One way this was enabled, for example, was through the

provision of State-funded healthcare (Meyer, 1981), which resulted in the creation of the NHS in 1948. However, providing healthcare was not only an instrument for the foundations of a welfare state but also grounds for establishing working practices that reflected Fordist ideals. However, it should not be presumed that the NHS was ever a 'Fordist service', as there are elements within healthcare services that do not always follow a Fordist ideal.

Fordism, the NHS workforce and nursing

A Fordist healthcare labour process system emphasises workforce hierarchy and a more acute division of labour (Mohan, 1995). Thus, the workforce is more segregated, with clear boundaries between groups of workers, such as medicine and nursing. In this instance, the workforce is more task-orientated and focuses on the process rather than the overall outcome, with working patterns and practices tending to be more rigid (Jessop, 1994).

In nursing, dominant Fordist principles are noticeable in the labour process as there was a more ingrained hierarchy within the workforce, with limited scope for career development and advancement (Rafferty, 1996). Nursing roles were tightly defined and heavily controlled by medicine (Walby *et al*, 1994). Therefore, a more Fordist organisational system would dictate that nurses did not have much autonomy and were restricted in their practice by medicine. This would mean they had a limited scope of practice and room for career development.

2.2.6 Post-Fordism

The decline of Fordism, though not its complete demise, has introduced the concept of post-Fordism. The decline of Fordism is perceived to have been instigated by the rise in globalisation and the shift towards a knowledge economy over a production-focused economy (Jessop, 1991). This was not just a UK phenomenon; the post-Fordist move has been recognised throughout Europe and the USA (Traynor, 2013. Dent, 2003). Post-Fordism can be considered to have started having greater dominance within the economy and working ideals from the early 1980s (Halford *et al,* 1997). The

shift signifies a more significant emphasis on market ideals for the organisation of services, emphasising competition to drive efficiency and enhance innovation (Pinch, 1994).

Post-Fordism and the NHS

One of the critical elements within the rise of a post-Fordist era in the UK has been the dramatic shift in the organisation and governance of the NHS. The most significant change in relation to this thesis is the introduction of the NHS internal market.

In 1989, the White Paper *Working for Patients* (DoH, 1989a) sparked the redesign of the NHS. In 1990, under the then Conservative administration, the introduction of market concepts to healthcare brought in the NHS internal market (Le Grand, Mays and Mulligan, 1998). The *Working for Patients* white paper was drawn up to address concerns over the NHS's ineffective practices and high levels of expenditure (DoH, 1989a). The White Paper became the catalyst for major legislative reforms, and its product was the NHS and Community Care Act 1990. This separated the finance and delivery of healthcare by establishing purchasing authorities on the demand side and NHS Trusts, separate legal entities to act as providers on the supply side (Propper, 1995). This was designed to bring competition in as the primary source of healthcare governance, implementing contracts for service provision between purchasers and providers to act as regulatory (Vincent-Jones, 2006) and accountability mechanisms, thereby rebutting concerns about efficiency and expenditure (Maybin, Addicott and Dissonant *et al*, 2011). The foundational principle is that the NHS would provide better value for money through competition.

There were further changes under New Labour from 1997 and the Conservative-Liberal Democrat coalition from 2010. Critically, under the Health and Social Care Act (HSCA) 2012, competition in the NHS was mandated in law. Due to the devolution of health law and policy, the internal market only remains in England, albeit having gone through various transformations (Timmins, 2013). When this thesis started, purchasers were Clinical Commissioning Groups (CCGs), established under the HSCA 2012, and the providers were NHS Trusts and Foundation Trusts (Ham, Baird and Gregory *et al,* 2015). Legislative changes occurred during this thesis and with the

introduction of the Health and Care Act 2022; while providers remain NHS organisations such as Trusts, purchasers are Integrated Care Systems (ICSs) (House of Commons Library, 2023)

Post-Fordism and the NHS workforce

The changes to the governance of the NHS also brought significant changes to working practices and environments for healthcare professionals and their subsequent career patterns and frameworks. The critical argument here is that changes in how a system is governed and organised are reflected in changes to the working practices within that system. In terms of the healthcare workforce, post-Fordism has signified a greater emphasis on flatter hierarchies, teamwork, networks, renegotiation of role boundaries and a shift to outcomes focus over process (Mohan, 1995). Overall, this has meant that working practices and structures have become less rigid (Walby *et al*, 1994).

The shift from provider-driven (Fordist) to buyer-driven (post-Fordist) dimensions has created 'axes of change' in healthcare systems. Axes of change can include ideological (for example, the demise of the trust in 'experts'), clinical (for example, target developments and closer monitoring) and economic (for example, contracts and commissioning of services) (Light, 1991). A significant axis of change with post-Fordism was the wider introduction and focus placed on new public management (NPM). NPM denoted an acute change in how healthcare professionals and NHS governance, more broadly, were organised (Simonet, 2015). NPM involves a greater emphasis on using general managers to oversee the performance and conduct of professionals, whereas before, this was largely conducted through professional self-regulation (Ferlie, Ashburner and Fitzgerald *et al,* 1996).[16]

Crucially, it is argued that these changes, including NPM, were about removing the authority of medicine. Although medicine was and arguably still is the dominant

[16] NPM has other components including standards and measures of performance and greater emphasis on competition within public services (Hood, 1991), however, the use of NPM to control the professions is the focus here.

profession, reforms such as NPM were introduced in part due to a concern from the state about the medical profession and its dominance.

Post-Fordism and nursing

If changes in health policy influence the scope and responsibility of medicine, it will subsequently impact nursing development (Traynor, 2013). Nurses have been used as policy instruments, including indirectly. For example, changes to junior doctors' working time directive in 2004 have been indicated by the RCSE (2016) as a key factor in the development of the wider surgical team, including surgical care practitioners (of which nurses are the main group) and advanced nurse practitioners.[17]

There are several ways in which axes of change have influenced the nursing profession. For example, the introduction of market mechanisms and financial control (Walby *et al,* 1994). In a more Fordist era, financial control sat with the medical profession; in post-Fordism, nurses are given more financial control; for instance, in NHS Trusts, budgets are delegated to the ward level, which nurses as ward managers control (Johnson, Larkin and Saks, 1995). Therefore, ward managers were able to determine skill mix and ward expenditure.

Another change is the rise of evidence-based medicine (EBM). The NHS reforms focused more on research and development (Traynor, 2013). Nursing was part of this shift, and there has been a rise in nursing research with a greater emphasis on clinical academics within the nursing profession. A greater research focus brings an enhanced focus on the quality of services, which means there is an increased emphasis on nursing having greater accountability, but this is judged to be balanced with greater autonomy. Additionally, there was a reduction in restrictive practices for nursing and new roles were developed. The *Working for Patients* (DoH, 1989a) White Paper signified that local managers, in consultation with professional colleagues, should re-examine areas of work to identify the most cost-effective use of professional skill, for example, a reappraisal of traditional patterns and practices, thus introducing the

[17] Surgical care practitioners are non-medical healthcare professionals, including nurses, who have extended their scope of practice to work as members of the surgical team performing surgical interventions and pre-operative and post-operative care under the supervision of a senior surgeon. Advanced nurse practitioners are nurses who work at an advanced level of practice. They generally have greater freedom and authority to act, making autonomous decisions in relation to the assessment, diagnosis and treatment of patients.

pathway to extended roles for nurses. This came from the 'new deal' for junior doctors in 1991, which paved a path for the enhanced status of nursing (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1992) and enabled the provision and focus on degree entry to the profession (Rafferty *et al*, 2015).

A final area for consideration is consumers and information (Johnson *et al*, 1995. Walby *et al*, 1994). The New Labour focus on patient choice enabled the greater development of interest groups and pressure groups, including Patients UK (Mold, 2010). This has been driven by discontent with the idea of the 'expert' and a greater willingness to challenge, resulting in increased legislation against healthcare professions, including nurses (Syrett, 2007). However, for nursing, the focus on consumers and information has also meant increased accountability and autonomy in practice, as they are seen to practice separately from medicine in an enhanced 'professional' capacity. For example, the DoH (1991) *Patient's Charter* introduced the named nurse, emphasising the nurse's accountability and changing the task-orientated nursing approach.

Fundamentally, under post-Fordist ideals, nurses were offered liberation and empowerment through the changes to the NHS (Beecham, 2000). However, how many of the post-Fordist ideals have materialised into reality or remain simply rhetoric, needs critical analysis. Additionally, a dichotomy within the NPM literature considers managerialism and managerialist organisations a threat to the professions, as they are deemed to lead to de-professionalisation (Evetts, 2009). This challenges professional autonomy and power, as opposed to providing the opportunities that post-Fordist reforms, at least in theory, would suggest. Much of the NPM literature has focused on the oppressive nature of NPM on professions (Evetts, 2009); however, another view is presented that proposes the benefits and opportunities provided by this shift. This does not suggest that this view is inaccurate, but it is not all negative. For instance, attempts at de-professionalisation in medicine have not always transpired, with doctors turning the tables and absorbing the attempts at reducing their autonomy into their practices and even enhancing it (Timmermans, 2008).

Since the inception of the internal market, some critical analysis has identified that although the market ideals put in place are advocated in policy and law, what has

transpired is 'neither market nor hierarchy' (Powell, 1990, p. 295). Thus, to illustrate the current situation in more detail, the concept of neo-Fordism will be used to demonstrate what is argued to be the current political-economic state of the NHS and the subsequent impact on nursing and its development post-registration.

2.2.7 Neo-Fordism

Neo-Fordism is a term used to describe a scenario where post-Fordist work models are prevalent and encouraged. However, elements of Fordist regimes and attitudes remain (Walby *et al,* 1994). This research does not place itself on the side of a more Fordist or post-Fordist NHS; for instance, it is not arguing for a particular stance that should materialise. However, it seeks to provide an account of the here and now.

Neo-Fordism and the NHS

Under the *Five Year Forward View* (FYFV) (NHS England, 2014b) and the introduction of the Sustainability and Transformation Partnerships (STPs), Accountable Care Organisations (ACOs) and Integrated Care Organisations (ICOs), an emphasis on more partnership working was introduced into the NHS, which went against the competitive mandates in the HSCA 2012. This is a neo-Fordist state of legislation vs. policy, which further compounded the difficulties and challenges that the NHS experienced in terms of development, effectiveness and efficiency.

Furthermore, analysis has indicated that relational commissioning and networks are prevalent and dominant; thus, the English NHS was not all about markets, despite post-Fordist dominance of ideals and governance (Le Grand and Bartlett, 1993). Therefore, within the NHS, the quasi-market development was more apparent (McNulty and Ferlie, 2002). Ferlie and Pettigrew (1996) state that because of being in neither a hierarchy nor a market, a blend of network-based forms of managing and organising the NHS has arisen to form a quasi-market. This is often termed networked governance, where mutual, informal contact, negotiation and adjustment achieve coordination (Ferlie, Fitzgerald and McGivern *et al,* 2010). As highlighted earlier in this chapter, legislative changes under the Health and Care Act 2022 have aligned the

policy aims of partnership and integrated healthcare with legislation. However, while the HSCA 2012 was in place, there was an incompatibility of the policy and legislative directions from the government.

A quasi-market would indicate that the NHS is still centrally controlled and managed, which is more of a Fordist ideal but has policy directives that align with post-Fordist attitudes. Thus, the NHS is becoming more of a neo-Fordist organisation, subsequently invoking neo-Fordist working practices.

Neo-Fordism and the NHS workforce

Neo-Fordist working practices and attitudes have aspects of flexibility, teamwork, networks and networking that align with post-Fordist attitudes but are still centrally controlled and governed, which is a Fordist mandate. An example is the Agenda for Change (AfC) *national* pay scales (Walby *et al*, 1994). An NHS Trust, for instance, cannot determine what pay their staff should or could be receiving; it has to follow national guidelines. This national pay mandate is more of a Fordist ideal, which clashes with the flexibility post-Fordism desires. Flexibility is a crucial and central part of modern working-day practices, particularly for women and families (Stone and Hernandez, 2013).

Furthermore, individual NHS Trusts set staff development and pathways with some directives given by national bodies. When this thesis started, HEE had some influence on development, with oversight from CCGs, STPs and ACOs on workforce development and planning. Additionally, although the FYFV from NHS England (2014b) promised a more joined-up approach to healthcare commissioning, which included workforce development and planning, this was impaired by the HSCA 2012 mandate for competition. Limited research has looked at the functionality and effectiveness of CCGs, STPs and ACOs (National Audit Office, 2018. Moran, Allen and McDermott, 2018. The King's Fund, 2016) which makes concluding the impact on the workforce challenging. In 2023, HEE merged with NHS England and assumed responsibility for all activities previously undertaken by HEE (NHS England, 2023a). It is too early to tell the impact of these changes on the NHS workforce.

Neo-Fordism and Nursing

Specific elements of a neo-Fordist labour regime directly impact the nursing profession. Research indicates that although the post-Fordist ideals were intended for empowerment and innovation within the nursing profession, this has not materialised. For example, Johnson, *et al* (1995) notes that a shift in control to ward managers has subsequently been accompanied by increased control by general managers over nursing budgets. This indicates that where autonomy is promised on one hand, it is taken away with another. The DoH (1999a) published *Making a Difference* under New Labour, which promised nursing a modern career framework. Instead, what has been framed as empowerment for nurses, for example, being functionally flexible to increase innovation and entrepreneurial advancements, has transpired to be more about increasing nursing workloads without any increase in remuneration or resources (Calpin-Davis and Akehurst, 1999. Cooke, 2006). Essentially, the glass ceiling of nursing career frameworks and development has been moved up rather than removed.

Subsequent promises by other government administrations have yet to alter this. Governments have promised that, as an employer – in terms of the NHS and public sector workers – they will make a more significant commitment to staff development (NHS England, 2019b). What is then expected in return is that staff are more flexible and productive. This bargain is highlighted by Thompson (2003); however, it is hard for an employer to keep. Cooke (2006, p.228) critiques the "*preserve of valedictory management literature"* by highlighting the creation of a *"virtuous circle between employers, employees and consumers leading to enhanced knowledge and skill for greater productivity and greater opportunity"* as simple rhetoric. Cooke (2006, p.228) suggests that the reality is unfulfilled and that unequal workplace relations remain, with nurses 'running uphill to stay still' due to the increasing demands on their working practice with limited additional remuneration and development progression.

In return for the empowerment opportunities promised in a post-Fordist model of working, resources would only be released in return for modernisation, a something-for-something arrangement (Hart, 2004). Nursing has tried to present its side of the deal. With the shift to a market focus on health, there has been a need to show 'value for money' in clinical practice. As a result, nurses need to show that what they do

works, in order to gain the State's attention to be allocated money. For example, clinical nurse specialists in cancer have demonstrated their value and contribution to cancer services and patient care (Macmillan, 2014), which has been acknowledged by the State (DoH, 2010a). Despite this, there is still a lack of political attention given to nursing skills and career development despite nursing research demonstrating that it is effective.

Furthermore, the internal market altered nursing post-registration organisation. In the Fordist era, schools of nursing, as they were then, were attached to hospitals and were part of the NHS (Dingwall, Rafferty and Webster, 1988). With the post-Fordist shift to the internal market, nursing schools could no longer be part of a provider organisation. Thus, nurses' pre-registration education was incorporated into universities (Gough, 1992). Post-registration courses followed. Once post-registration courses were moved away from hospitals, it has been argued that this made it harder for nurses to access post-registration development, as courses were no longer part of their mainstream development entitlement (Gough, 1992). Although NHS Trusts try to provide staff development training, more formal qualifications remain with universities to run and deliver.

Critically, post-Fordism would imply that nursing is not managed by numbers; for instance, post-Fordism would imply more focus on skill mix and development, whereas, in a Fordist model, nursing is conceived in terms of mass numbers able to produce a 'mass care' output. Both attitudes and approaches to workforce development are apparent in the NHS today. Thus, nursing has ended up in a push-pull between Fordist and post-Fordist ideals, which have impacted professional practice and development. Therefore, despite post-Fordist promises, nursing career frameworks and structures remain locally determined without a national direction, resulting in fragmentation, a lack of transparency and confusion. Rafferty *et al*, (2015, p.5) considers there has been a tendency for every new healthcare reform initiative to revert the focus to nursing pre-registration education and development which has *"set the counter back to zero"* for nurses' post-registration development.

Exploring the mechanisms that may underpin the challenges that nurses' post-registration has faced, is central to understanding and developing better workforce

development strategies and policies to meet service demands. Furthermore, gaining insight into front-line staff and decision-makers perspectives is essential to understanding professional development expectations and requirements better.

2.3 Part two: The professions – A theoretical overview and framing of the conceptual approach

This thesis will now consider the broader body of literature, considering the sociology of the professions (SoP), and will explore the nursing profession and its development. Alongside this, considerations will be brought to how the theory explains nurses' post-registration development in relation to the changes from Fordism, post-Fordism and neo-Fordism. It will then present the conceptual approach of this research and will conclude by highlighting the research gap and the overall research question.

2.3.1 The sociology of the professions

The SoP literature is the focal collection of work used here to frame the research area. Generally, there are two main approaches within SoP: functionalist and interactionist (Macdonald, 1995). The functionalist view was the dominant theoretical perspective from the early 20th century until the late 1960s (Macdonald, 1995). It considers that professions are a moral force for society, with key work coming from Durkheim (1957), who believes that the division of labour and professional groups is an important stabilising factor in society (Lynn, 1963). Additionally, there is a consideration of what makes up a profession and the ‘ideal type’ of professionalism conceived within the 'trait' approach. Notable works have come from Goode (1957) and Hickson and Thomas (1969), the latter of whom developed the Guttman Scale of Professionalism. Furthermore, the professions have been categorised within the trait approach, including Etzioni's term 'semi-profession' (1969). Over the years, the functionalist view has been considered to encompass a greater positivist and narrow approach to studying the professions.

The interactionist perspective arose in response to the functionalist approach, focusing on how the professions gain status. Thus, it is more focused on process rather than outcome. Core work has come from Friedson (1970a, 1970b), who first proposed the idea of the 'market shelter', indicating that within an economic market, professions gain autonomy and elicit control by obtaining a special societal position (Friedson, 1970a). Friedson (1970a) considered that it was the control over or autonomy in work and *how* professions became established rather than the specific characteristics of a profession which was the hallmark of professionalism. Characteristically, a market shelter enables a profession to have control over entry, such as who qualifies based on training, control over training, for example, educational requirements, including career progression and structure, which can hold off competitors, third parties and market forces (Friedson, 1994. Timmermans, 2008). A market shelter is a relationship between the profession, the public and the State. It is reflective of an economic niche and is often granted by the State through state-determined legal privileges (Johnson, 1972). For example, the professions are largely enabled to self-regulate through both formal (including The Medical Act, 1983 and The Nursing and Midwifery Act 2001) and informal mechanisms (such as ethics codes such as the NMC Code of Conduct) (Macdonald, 1995). Generally, a market shelter is a 'licence and mandate' for a profession to control its work. It is granted by society by winning the support of the political, economic or social elite (Friedson, 1970b).

Within the interactionist perspective, further notable work has come from Larson (1977), who developed the concept of a 'professional project'. This is a means through which professions, or aspiring professions, try to translate their skill or knowledge into other social and economic rewards (Larson, 1977). A strong market shelter is generally deemed to be achieved through successful professional projects classically through further education and an increase in regulation of clinical practice (Cooper, Lowe and Puxty *et al*, 1988). This is exemplified by developing a post-registration career structure with criteria for progression and designated entry standards (Macdonald, 1995. Larson, 1977). Further influential work has come from Abbott (1988), who introduced the systems of professions and how different professions negotiate space from and for one another to enhance or create professionalism. Although Abbott

positioned himself juxtaposed to Larson by conceiving that privileged jurisdiction and negotiation of professional boundaries were more influential than professional projects to determine professionalism (Timmermans, 2008. Macdonald, 1995), it is argued that Abbot's work grew from that of Larson. Thus, although these two work segments initially appear at odds, they discuss different aspects of the professions rather than diametrically opposing each other.

Within the interactionist approach, there is a split in theories around supply and demand (De Vries, Dingwall and Orfali, 2009). So far, the approaches discussed above centre on *professional demand*. Here, market closure is more akin to self-interest from the professions, which is driven and established by the professions as they get the State to provide economic or legal privileges because of their actions (Dingwall and King, 1995). However, *supply* theories consider the greater involvement of the State in enabling a profession to undertake a successful closure of the market (Dingwall and Fern, 1987. Dingwall, 1999, 2008). For instance, De Vries *et* al (2009) note that historically, more occupations are seeking the privileges that would afford them 'professional' status than are achieving this. Demand theories have been unable to explain why this is the case, and supply theories convince that market privilege is only obtained when there is a 'coincidence with a State purpose' (De Vries *et al,* 2009). For example, Holloway (1991) argued that the UK's licensure of the Royal Pharmaceutical Society was granted not because of the organisation of pharmacists towards this goal but because the State was responding to an increase in moral panic around the strength of drugs available. In this instance, the State undertook a 'State project' to develop its influence and projection into public health (Dingwall, 1999). Supply theories of professionalism have been adapted into previous work by Friedson (1986, 2001) and Johnson (1995). Subsequently, supply theories suggest that a licensing request would only be granted to a profession, for example, if the state was interested in closing an aspect of that same market (De Vries *et al*, 2009).

The development of the Nursing Registration Act 1919 can illustrate this. This Act was arguably the first critical professional project of nursing in the UK and sought to establish a state register for nurses, which is seen as a crucial professional project (Larson, 1977). It was also the first key consideration in the UK of the relationship

between the State and the nursing profession. Dingwall, *et al* (1988) and Rafferty (1996) have highlighted that the success of the Nurses Registration Act 1919 was generated by Governmental interest in creating a national health service after the First World War that would require rationing of nurse training. Therefore, creating a State register of nurses was a desirable tool for the government at that time. Thus, the 'professional victory' was not as much a victory for gaining professional power for nursing as it may appear, and despite surfacing as a nursing professional project, the 1919 Act was created as a State project.

Although the supply interactionist approaches enable a more contextual account of the professions and their development, it is considered here that a conceptual framework needs to be able to move beyond a one-dimensional, static approach. This is because, arguably, the supply and demand aspects in the NHS are currently working around each other and, at the same time, are bound in a complex ecology (Light, 1995). This idea applies not just to the supply and demand aspects of the interactionist perspective but also to the functionalist and interactionist viewpoints within SoP. To clarify the position of this research, the supply aspect is a focal point because it is concerned with State-profession organisations and interactions influenced by PE. Here, the concept of the 'State' is that it is not just an economic entity but also political, and thus puts the State's framing around a political-economic stance. This is because the political ideology and actions of the state cannot be disentangled from economic actions and influence (Weingast and Wittman, 2006). Political ideologies and philosophies of varying government administrations will alter economic behaviour, altering approaches to healthcare funding and structure and, thus, working practices and healthcare professional development (Smelser and Swedbery, 2005. Traynor, 2013).

Considering the changes in the landscape of PE and SoP, the influence of the post-Fordist era suggests that nurses should have a stronger market shelter. In theory, this should have materialised through enhanced control over training through better career structures and frameworks owing to, for example, the expansion of roles, the scope of practice, accountability and degree-level entry to the profession. However, this chapter has highlighted that this has not been the case. Despite nursing

professional projects, including registration and degree entry to the profession, their market shelter remains weaker than medicine's as exemplified, for example, by the challenges with nurses' post-registration development. Post-Fordist ideals and promises paved the way for many more professional projects and advancements in nursing, for example, through *Modernising Nursing Careers* (DoH,2006), increased financial control and responsibility, and the rise of EBM. Yet, these changes have not materialised enhanced post-registration development and thus a stronger market shelter, which conflicts with what the SoP literature considers should have happened (Macdonald, 1995).

To state that neo-Fordism is present and thus explains why nurses have not achieved stronger, more formal and standardised post-registration development, for example, due to the rhetoric of autonomy and empowerment, is insufficient. While conceptualising neo-Fordism and highlighting the tensions is important, there is no detail of the 'why' and 'how' and what processes, routines, or specific governance mechanisms may impede nurses'-post-registration development in detail. To only place the reasoning of the absence of nurses' post-registration development in a solely theorised way would not provide greater clarity on the system mechanisms holding the nursing profession back. It is exploring, understanding and addressing the system mechanisms that will enable an appropriate and effective evidence base to inform policy and strategy decisions at a national, regional and local level, to move the profession forward.

2.3.2 Gender, nursing and the sociology of the professions

An important underpinning consideration of why nursing has encountered challenges with its post-registration development is the influence of gender. In the history of nursing in the UK, the concept of nursing being a profession is consistently challenged. This debate has been dominated by opinions on gender and the professions. Nursing is considered women's work and, as such, not valued. Historically, nurses had little power or status in healthcare, not least because the caregiving role was seen as essentially 'feminine'; therefore, natural and not skilled (Needleman and Nelson,

1988. Kuijper *et al,* 2024). The gender dynamic and view of work within and of the nursing profession is acknowledged to influence post-registration development (van Schothorst-van Roekel *et al,* 2021). Davies (1995) considers that the lack of support for post-registration development is due to the assumption that nurses will leave. Historically, nursing has been managed on the assumption that there is a high recruitment-high waste model due to the challenges of combining paid work with childcare and domestic responsibility (Allen, 2001). Subsequently, post-registration development is not emphasised or concentrated on in the same way as medicine, which is based on the assumption of a masculine low intake-low waste model (Allen, 2001). The apparent lack of skill associated with the profession being gendered means that nursing then struggles to gain recognition and reward as a profession, which can assist in support for post-registration development.

Within the SoP literature, considerations of gender have influenced the view on professions. Although the functionalist approach has diminished in influence, its impact remains. From a historical functionalist perspective, Etionzi (1969) characterised 'semi-professions' as those with a larger female demographic, including nursing, deemed subordinate, particularly to medicine. The interactionist approach within SoP has also been criticised for being based on the development of classically 'male' professions (Allen and Hughes, 2002). Analysis by Witz (1992) argues that SoP has too quickly interpreted successful professional projects of class-based male occupations, such as medicine, as the defining model for professionalism.

Furthermore, the trait approaches in SoP have been argued by Davies (1996) to consist of a 'masculine model', whereby the traits of a profession, such as a theoretical knowledge base and autonomy (Goode, 1960), are viewed as more 'male'. This is argued to have given men a greater advantage over women in the profession. Although men make up only 11% of the register (NMC, 2024a), men tend to rise to prominence within nursing, including positions of leadership (Punshon, Maclaine and Trevatt *et al*, 2019). This is partly argued to be because the traits associated with leadership are often cited as 'male-centric', which then benefits men rising through the ranks over women (Davis, 1995). Furthermore, although the trait approaches and view of the gender demographic of a profession can be conceived as outdated, the gendered

nature of a profession is deemed to influence its ability to interact with the State (Gunn *et al*, 2019). Allen (2001) contends that it is an overstatement to place nursing's position as a profession, its work and development only through the lens of gender, particularly considering the role that economics plays in shaping health service work. Consequently, gender should be acknowledged and considered, but not as the only means and reason for the position of nursing.

Despite its well-developed numerical strength in the UK, nursing thus does not have great professional power (Latimer, 2014). It has a weak market shelter, characterised by a lack of career structure and pathways. Nurses have struggled to gain a strong professional voice despite numerous professionalising projects, including becoming an all-graduate profession in 2013 (Rafferty *et al*, 2015). Therefore, it is prudent to explore why nursing, unlike medicine, has struggled to gain professional ground with post-Fordist reforms. Consequently, the underlying consideration is why, given the post-Fordist promises and ideals for development, these have not translated into a stronger market shelter, which the SoP literature would anticipate for nursing. To frame this consideration further, this thesis uses Light's countervailing powers (CPs) framework (1991, 1995, 2010) to consider the profession-state organisation and relationships as a conceptual framework.

2.3.4 Theoretical focus: Countervailing powers and the professions

The CPs framework offers a unique perspective on profession-state relations, enabling a dynamic understanding of these interactions. Developed as a conceptual framework, the CP framework provides a foundation for viewing state-professions relations as constantly evolving rather than static (Light, 1995). By enabling changes to be traced over time, the CPs framework allows for a focus on the impact of Fordism, post-Fordism, and neo-Fordism on the NHS and nursing professional development. As a sociological concept, CPs are not confined to the ideas of buyers and sellers; thus, nursing as a profession is also considered a CP, but CPs also include political, social, and economic forces (Light, 1995). Therefore, the CP framework is not a directive to how nursing can 'fight back' but rather a consideration of the social, political and

economic field of forces and their intersections (Light, 1991). The concept of CPs has been built on by Johnson (1972) and Larson (1977) and their analysis of the relations between the professions, State and market (Light, 1995). Light (1991) notes that CPs are political and economic processes, thus supporting the use of this conceptual framework for a PE focus.

At the time of writing, from conducting a literature review, the CPs framework has not been used to analyse the development of the nursing profession. While some studies have used the CPs framework to consider the relationship between nurses and doctors (Hafferty and Light, 1995. Hartley, 2002), complementary and alternative medical practitioners (Almeida and Gabe, 2016), and organisational power and medical autonomy (Senier, Lee and Nicoll, 2017), this research is a unique reconfiguration. It applies the framework directly to a non-medical profession: nurses. This original approach has the potential to generate new insights into the state-profession relationship, and market shelter development for nurses, thus contributing to the field of the sociology of the professions.

One critical elaboration of the CPs framework in this thesis is developing the idea of indirect CPs such as that developed by Traynor (2013) who has stated that nurses have become policy instruments. Nurses are perceived as more pliable than doctors and open to more influence by the government (Traynor, 2013). This thesis presents that indirect CPs are coming from policies developed by the government, which will influence another group who had no part in developing the policy itself. For example, arguably, the development of surgical care practitioners, in which nurses are the main professional group, has resulted from the government changes to junior doctor working hours, which led the RCSE to develop surgical care practitioners (RCSE, 2016).

Light (1995) further recognised that the characteristics of a profession will affect its relations with CPs. Thus, CPs and professional characteristics (PCs) will influence each other and will change and vary in degrees of intensity and influence over time. Therefore, CPs can create, maintain or alter the characteristics of a profession and its professional practice and subsequent interactions with CPs. The interactions between PCs and CPs can occur at any one time. The PCs and CPs will be in flux, and the interactions should not be viewed as static or binary regarding influence and impact.

Potential CPs and PCs are detailed in Table 1. The two columns in the table are separate, and an entry in one column does not represent a direct influence on the corresponding entry in the next column. This table is focused on the nursing profession in the UK, though there could be parallels with other non-medical professions such as physiotherapy. This enables a framing of the complex ecology that encompasses a profession and its development (or prospect) at a given time. The below, shown in no particular order, are only examples and should not be considered exhaustive.

Table 1. Countervailing powers and professional characteristics

Countervailing powers <u>examples</u> – direct and indirect	**Characteristics of the profession and professional practice that influence relations with countervailing powers <u>examples</u>**
State and the welfare system: - Public healthcare system (within this healthcare governance and the presence of an internal market/no internal market) (Light, 1991) - and implications for women (Johnson *et al,* 1995. Gunn *et al,* 2019)	The demographic composition of membership – e.g. gender, class (Light, 1995. Gunn *et al*, 2019)
Labour market – e.g. women's entry to other professions, i.e. law and medicine Women's entry to higher education (Dent, 2003)	Technological advancement and expertise in practice, e.g. critical care (Light, 1995)
State and the relationship/ position with the medical profession, e.g. legislative mandate with junior doctor working hours (RCSE, 2016)	Educational entry and training for the profession (pre and post-registration) – control of training (Friedson, 1970a. Larson, 1977).

Including the number of doctors in the healthcare system (Dent, 2003).	
Patient interest groups and healthcare activism (Light, 1991 – patients as consumers aspect, Vinson, 2016)	Degree and nature of competition with adjacent professions, e.g. allied health professionals and advanced practice (Light, 1991. Abbot, 1988)
Other professional groups (outside of medicine) advancement and development, e.g. physiotherapy, operating department practitioners, and nursing associates (Light, 1991. Abbott, 1988).	Position/relationship within general management in the workplace, i.e. NHS Trusts (Dent, 2003)
Organisational governance; management and leadership, i.e. general management in NHS Trusts (Light, 1991)	Union and professional body standing/strength with the profession (Walby *et al,* 1994)
Unions and professional bodies - relations with the state positions of strength/weakness (Edwards, 1979. Braverman, 1974. Wallenburg *et al,* 2024)	Remuneration (Light, 1991, 1995)
Presence/influence of other organisations, e.g., HEE and NHSEI	Internal professional relations and unification, i.e. the discord or disagreement between different groups within a profession
Media – representation of the professions, i.e. newspaper accounts of nurses (Francs Report see Latimer, 2014)	Loci of practice and degree of autonomy, i.e. hospitals, community, prisons, armed forces
Patient demographics, ageing and co-morbidities, alongside health inequalities which are deemed to be in	

part driven by state economic and political decisions (Institute of Health Equity, 2020. Gunn *et al,* 2019)	
Universities and higher education (Abbott, 2005)	

Counters to this approach may include that it is too 'meta' and lacks specificity. However, because the CP framework is a conceptual framework, not a theoretical one, within the framework, it is possible to consider the interactions of only a couple of segments while acknowledging the presence of others. Critically, however, this conceptual approach acknowledges the complexity of professional development and that enacting a more reductionist approach would fail to capture what is currently acknowledged and understood to impact professional development. This thesis is focused on those on the CPs side that may be placed under an umbrella term of PE, in this instance, the State publicly funded healthcare system and its governance and system, for example, the internal market in England and the subsequent organisational governance set up (for example NHS Trusts) and the change to working practices and requirements. On the PC side, the focus is on post-registration training and career development of nurses (the control over training).

One key aspect of this thesis is the notion of professional trajectories and what happens to a profession's market shelter once it is established. Timmermans (2008) has highlighted, through using the work of Light (1993, 1995 and 2010), that depending on the broader 'force field' of CPs, a market shelter can be both an enabler to engage with other parties sufficiently or, can act as a constrictor that may stifle professional innovation and flexibility in changing political-economic environments. Timmermans (2008) notes that clinical medicine, rather than being controlled and de-professionalised by the rise in EBM, which arguably was introduced to try and mitigate professional dominance and autonomy (Timmermans and Kolker, 2004), has been able to turn EBM to its advantage. It has turned EBM guidelines into ***their*** guidelines, which have been constructed and promoted by the profession. Clinical medicine has thus responded by being dynamic and flexible to changes in the healthcare landscape.

In contrast, forensic medicine, which appears to have a very strong market shelter, has instead turned its market shelter into a 'bunker', which has locked it into a status quo which has left it unable to respond to changes in the healthcare sector (Timmermans, 2008). It is conceived that clinical medicine showcased an ability to engage third parties in 'political, economic and legal means', which has resulted in de-professionalisation attempts by the State being weakened (Timmermans, 2008). Although this research considered clinical, forensic medicine and the rise of EBM rather than nursing development, it does provide a link between the development and strengthening of a profession's market shelter and CPs.

2.3.5 Alternative theoretical approaches

Whilst a neo-Weberian approach has not been used in this thesis, there are links between this and Light's (1991, 1995, 2010) CP perspective. Both approaches have a focus on a market model of actors, however, Light also includes systems theory in his framework, while the neo-Weberian perspective does not (Riska, 2010). Light's systems aspect provides greater consideration to the interdependence and fluid boundaries between interacting groups and the broader context they exist within, thus providing a pluralist perception of power in health care (Riska, 2010). As stated earlier in the thesis, the CP framework considers the social, political and economic field of forces and their intersections, including with and through professional groups, such as nursing (Light, 1991). This hybridity of systems theory and a market model of actors' perspective gives the CP framework more of a holistic notion of power and influence, more closely aligned to the open-system perspective of PE. Previous research linking a neo-Weberian approach with Light's CP framework (Adams and Saks, 2018) has indicated that though they are similar, they are also different. For example, Adams and Saks (2018) p.72 highlight that a more sophisticated neo-Weberian analysis of state-professions based on social actions which are faced with a range of countervailing arguments that significantly moderate outcomes *"commensurate with the concept of countervailing powers classically outlined by Light (1995)".* Saks is a neo-Weberian and has previously stated that Light and an enhanced neo-Weberian approach contain *"similar arguments about the state and professions*

advanced by Tracey Adams and myself" (Saks, 2020). Saks (2020) further claims that an enhanced neo-Weberian approach and difference between that and Light is *"the heritage that we are seeking to reclaim as neo-Weberians from Max Weber's original work"*.

The neo-Weberian approach to studying professions is well established (Saks, 2016), including within the UK and Europe (Saks, 2010. Olgiati, 2003), but it does not examine state decision-making and state actors. This lack of examination is acknowledged as a shortcoming of the neo-Weberian approach and subsequently, there is often a black box of state decision-making from a Weberian perspective (Saks and Adams, 2019). Consequently, there is a lack of consideration of the processes that occur due to state-decision making, including in and through policy and with state actors, which impacts the profession's relationship with the state, their professional formation and market shelter development and strengthening. State actors are organisations associated with or representing a government and conduct arm's-length work. Conversely, they (state actors) mediate between the state and professions in what might be considered a model 'co-governance' between state actors and the state.

The lack of examination of the state and state actors is not confined to neo-Weberianism. Foucauldian and Marxist theorists, such as Esland (1980), Navarro (1986), Saunders (2007) and Johnson, (1993), (1995) are additionally highlighted as not emphasising the role of state actors in professional formation, which ultimately leads to an incomplete picture of profession-state relations (Saks and Adams, 2019). Consequently, these approaches were also not utilised for this thesis. A case has been made for an enhanced neo-Weberian approach to better encompass the state social action, which could acknowledge the role of state actors (Saks and Adams, 2019). However, the CPs framework by Light is argued in this instance to provide a clearer avenue to exploring the influences and impacts on nurses' post-registration development, incorporating and enabling a flexible and dynamic approach to the multi-faceted elements of PE and healthcare governance.

As highlighted earlier in this chapter, the state is inherently political, and the development of the welfare state, including the formation and implementation of policy, is a political act underpinned by processes of power. Additionally, it can be

argued that the 'state' is a human entity developed through liberal democracy. It is not a static, machine-like entity, and *"…a shadowy body that hardly intrudes upon the scene"* (Parkin, 1982 p. 101). To utilise and explore nurses' post-registration development through a PE lens, a better encompassing of the state and co-governance through state action is needed. Furthermore, Light (1991, 1995, 2010) does not ascribe a particular identity to the state. Therefore, changes in the state's nature, including changes in political parties and ideologies, are enabled. This is important in this context because this thesis explores the nature of PE over time, including changes to how the state alters policy directions and mandates on healthcare. Consequently, analysing state influence and impact is open and flexible to consider all possible options rather than viewing the state and its actions in a particular way. It allows for dynamic response and interpretation of state actions and impacts on the nursing profession and an in-depth exploration of the state-profession relationship, which includes state actors.

In this thesis, a more significant consideration of state actors is needed because it is not just the state as a government that will influence the professions within the NHS. At the time of writing and throughout this thesis, multiple state actors were and still are present in the English NHS. The UK government has 606 departments, agencies or public bodies (GOV.UK, 2024). While the DHSC is one of 24 ministerial departments, it works with 23 agencies and public bodies (GOV.UK, 2024). These include the UK Health Security Agency, Care Quality Commission, NHS England, NHS Pay Review Body, NHS Business Services Authority, NHS Resolution, and the National Institute for Health and Care Excellence (GOV.UK, 2024). These will influence and impact the professions, for example, through pay reviews or by regulating and monitoring the organisations they work within. NHS organisations, including Trusts and Foundation Trusts,[18] are also state actors and play a pivotal role in nurses' post-registration development. Employers are a pivot point between the state and the professions. Thus, utilising a framework such as Light (1991, 1995, 2010), which can provide a

[18] Foundation Trusts are organised and governed in a different way to NHS Trusts, though both are part of the NHS. Foundation Trusts have greater freedom and flexibility to decide how to organise their services to meet their population's needs.

better account and focus on state actors' role in influencing nurses' post-registration development, is critical.

Furthermore, highlighting the presence of NHS Trusts is important in the rise of multi-level and polycentric governance and co-governance. Multi-level and polycentric governance convey the dispersion of power from the national, central government to other 'centres' (Cairney, 2020). Multi-level includes national, regional and local government, and governance describes power sharing between those with formal authority and informal influence (Cairney, 2020). NHS Trusts and Foundation Trusts are not independent from the government. While they have a degree of autonomous level decision-making, they are still part of the broader NHS structure accountable to the central government and receive support from them. For instance, the Secretary of State for Health can give financial assistance to any NHS Trusts and Foundation Trusts, including loans (DHSC, 2023). Additionally, the recent changes in legislation and the creation of ICSs in the Health and Care Act 2022 gave statutory powers to ICSs. While this devolution of greater powers down to regional levels gave greater autonomy and accountability, there is still a central priority setting for ICSs, and their success depends on how NHS England and DHSC work with them (HSCC, 2023). A report from the National Audit Office (2022) stated an inherent tension exists between local needs-based strategies and delivering national NHS mandate targets.

Consequently, due to the complex governance system that exists in the NHS, the relationship between the state and state actors is of paramount importance to encompass within a theoretical perspective, which Light's CP framework, as a system theory and market model of actors approach, can deliver. As Richards and Smith (2004) state, a tenet of multi-level governance is the dispersal of authority and decision-making to a wide range of bodies, and the previous state-centred and state-driven activity has become a mix of hierarchies, markets and networks. Subsequently, this aligns with the earlier discussion of this chapter and the current prevalence of neo-Fordism impacting the NHS and the nursing profession. Rhodes (1997) highlights that there is no longer a mono-centric or unitary government, and thus, utilising a framework such as Light (1991, 1995, 2010), which can accommodate this, is imperative.

In acknowledging the presence of state actors, this focus also considers non-state actors. These organisations are independent of the state (Morgan and Yeung, 2007) and sometimes referred to as the third sector, such as think tanks, including the Health Foundation and the Nuffield Trust. Other entities include charities such as the British Heart Foundation, non-governmental organisations (NGOs), trade unions, and organisations of professional groups such as the RCN and the NMC. These bodies are not confined to a nation; for example, the World Health Organisation, an NGO, influences across national borders. These types of actors are considered to have political influence but do not work for a government. For example, the rise in pressure groups and health consumer groups in the UK is viewed to have become part of the health policy process (Jones, Baggott and Allsop, 2004). Furthermore, Light (1991) recognises the role of pressure groups as a countervailing power on the professions. Consequently, non-state actors will influence state mandates such as national strategy and policy through lobbying and disseminating their own research and analysis on problems and issues. Therefore, it is a challenge to create a definitive dividing line between bodies that will or will not influence the professions. Non-state actors may have an indirect influence, but because they can influence the state's and state actors' actions, they arguably still impact the professions, including nursing.

2.3.6 Light and Spencer

It is important to frame the work of Light (1991, 1995, 2010) more broadly in the systems of professions. While Light (2010) discusses Abbot's (1988) system of professions alongside the CPs framework, Spencer (1896) arguably offers an alternative system of professions applicable and relevant to this conceptualisation. Abbot and Spencer conceive of 'occupational ecology', albeit with different foci, in which professions grow, develop, move and interact (Dingwall, 2008). Abbot's (1988) ecology is primarily focused on the processes by which boundaries are drawn and redrawn between elements of a system, for instance, in relation to the division of labour, whereas Spencer (1896) focuses greater attention on the channels of interchange between system elements and across boundaries (Dingwall, 2008). Subsequently, Spencer places the State-profession relationship more centrally when

considering professions and their development. In contrast, Abbot does not specify clearly where the state stands as an actor in relation to the 'system of professions' (Dingwall, 2008). Furthermore, a greater focus on the state and system elements means that the role of state actors can be better accounted for. As highlighted earlier in this chapter, this thesis is focused on the supply aspect within the interactionist perspective in the sociology of the professions because it is concerned with State-profession organisations and interactions influenced by PE. Thus, Spencer's (1896) focus on the channels of interchange resonates with exploring the state's and state actors' roles in greater focus concerning PE. In framing Light with Spencer, a consideration of market shelters is still relevant. While Spencer is not as focused on jurisdiction control as Abbot is, Spencer does not negate it. Spencer is focused more on the contract terms that may define that jurisdiction and the terms that govern interchanges among system elements rather than the jurisdiction itself. The difference is framing is subtle but allows for exploring the 'why' and 'how' nurses lack progress in achieving greater market shelter strength.

The CPs framed by Light (1991, 1995, 2010) are working in the 'spaces in between' the state and profession, and in relation to Spencer's (1896) system of professions, the 'channels of interchange'. Spencer's consideration of the system of professions is thus well placed to consider these 'in-between' spaces, the grey areas of influence which subsequently may give an illuminating framing to CPs to consider the problems with nurses' post-registration development.

2.4 Part three: The research gap and question

There is no recent empirical research looking at the PE changes in detail concerning nursing post-registration development. Some critical analysis has looked at the PE changes impact on the professions (but not post-registration development specifically), for example, Allen (2001), Traynor (1999, 2013), Lloyd and Seifert (1995), Johnson, Larkin and Saks (1995), Walby *et al* (1994), Moran (1999), Paton (2006), Kirkpatrick, Ackroyd and Walker (2005), Dent (2003), Cheyne, McNeil and Hunter *et al,* (2011), Burnes and Salauuroo (1995), Buchan, Hancock and Rafferty (1997).

Aspects of the NHS internal market reforms have been considered in other areas including medicine and nursing relationship (for example, Walby *et al,* 1994, Radford, 2012), management relationship with healthcare staff (Griffiths and Hughes, 2000), professionalism and the impact of NPM (Cooke, 2006. Evetts, 2009), talent management and nursing (Haines, 2016) and human resource management and the impact on health care organisations and professionals (Harris, Cortvriend and Hyde, 2007. Hyde, Harris and Boaden. 2013). Some recent studies have looked at the European Union (EU), including the UK, regarding health workforce development trajectories and health policy (Pavolini and Kuhlmann, 2016) which shows a macro-level approach to professional development. There has also been some critical analysis from other countries, including the US (Ritter-Teitel, 2002), which looks at restructuring healthcare practices and hospitals on nursing practice.

Consequently, taking a more PE focus to consider the professions is not well documented in previous research at the time of writing. This is important to do here when the reforms being used as a focal point were and are both political and economic. Additionally, at the time of writing, the CP framework has not been used to explore the development of the nursing profession post-registration. Given the current gap in the research surrounding the impact of the changes in PE in the UK on nursing post-registration development, the research question is:

'Why has nursing in England not established a stronger market shelter through post-registration development and career frameworks, despite post-Fordist reforms?'

2.5 Chapter conclusion

In this chapter, PE has been outlined, followed by its relationship to considering the welfare state. Alongside this, the role of policy in enabling state mandates and directives in relation to this was explored. Policy acts as a vehicle and mechanism through which problems are framed, as well as the tools and instruments used to achieve the state's goals. Health and healthcare are core components of the welfare state in the UK, and subsequently, policy plays a crucial role in influencing the

professions, including nursing. The changes in PE were viewed through the lenses of Fordism, post-Fordism and neo-Fordism. This analysis considered that post-Fordism implies that nursing is not done by numbers; for instance, it is more interested in skill mix and development, whereas, in a Fordist model, nursing is conceived more along the ideals of mass numbers able to produce a 'mass care' output. However, both approaches to workforce development are apparent in the NHS today, as a neo-Fordist context prevails. Thus, nursing has ended up in a push-pull between Fordist and post-Fordist ideals, which has hindered professional practice and development.

To frame the PE influence on nurses' post-registration development, this thesis utilises the sociology of the professions as a literature base. Within this, the concept of a professional market shelter is focused upon, with a supply perspective considering the state-professional relationship. The influence of the post-Fordist era suggests that nurses should have a stronger market shelter. However, this chapter has highlighted that this has not been the case. Nurses' market shelter remains weaker than medicine's. While highlighting neo-Fordism and the tensions is important, there remains limited in-depth detail of the system mechanisms holding the nursing profession back. The conceptual framework through which to explore this is Lights (1991, 1995, 2010) countervailing powers framework. This framework has been chosen instead of other approaches, including neo-Weberian, Marxism and Foucauldian, due to its ability to conceptualise the state and state actors in greater depth and freedom.

Consequently, the main research question in this thesis focuses on exploring why nurses in England have not established a stronger market shelter through post-registration development and career framework despite post-Fordist reforms.

Chapter 3. Methodology

3.1 Introduction

This chapter is structured into three main sections. First, the philosophical underpinnings of this research address the ontological, epistemological, and methodological foundations. Second, the methods section considers the research design, methods, data collection and sampling, data analysis, and ethics. Finally, this chapter presents a reflexive account of this research and a statement on how the COVID-19 pandemic impacted and changed its course.

3.2 Part one: Philosophical underpinnings

3.2.1 Ontological foundations

Broadly, ontology is focused on the 'philosophy of reality' and what kind of 'things' or 'substances' there are, including the range of entities and relations in the world (Benton and Craib, 2011). This research utilises constructionism, considered a social ontology, whereby what may be regarded as independent or real objects are social or cultural constructs (Benton and Craib, 2011).

The focus of this research is on nurses' post-registration development. While this phenomenon is 'real', it is also socially constructed. Nurses' post-registration development is not a physical object that can be touched or 'seen'. Nurses themselves and employers will have different opinions and views on what it is, should or could be, and individual meaning will be placed on its value. Additionally, the political-economic environment, women's place in society, the gendered dynamic of the profession and health system design will shape and alter how working practices, and therefore nurses' post-registration development, are viewed. Subsequently, this will impact what and how many resources are allocated to it. Thus, there is no 'one' way to view and 'quantify' nurses' post-registration development. Additionally, as highlighted in the literature review, policy is socially constructed (Jones, 2014); therefore, utilising constructionism aligns with the foundations on which the thesis is placed.

To gain knowledge of a phenomenon that is socially constructed and impacted by gender, it is important to utilise an epistemological basis that enables consideration of knowledge claims and the gender and power dynamics within the research area.

3.2.2 Epistemological foundations

Broadly, epistemology considers the 'theory of knowledge', 'what is knowledge?', 'what can be known?' and 'how do we know?' (Greco and Sosa, 1999). Crucially, epistemology considers how we know reality through knowledge constructions; therefore, ontology and epistemology are interlinked (Blaikie, 2018).

Underpinning this research is a feminist epistemology, which compliments a constructionism ontology (Locher and Prugl, 2001). A feminist interpretation of epistemology additionally considers 'who knows?', 'who can know?', and 'what can be known?' (Harding, 1991). Over the years, knowledge recognition has been reformulated, and the 'standard view of science', or the 'view from nowhere', has gradually been eroded (Harding, 1991). The objective and independent knowledge claims that such a view encourages have been revoked by the feminist critique, which has highlighted that knowledge is bound up in cultural, historical and social domains that influence its creation and direction (Gross, 1986). This ascribes a form of a 'politics of knowledge', which argues that there is a location to knowledge and is intertwined with power (Herrnstein Smith, 1997). It is further contended that the situation of 'the knower' will be influenced by their own socio-economic and cultural background and situation (Haraway, 1988). As a result, our knowledge is said to be partial and changing rather than universal or transcendent (Tuana, 2001). Furthermore, as highlighted in the literature review, policy is synonymous with the process of power and ideas and, consequently, the formation of knowledge (Cairney, 2020). Critically, it is argued that power plays a role in deciding what knowledge is and, therefore, will determine the process of determining policy problems, agenda setting, tools and instruments.

Regarding the research process, a feminist perspective advocates for considerations about epistemological claims, including co-construction of knowledge, reflexivity, power relations and dynamics (Stanley and Wise, 1993). Crucially, however, it is not

the method(s) used for data collection that makes feminist research distinctive (Campbell and Bunting, 1991) but the purpose of inquiry combined with the relationship between researcher and subject (Harding, 1986). A feminist perspective acknowledges that the researcher is active in the research process, and therefore, knowledge is constructed by participants and researchers rather than 'discovered' by researchers (Stanley and Wise, 1993). There is no 'veil of objectivist neutrality', and researchers should not claim to be able to produce a mirror image of a phenomenon or participants' experience (England, 1994, p82). Additionally, a feminist perspective is critical of the traditional power relations in the research process (Usher, 1997). To address this, researchers can position themselves as learners and recognise that they rely on the participants' greater knowledge to determine research outcomes (England, 1994).

However, feminist epistemology is not 'one' thing, and it encompasses a wide degree of difference. Alcoff and Potter (1993) contend that it is more appropriate to consider feminist epistemology plurally, and Harding (1986) denotes categories of feminist solutions as empiricist, standpoint or postmodern. Rather than these approaches being siloed, Grasswick (2006) shows that they overlap and interrelate. Likewise, Hoffman (2001) present that they should not be regarded as separate, incompatible or opposed. Feminism is a collection of positions and inquiries, and therefore, this research uses a feminist epistemological perspective underpinning in its broadest sense. A feminist perspective is also advocated for here due to the gender dynamic within nursing. Nursing is a heavily gendered profession where only 11% are men (NMC, 2024a), which has impacted the development of career structures and frameworks (Whittock, Edwards and McLaren *et al.* 2002). Extensive research has considered the gendered aspects of nursing and how this impacts the profession, including Warner, Black and Parent (1998) and Davies (1995). As this research focuses on a female-majority workforce, their careers and the neglect of nursing workforce development, a feminist commitment to epistemology is important (Doering, 1992. Wuest, 1994).

Additionally, as this thesis is focused on recognising the power dynamics in the research area, it is important to respect and reflect that from an epistemological

perspective. This results from the power dynamics within the CP framework and the State-profession relationship. Therefore, utilising an epistemological stance to acknowledge power creates enhanced methodological coherence and greater unity between the theory and research area. There is literature to support the use of a feminist perspective and power constructs without only a focus on gender (Stanley and Wise, 1993). For an in-depth account of how feminist epistemology can be used as a base for research that considers power with and beyond gender, see Field-Richards (2017).

3.2.3 Methodology foundations

At its core, research methodology is the bridge between philosophy, methods and data collection. The importance of detailing the research methodology allows for methodological coherence. Consequently, research methodology can be determined as the 'theory and analysis of how research should proceed' (Harding, 1987, p2). Broadly, the methodology concerns what, why, from where, when and how data is collected and analysed (Guba and Lincon, 1994). Establishing methodological coherence can enable transparency in, and delineation of, epistemological assumptions and claims for 'truth' which enables defence and justification for the research process as a credible form of inquiry (Crotty, 1998). Ontology and epistemology construct the foundations upon which a research methodology is formulated (Grix, 2010). Considering the constructionist ontology and feminist epistemological foundations, this research utilises an interpretive methodology. Classically, interpretivism is a research paradigm incorporating constructionism (Benton and Craib, 20211), and feminist epistemology is compatible with the interpretive paradigm (Kiguwa, 2019). Thus, there is unity and coherence in this blend of approaches. There is not one methodological approach that is advocated for in considering feminist epistemology (Harding, 1986) and interpretivism and a critical paradigmatic approach are both used alongside feminist epistemology (Kiguwa, 2019). A core component of this research it to explore and understand the influence of PE on nurses' post-registration development, rather than seeking to empower nurses'

themselves to change society and their post-registration development radically. The latter focus is associated with a critical paradigmatic approach (Neuman, 2002), and is thus in this context, not aligned with the focus and purpose of this research. Another core implication for utilising a feminist epistemology relevant to methodology is reflexivity, which considers the role the researcher plays in producing knowledge (Stanley and Wise, 1993). Reflexivity is discussed in greater detail in part three of this chapter *'Reflexivity and COVID-19 adjustments'*, which includes a general account of reflexivity and then specifically applied to this research.

Interpretivism is grounded in the assumption that reality is socially constructed, subjective and multiple (Crotty, 1998). Therefore, interpretive approaches explore, question and observe to generate a rich and deep understanding of the investigated phenomenon (Blaikie, 2018). Additionally, interpretivism aids in exploring the historical, social and cultural context within which a phenomenon exists (Crotty, 1998). This is critical for this research, as nurses' post-registration development exists within and due to multiple conditions and events. To 'only' consider the perspective of nurses, for example, in exploring post-registration development, would blind and restrict this research to critical factors which may underpin experiences, perspectives and of nurses themselves.

A qualitative research approach is encouraged within an interpretive methodology (Blaikie, 2018); thus, this research follows a qualitative design. Qualitative research is conducted to enhance understanding of cultures, beliefs, human experiences, values and situations (Creswell and Poth, 2017). It seeks to make the world visible through interpretive practices, which produce representations, including interviews, recordings, and field notes (Denzin and Lincoln, 2011). Subsequently, qualitative research can use a variety of interconnected, interpretative practices to try and gain a better understanding of the phenomenon being studied (Denzin and Lincoln, 2011). Therefore, this research utilised a multi-method and multi-level design detailed in the forthcoming section. A qualitative approach was considered appropriate to address and explore the research question because nurses' post-registration development is socially constructed and subjectively lived. Furthermore, the research area is highly complex, and little is known about it, which Sofaer (1999) contends is a suitable base

for qualitative inquiry in health system research. Additionally, as the research question was formulated to be open-ended and exploratory, employing qualitative data collection and analysis aligns with the underpinning strategy of qualitative research (Elliot and Timulak, 2005).

3.3 Part two: Methods

3.3.1 Research design

The research followed a multi-level, multi-method, qualitative design. For the multi-method aspect, national policy document analysis was followed by three levels of semi-structured interviews, where the policy document analysis guided the semi-structured interviews. Fig.2 presents an overview of the research design and structure.

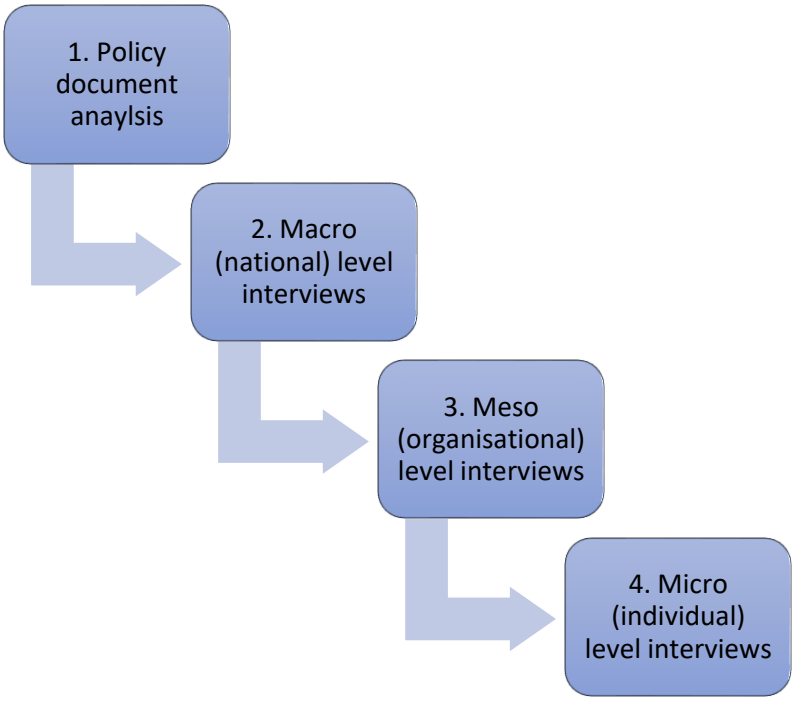

Fig.2 Methods and research design overview.

Macro refers to individuals working in national-level organisations which help create or influence national policy. Meso refers to organisational leads, such as Chief Nurses, and micro refers to registered nurses working in clinical, educational, managerial or research roles.

Multi-level

In this research, the multi-level component refers to the different levels of analysis: national policy, macro, meso and micro. Caronna (2010) highlights the complexity and multi-layered nature of studying issues within a healthcare system. Healthcare organisations' structures and cultures, professional practices and identities, wider political and economic factors, and broader social values and belief systems all operate alongside each other. As a result, exploring and understanding a phenomenon within this requires an approach that can analyse process and change while allowing for different perspectives (Caronna, 2010). Furthermore, as highlighted in the literature review, there is a multi-level system of governance. Thus, the dispersal of power and allocation of responsibility and accountability need to be considered through the levels in which they are placed. Nurses' post-registration development exists within this mosaic system. Subsequently, a research design needs to reflect the tension or pivot points that can broadly be attributed to affecting the phenomenon under study. While this design was based on the literature informing the context and environment of nurses' post-registration development, it was also formed through my experience working as a registered nurse. My background and exposure to post-registration development gave me a direct insight into the phenomenon under study. This research topic was formulated from my own experiences, and thus, it was also pragmatically designed to reflect what I knew of the system.

In detail, with reference to Fig.2., the outputs from the policy analysis were used to produce a skeleton interview guide for the macro-level interviews. The outcomes from the macro interviews were then used to inform the interview schedule at the meso-level while also exploring the themes from the policy analysis. Practically, national policies and guidance from the macro level help guide meso-level decisions and developments. Therefore, it was important to consider the challenges and opportunities an organisation may face when implementing national policies and how these affect nurses' post-registration development. Themes derived from the analysis of policy, macro, and meso-level interviews were subsequently informed by the micro-level interviews. Alongside exploring how the nurses viewed their post-registration development, it was also important to link this with their awareness, or not, of the

organisational and wider policy directives that affect their career and development. All the interview guides can be found in Appendix 1. This enabled a thread to be drawn through the different levels of analysis to link them together, creating coherence and a holistic account of the challenges with nurses' post-registration development.

Multi-method

There is debate about the exact distinction in terminology for a multi-method design (Anguera, Blanco-Villasenor and Losada *et al.* 2018). Nevertheless, a multi-method design can combine aspects within qualitative *or* quantitative approaches, unlike mixed methods, which combine quantitative *and* qualitative approaches (Hesse-Biber and Johnson, 2015). The benefits of utilising a multi-methods design include answering broad research questions, providing a more comprehensive and complete approach to the phenomenon(s) under study, and triangulation (Davis, Golicic and Boestler, 2011). These benefits can help improve the research study's trustworthiness, facilitating a multifaceted, richer analysis of a complex and multi-layered social world (Hesse-Biber and Johnson, 2015). This aligns with the constructionist approach to research used for this study (Mik-Meyer, 2020). In relation to this research, utilising a multi-method approach was important to gain a greater sense of the context, including the historical developments in which nurses' post-registration development was operating. This aligns with the aim of an interpretive methodology, which advocates for exploring the context within which the phenomenon under study sits. The policy document analysis, in this case, provided the initial context and developments that framed nurses' post-registration development. Then, the semi-structured interviews could explore and navigate these in greater detail. I was conscious of incorporating participants' reflections on their situation, the components I identified in the policy document's analysis, and the different views and opinions expressed in the different levels of interviews. This allowed me to incorporate their reflections into my reasoning when analysing the data.

Challenges to multi-method research include time availability and training in multiple methods and analysis (Davis *et al.* 2011). Pragmatically, time was a challenging factor in relation to this research. I created Gantt charts to guide and organise the research process to overcome this challenge. These timeframes were reviewed and regularly

discussed within the supervision team to keep the research within an appropriate time frame. Additionally, this process allowed a dynamic and responsive approach to challenges that arose. This included responding to the difficulties with recruitment at the meso-level interviews which is discussed in greater detail later in the chapter. I regularly completed training needs analysis early in the research process, alongside designing the research, to identify any gaps in knowledge and skills that this research would require. Subsequently, I undertook a module in public policy to assist with the policy analysis component.

The aim of using a multi-method design in this research was to capture the State directives and mandates in policy document analysis and then explore them, their development, enactments and impact at a national (macro), organisational (meso) and professional (micro) level through semi-structured interviews. As highlighted in the literature review, policy is a core component of the PE landscape and, thus, needs to be a focus in relation to the professions. This design aimed to capture the State-profession relationship while acknowledging the intermediate factor - organisations, such as NHS Trusts, which act as state actors and the mediators in this relationship. As these three components, the State, organisations, and professions, are interlinked, this research design with the multi-level and multi-method aspects aimed to encapsulate this system and its interactions.

Fundamentally, the research objective was to develop themes from the policy analysis and explore individuals' beliefs about them at the macro, meso, and micro levels in relation to nursing post-registration development. However, the policy themes were not intended as a fixed analysis framework. For example, it was unknown at the start that themes developed from the policy analysis would necessarily thread through all the stages of analysis. Therefore, the analysis needed to be flexible, adaptive, and dynamic to respond to the individual opinions and experiences expressed by participants within the different levels of interviews.

3.3.2 Data collection method: policy document analysis

Document analysis is a procedure to examine data and interpret it to elicit understanding, gain meaning and establish empirical knowledge (Bowen, 2009). Sources of text can include books, diaries, journals, letters, newspapers and policy documents (Bowen, 2009). In general, document analysis can be used to seek and understand elements of how documents are active agents in organisational and everyday life (Flick, 2018). This is because many elements of life, including the coordination of professionals and services such as healthcare, are bureaucratically organised (Flick, 2018). As a result, documents can be the glue that binds people and their work together (Flick, 2018). Documents can be viewed as 'social facts', which Atkinson and Coffey (1997) observe is due to them being socially produced, shared, and organised.

Document analysis is often used in conjunction with other qualitative methods for triangulation (Bowen, 2009). Triangulation aims to corroborate information through different data sources and methods in the study of the same phenomenon and is considered to enhance the credibility of a study (Denzin, 1970. Eisner, 1991). Furthermore, documents can explain the context in which research participants function. In this study, the context is one in which nurses, organisational leads and national-level individuals navigate the nursing post-registration landscape. Additionally, the analysis of documents can be used to formulate questions that need to be asked to understand a particular situation and provide a means of tracking change and development (Bowen, 2009). These elements are particularly central to this study as a timeframe of policy documents and government administrations was being considered. Additionally, this research explores reasons or reinforcements for why the post-registration landscape for nurses is in its current state. Therefore, document analysis of national-level policy provides a foundational grounding and enables some elements of historical and current contexts to be explored in the semi-structured interviews.

3.3.3 Data collection and sampling: policy document analysis

The identification of documents consisted of three main stages:

1. *Database, archive and manual searching*. Using keywords such as nursing development, NHS workforce, NHS workforce planning and nursing post-registration careers, documents between 1989 and 2020 were identified. This time frame was chosen to reflect the start of the significant shift into the post-Fordist era in the UK (mid to late 1980s). The pivotal point for reference was introducing the internal market into the NHS after the 1989 White Paper *Working for Patients* (DoH, 1989a). Therefore, this document was used as a designated starting point. The year 2020 was the endpoint due to the time frame for data collection. A snowballing strategy from documents was also used to identify other relevant material, such as searching reference lists.
2. *Identifying documents to be included.* Inclusion criteria at this stage were documents pertaining to NHS policy, nursing post-registration development and the NHS workforce from government and independent organisations in England, including state and non-state actors. The included documents at this stage were 81, and this number was reached due to the sampling saturation point. The documents were organised into chronological order and colour-coded to represent the government administration then in power. Colour coding was used to indicate the focus, direction, and volume of policy from different governments (Appendix 2). At this stage, it was recognised that a limit was needed for policies with an English focus (post-devolution) and not the UK overall. This limitation is because NHS governance, structure, and policies differ across the UK. Therefore, a comparison between these would require a separate thesis project.
3. *Narrowing down the document list for analysis*. As a result of the volume of documents identified in stage two, the inclusion criterion was narrowed to include documents broadly about NHS policy, the NHS workforce and nursing development. This was because 80 documents were considered too large a sample to analyse within the time frame. Exclusion criteria were specific documents focusing on areas of nursing practice, including advanced practice

and clinical academic careers, since this research focuses on nursing post-registration development in general rather than different components. Another exclusion criteria were documents from non-state actors, such as the Health Foundation and the Nuffield Trust. This was because a high volume of documents was still in place after the first exclusion criterion was applied. Due to the focus of this study being on the state mandate's influence on nursing development, independent bodies were deemed outside that sphere in this instance. However, although these documents were removed from the direct analysis, they were still included in wider reading to help understand the workforce context and landscape. As highlighted in the literature review, non-state actors can play a role in influencing a state's policy mandates and direction. The total number of documents at this stage was finalised at 47, which were again organised into chronological order and colour-coded to represent the then-government administration in power (Appendix 3).

3.3.4 Data analysis: policy documents

The document analysis was conducted using thematic analysis guided by Braun and Clarke (2006), shown in Fig.3.

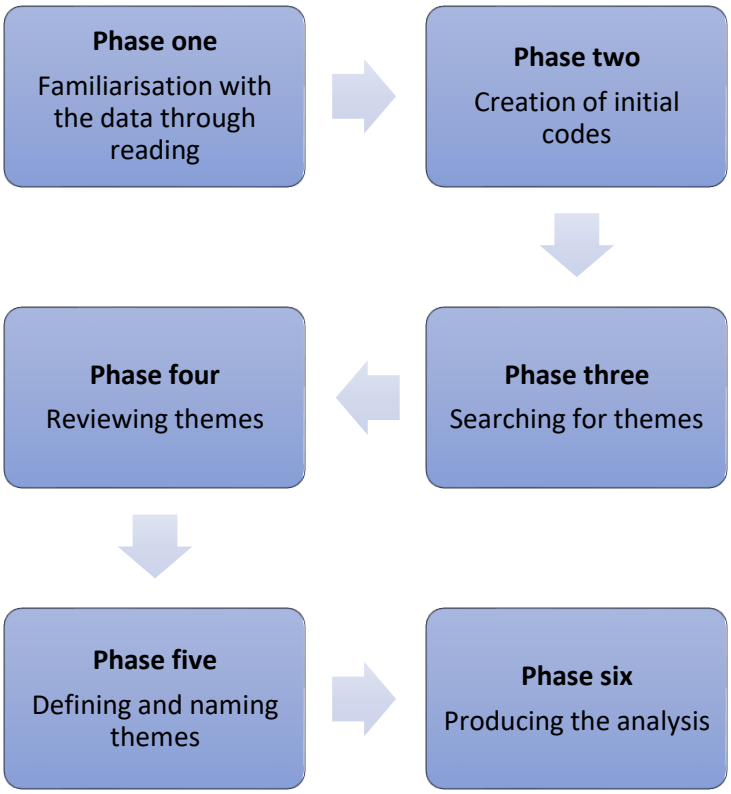

Fig.3 Thematic analysis by Braun and Clarke (2006)

Thematic analysis, in its broadest sense, is a method for developing, analysing, and interpreting patterns within a qualitative data set, such as documents and interviews (Bruan and Clarke, 2022). The purpose of thematic analysis is to systematically process data coding to develop themes, which are the core output (Braun and Clarke, 2022). Themes are a pattern of shared meaning and a central organising concept for data (Braun and Clarke, 2013). At its foundation, thematic analysis is theoretically flexible, and Bruan and Clarke (2022) define their approach as reflexive. Here, reflexivity is concerned with the researcher's impact and influence on research and is embedded within the values of qualitative research (Braun and Clarke, 2022). Thematic analysis is not inherently reflexive. Other approaches include coding reliability and codebook thematic analysis have their own practices and processes (Bruan and Clarke, 2019). For example, a coding reliability approach, such as that of Joffe (2011), recommends using a coding frame and calculating an inter-reliability score with multiple independent coders. Using inter-reliability scores places the coding reliability

approach within a realist research paradigm (Braun and Clarke, 2022), which is not the basis of this research and, therefore, inappropriate. The reflexive thematic analysis approach was used to align with the feminist epistemological underpinnings for this research, which requires the researcher to recognise and acknowledge their role in the research process and production of knowledge. As highlighted earlier, the reflexivity section in part three of this chapter provides a detailed reflexive account of my positionality regarding the research process and knowledge production.

While Fig.3 outlines phases that thematic analysis may go through, Braun and Clake (2022) state that there are no strict rules for reflexive thematic analysis. Instead, there are guidelines. This position is justified because the researcher is situated and an integral part of the analysis. The analysis, therefore, occurs at an intersection of the dataset, research context, researcher skill and their locatedness (Braun and Clarke, 2022).

Although Braun and Clarke (2006) provided the framework for analysis, the conduct of this analysis was also underpinned by the work by Taylor, Rizvi and Lingard *et al.* (1997), which considers that the study of policy needs to come from three aspects: policy context, text and consequences. Policy documents are produced in the context of a political arena (Cardno, 2018). Therefore, the socio-economic environment requires understanding to gauge the issues and pressures that have given rise to a policy (Busher, 2006). The policy text remains the core focus of the analysis, but a questioning stance needs to be taken to look beyond the words and recognise these have been written for a purpose (Bell and Stevenson, 2006). The consequences are related to how policy is interpreted and implemented. Thus, the effectiveness of policies or procedures must be considered to provide an overview of challenges or opportunities (Alexander, 2013).

The analysis itself was conducted using abductive reasoning. Although a prescriptive framework was not utilised to analyse the policy documents, the analysis was approached by searching for reasons or reinforcements as to why nursing post-registration is in its current state. Furthermore, as discussed in the literature review, the CPs framework by Light (1991, 1995, 2010) prompts the researcher to look for

things(s) that would reinforce the situation of nurses' post-registration development and is thus not wholly an inductive approach.

The reflexive thematic analysis was done manually, including coding and generating themes. No computer assistant qualitative data analysis software like NVivo was used. Braun and Clake (2022) state that there is no best or ideal way to code and that the chosen process needs to reflect what works for a researcher. I used a manual process because I found it a better way to engage with my data. I initially started using NVivo; however, I found the process obstructive and felt it placed a barrier between myself and the data. I could more fully immerse myself in the analysis when I undertook a manual process, such as handwritten codes on the printed data and writing code labels on hard-copy file cards. With reference to file cards, each card on the back had a note on which document the code was related to and where to find it, such as line and page number. Furthermore, I found that I could better engage with the process of reflexive thematic analysis using a manual process. Because I felt as if I was 'doing' the analysis by physically writing out codes and using cards, I felt like a more central part of the process. This subsequently helped me to reflect on my position and contribution to the research with greater strength, which enhanced my insight and clarity. Consequently, this allowed me to fulfil the requirements of reflexive thematic analysis with improved understanding.

While there are no strict rules, only guidelines, the details of the policy document analysis in line with the thematic analysis guide of Bruan and Clarke (2006) and considering Tayor, *et al* (1997), are given below*:*

Phase one: The documents in Appendix 3 were read to gain a general view of their focus and direction. They were then re-read, and notes were made about the patterns or absences throughout the analysis, including how issues, problems and solutions relating to nurses' post-registration development were framed. A general overview of the focus on nursing post-registration development over time was written down by considering how and when the documents were published and how they fed (or did not feed) into each other.

***Phase two*:** From these notes, codes were formed. Codes related to the absent or consistent reinforcements connected to nurses' post-registration development. Codes were created that reflected semantic, very explicit meanings, and at a latent level, with more conceptual and implicit foundations. The range of levels of analysis, semantic through to latent, was kept flexible. As the analysis progressed, latent and semantic codes were used to help capture the analytic perspective on the data set.

***Phase three*:** These codes were then subsequently grouped into themes. At this stage, themes were developed owing to considerations of Lights' (1991, 1995, 2010) CP framework and something or a group of things acting as reinforcements concerning nurses' post-registration development. This follows Braun and Clarke's (2022) position that analysis can be theoretically grounded and that theme development is an active process based on the research question and the researcher's insights and knowledge.

Phase four: Alongside the documents focusing on nursing post-registration development, consideration was given to the wider healthcare governance policies and legislation in England (and the UK pre-devolution) that were introduced or in place at the time. Other key documents considered were reports on patient quality and safety, for example, the Francis Report (2013). Although these were not analysed directly, an awareness of the broader political and economic stance on healthcare was included. Additionally, contextual evidence was sought to explore the context and consequences of particular policy initiatives or governance changes to help frame the data set in light of the research question. This then helped to review and refine the themes, which enabled the identification of important patterns across the data set in relation to the research question. Additionally, at this stage, how the themes linked together and were related were considered. Consequently, themes were developed individually and together to create a narrative and a shared, intersecting meaning.

***Phase five*:** In this phase, the earlier creation of a narrative within the data in phase four was built on. A brief synopsis of each theme was written to help clarify and consolidate their meaning, relationship to each other, and relationship to the research question. Additionally, while their relationship was important, ensuring that the themes were clearly demarcated was critical. For example, similar themes were either

absorbed into another theme or discounted. From this work, themes were defined, named and chosen based on their strength, depth, and originality.

Phase six: In this phase, the write-up of the analysis was formalised. The write-up had already been started during previous phases, for example, phase five and synopsis development. Thus, this phase developed and finalised it. Quotes from documents were used to illustrate examples and form evidence alongside the contextual evidence gathered from phase four. Additionally, due to the multi-method design, questions were formulated to reflect the analysis and act as an interview guide for the macro-level interviews. The questions were based on each of the final themes identified to enable the multi-level component of the research to have an established foundation.

3.3.5 Data collection method: Semi-structured interviews

Semi-structured interviews combine theoretically grounded and open-ended questions (Galletta and Cross, 2013). As a result, data is grounded in the experience of participants and guided by constructs and phenomena from within a discipline that are under investigation (Galletta and Cross, 2013). The duality of researcher- and participant-driven data creation enables a co-production of knowledge (Wengraft, 2001). Although a feminist perspective on methodology does not designate specific data collection methods (Campbell and Bunting, 1991), due to the co-produced nature of the knowledge foundation, semi-structured interviews were an appropriate method to use within this study.

Furthermore, semi-structured interviews enable phenomena to be explored in-depth as data is gathered from participants with personal experiences in the research area. The in-depth nature of semi-structured interviews creates richer and more focused data surrounding participants' lived experiences in relation to, in this study, nurses' post-registration development. The lived experience in this research is established from the perspective of macro, meso and micro-level individuals.

Developing a written interview guide is one aspect of conducting semi-structured interviews (Given 2008). The interview guide ensures that the phenomenon under

investigation is covered but initiates open-ended responses. As the interview guide is only an outline, interviewers must be prepared to be creative and think on the spot in response to answers or seek further clarification and examples (Wengraft, 2001). Due to my professional background and experience, the literature review and comprehensive document analysis, I felt confident in responding appropriately to questions as the interviews progressed. I also have previous experience conducting semi-structured interviews through previous research projects. Consequently, I drew on that experience to help me feel comfortable and confident with generating an interview guide and being able to respond dynamically during the interview process. As acknowledged in the document analysis section, an interview guide for the macro-level interviews was produced from that analysis. After the document analysis, the interview guide for the macro-level interviews was checked within the supervisory team to ensure that themes that had been established from the documentary analysis were then carried forward into the interviews. The interview guide for the meso and micro-level interviews was developed at the end of each previous stage. The process of checking these guides was also conducted within the supervision team to ensure that the questions were clear and appropriate considering the previous analysis and research question.

3.3.6 Data collection, sampling, and recruitment: semi-structured interviews

Macro

Sampling for the macro-level participants was purposeful, and personal and professional networks were used to contact individuals identified in national-level organisations. Purposeful sampling was utilised to ensure that the data collected could answer the research question. Consequently, random sampling was not appropriate.

The organisations targeted for recruitment were established through reading the literature. They were identified as influencing nursing development in various ways, including those from non-state actor organisations such as unions, higher education oversight and professional bodies. This meant that not all the organisations identified were part of the NHS, as, for example, Royal Colleges and national educational

organisations work independently from the government. Although non-state actors' outputs were generally excluded from the document analysis, they are impacted by national-level policy and will reflect that in their work and mandates towards the nursing profession and national policy. Furthermore, as highlighted in the literature review, non-state actors will influence policy mandates. Therefore, these groups still contribute to and influence government-level policy and were included in the sample of organisations.

The organisations sampled included the RCN,[19] HEE,[20] Public Health England,[21] NHS Employers,[22] The NMC,[23] Council of Deans of Health,[24] and NHSEI.[25] At the time of data collection, these organisations represented the national bodies that played a role or influenced policy development for the nursing workforce in England.

Individuals within the organisations were identified and sampled by their job titles and job roles, not for their underlying qualifications. For instance, they did not need to be registered nurses; they could be policy leads, workforce development leads, or Chief Nurses. These individuals were able to offer the insight required into the influence and creation of policy at a national level and how this has impacted the nursing profession.

The main data collection occurred from October 2020 to April 2021; eight participants were recruited. Four participants were female, and four were male. Participants were interviewed for an average of 1 hour, and all the interviews were conducted virtually on Microsoft Teams at a time that suited them. The interviews were recorded using

[19] The RCN is the professional and trade union for nurses in the UK.
[20] As highlighted previously, in 2023, HEE merged into NHS England, however, at the point of data collection, it was a non-departmental body of the DHSC created in 2012. Its function was to help plan, recruit, educate and train the health workforce, including nurses, in England.
[21] In October 2021, post-data collection, Public Health England became the UK Health Security Agency and Office for Health Improvement and Disparities. Public Health England was an executive agency sponsored by the DHSC. Nurses sat within its governance structure, and it had a chief and deputy chief nurse. It supported the NHS in taking action to improve public health across England.
[22] The employers' organisation for the NHS in England. It aims to help organisations to develop their workforce and improve staff experiences.
[23] As highlighted previously, the NMC is the regulatory body for all nurses, midwives, and nursing associates in the UK. It sets the standards for undergraduate education and orchestrates revalidation. The NMC also sets some post-registration standards, for example for specialist community nursing.
[24] The Council of Deans of Health is an organisation which represents the UK's university faculties who are engaged with educating nurses, midwives and allied health professionals. It is not just concerned with undergraduate education, but also professional development post-registration.
[25] Post data collection, in 2022, NHSEI merged, becoming one single organisation. In 2018, and at the time of data collection, NHS England and NHS Improvement, previously two separate bodies, were augmented. The Chief Nurse for England and their deputies sat within this set-up. Within NHSEI (at the point of data collection) focus was the healthcare workforce, including nurses, across England.

an audio voice recorder. Online interviews were conducted due to the COVID-19 pandemic restricting face-to-face meetings. Thus, this method was a pragmatic step to overcome a challenge. Follow-ups were carried out for points of clarity with seven participants. Six participants chose to confirm the clarity points through a Microsoft Teams Meeting, while one participant chose email. At the end of their main interview, each participant was asked if follow-ups for clarity were possible, and all eight participants agreed.

Meso

As with the macro-level participants, sampling at the meso-level was purposeful. Professional and personal networks were utilised to contact potential participants. At this level, snowballing as a recruitment technique was utilised. Snowballing refers to when a participant helps to identify and or recruit people they know who would be interested in the study (Parker, Scott and Geddes, 2019). In this instance, participants contacted other potential interviewees, and if they agreed, I was sent their contact details to follow up and arrange an interview. Recruitment of organisational leads in healthcare is a challenge. Snowball sampling is a recognised method of helping with recruitment in difficult-to-reach populations and can decrease the time taken to complete data collection (Parker *et al,* 2019). Decreasing time taken was an important factor in this research; as highlighted earlier, multi-method research can be challenging in light of time restrictions.

Individuals were targeted due to their job role rather than their underlying qualifications. For instance, they did not need to be registered nurses. Workforce leads, and Chief Nurses of NHS organisations were the main targets. However, individuals with an extensive background and influence at an organisational level in workforce planning and management were also considered.

The organisations targeted were NHS organisations across England in different geographical locations, including NHS Trusts, NHS Foundation Trusts and ICSs. The decision not to focus on one specific area, for instance, the East Midlands, was because the governance structures of the NHS in England at present mean that different regions will have different approaches to the and management of the

workforce. Therefore, the variability in approaches will impact how policy is implemented at an organisational level. To better understand the overall nursing development position, it was decided to seek views and opinions from different regions.

The main data collection took place between November 2020 and August 2021. Eleven participants were recruited for this level. Ten were female, and one was male. Six participants were recruited between November 2020 and December 2020. However, from January 2021, the COVID-19 pandemic in England was heightened, with significant pressures being reported on healthcare organisations and staff (Office for National Statistics, 2022). Therefore, it was discussed within the supervisory team that further recruitment and data collection should be suspended at the meso level. At this time, many potential participants were tasked with running their respective NHS organisations during the pandemic. Those who were not, for example, workforce development leads, were redeployed into other areas of their hospitals to support the pandemic effort and were thus not available for interviews. The pressure placed upon staff and NHS organisations at this point was considered detrimental to data collection. Furthermore, from an ethical standpoint, pursuing potential participants for interviews during an intense period in the pandemic was deemed inappropriate. Recruitment restarted in April 2021, owing to reports from personal and professional networks that the pressures on staff and organisations are easing. Despite recruitment restating in April, participant interviews were only able to recommence in July 2021.

Regionally, the geographical spread of participants interviewed included the East Midlands, Southwest, London, and the North West. Ten participants were from NHS Trusts and their respective hospitals, and one from an ICS. Participants were interviewed for an average of 1 hour, and all the interviews were conducted online on Microsoft Teams at a time that suited them. Interviews were recorded using an audio recorder. Like the macro level interviews, online interviews were conducted due to the COVID-19 pandemic restricting face-to-face meetings. However, significant time pressures were present for meso participants. Thus, online interviews were logistically more appropriate. Hence, the online interview method was a pragmatic step to overcome multiple challenges. Follow-ups were carried out for points of clarity with

four participants. All participants chose to confirm the clarity points through a Microsoft Teams Meeting. At the end of their interview, each participant was asked if follow-ups for clarity were possible, and all eleven participants agreed.

Micro

As with the two previous levels of interviews, sampling at the micro level was purposeful. Potential participants were contacted using professional and personal networks. At this stage, social media through Twitter (now X) was used to increase the reach of the recruitment process. Social media is a recognised method of enabling recruitment and can provide access to participants from broad geographical areas and diverse populations (Darko, Klieb and Olson, 2022). Furthermore, I was conscious of trying to gain a diverse sample for the interviews, and healthcare professionals are a challenging group to recruit due to issues around time and workload constraints (Broyles, Rodriguez and Price, *et al,* 2011). Social media presented a wide pool of potential participants and subsequently improved my research to enable as many potential particulates as possible to be involved. Utilising multimodal recruitment strategies is recommended to facilitate qualitative health research (Broyles *et al,* 2011).

Twenty-seven participants were recruited in total. The main data collection took place between September 2021 and October 2021. Nurses at all levels and stages of their careers could participate, as it was important to gain a broad understanding of post-registration development for the nursing profession. Nurses working in clinical, research, management, educational and hybrid roles were included. Recruitment was not restricted to a particular AfC band to enable nurses to be involved at the beginning, middle and late stages of their careers. The recruitment aimed to gain a diverse sample rather than a statistically significant one, which would not have been possible for this research.

Demographically, there were twenty-three females and four males. Regionally, the geographical spread included the East Midlands, East of England, London, Southeast, and the Northwest. The number of years qualified ranged from 1.5 to 41; all were degree-trained, either having done a degree course initially or having subsequently

topped up during their careers. Twenty-six were UK-trained, while one was trained internationally (New Zealand). Eighteen were adult-trained, three were child, three were mental health, and three were dual-trained (adult and child, adult and midwifery, and adult and paramedic). No learning disability-trained nurses were able to be recruited. Eighteen participants worked in the acute sector, six in the community, two hybrids (primary care and an NHS Trust, and higher education and an NHS Trust), and finally, one worked for a national organisation (but not at a level that would place them in the meso category of participants). The AfC banding range, which was self-reported by participants, is detailed in Table 2 below:

Band	Number
5[26]	4
6	5
7	5
8a	5
8b	3
8c	1
9	0
Mixed[27]	3

Table 2: AfC banding range for the micro-level interviews

One participant was on the Very Senior Managers pay framework,[28] which is not on the AfC scale.

[26] Band 5 is the entry point for registered nurses once they have qualified

[27] One participant held three different posts, with three separate bandings ranging from band 5 – 7. The participant themself did not believe they only fitted one banding. Thus, they requested to be 'mixed'. Two other participants who held hybrid roles also did not consider that they could clearly identify themselves as a band, so they requested they be considered in the 'mixed' category.

[28] Very Senior Managers include those leading or supporting the leadership of an organisation. While they can be directors, which may place them in the meso-level category, this participant was not. Therefore, their lack of organisational influence on nurses' post-registration development enabled them to be interviewed at the micro level.

3.3.7 Data analysis: semi-structured interviews

The interviews for all three levels of analysis were transcribed verbatim using a combination of professional and Artificial Intelligence (AI) transcription services. The professional service was a university-authorised provider, and the AI service was an internal university service available to researchers. The mix of transcription services was due to financial cost. The AI service was utilised when the professional transcription service was too expensive. The research allowance budget for the project would only enable part of the transcription cost to be met with the professional service, and the AI service was not operational when some of the interviews needed transcription. Thus, to not delay the progression of the research, the professional service was used in the first instance. All transcripts were checked alongside the audio recording to ensure they were accurate.

The phases and position of Braun and Clarke's (2006) reflexive thematic analysis were used for all the semi-structured interviews as with the document analysis. Thus, the details behind the analysis approach remain the same as previously stated. As with the document analysis, an abductive reasoning approach was utilised for the semi-structured interview analysis. However, because the document analysis informed some of the direction of the semi-structured interview questions, the interview analysis was not an inductive approach. No descriptive framework for analysis was used; however, as acknowledged above, the analysis from the different levels was being considered together. Therefore, the analysis itself may, at times, have been acting as a framework and guide for analysis at different levels.

Each set of interviews was analysed within their respective levels. While there were three analysis points for the interviews, the following breakdown of the different stages reflects all the interview analyses, irrespective of level. The details of the semi-structured interview analyses in line with the thematic analysis guide of Bruan and Clarke (2006) are given below:

Phase one: The interviews were read to gain a view of their focus and direction. They were then re-read, and notes were made about the patterns or absences apparent

throughout the analysis, including exploring the core themes identified in the document analysis.

***Phase two*:** From these notes, codes were formed. Codes related to the absent or consistent reinforcements connected to nurses' post-registration development. Like the document analysis, latent and semantic codes were utilised together to analyse the data sets. Some codes related to the previous levels of analysis, for example, policy to macro, macro to meso. However, codes were also generated that were specific and unique to a particular level. This subsequently ensured that each level's coding was done individually to recognise any challenges or tensions, for example, present at that specific level.

***Phase three*:** These codes were then subsequently grouped into themes. Like the document analysis, themes were developed owing to considerations of CPs and something, or a group of things, acting as reinforcements concerning nurses' post-registration development. Shared patterns and meanings were considered in the generation of themes and how they may be associated together and individually.

Phase four: Reviewing the themes within each level involved, considering how they linked together and the narrative they could produce. However, while analysing the interviews within their specific level, considerations were also made about how the analysis may link together across the different levels. Each interview level was considered separately, but threads running throughout were also identified. This aspect was the most prominent at the micro level, with the most analysis from other levels behind it. Consequently, particular attention was paid to ensuring that the micro-level participant's voices were not lost in the previous level analysis. While attention was paid to ensuring that each level of analysis had its base and was not 'taken over' by previous analyses, the micro-level interviews required the most. This is because this level was last in the analysis order.

***Phase five*:** The narratives from reviewing the themes were built on by following the same practice for the document analysis and writing a synopsis for each theme. This helped clarify which themes were defined, chosen and named based on their strength,

depth, and originality. Fundamentally, themes were selected individually and together, which helped to create a coherent narrative across the data set levels.

Phase six: As with the document analysis, the write-up of the analyses was formalised in this phase. Writing up had already been started during previous phases, for example, phase five and synopsis development. Thus, this phase developed and finalised it. Quotes from the interviews were used to illustrate examples and form evidence. Each quote was chosen to reflect the position of participants, and consideration was given to whom the quote was coming from. This was to ensure that no one participant's voice had dominance. Theme content needed to reflect the participant group as a whole; therefore, quote choice was an important consideration to ensure that the breadth and depth of participants' voices were captured.

3.3.8 Multi-level analysis

Aiken, Hanges, and Chan (2019) highlight the need for researchers to consider the interdependency of processes and feedback loops affecting interaction patterns over time and the codetermination of phenomena. The different levels of a system, and thus analysis, are interconnected and codetermine the behaviour of different elements and or actors across a system, such as healthcare (Aiken *et al,* 2019). For the discussion chapter, I combined all the findings and levels of analysis, policy, and semi-structured interviews. I considered the findings and levels of analysis together as an overall data set. Consequently, the three core themes in the discussion reflected the threads that I, as the researcher, considered to answer the research questions in greatest strength and depth.

To help guide this process, I utilised the reflexive thematic analysis by Braun and Clarke (2006), which was used for the policy document analysis and the semi-structured interviews. The coding and theming stages were slightly different, as I was considering four sets of secondary data due to my initial analysis interpreting the original primary data from the documents and interviews. As highlighted in the interview analysis breakdown, I incorporated multi-level analysis aspects while forming themes. This process considered the completed data analysis sets altogether.

Phase one: I reviewed all the data chapters and made notes about phenomena, influences and impacts across each set. This included reviewing the original notes made at each level of analysis and considering how the analysis may link together across the different levels.

Phase two: Codes that reflected the absent or consistent reinforcements connected to nurses' post-registration development across the different levels were formed. As with the document and interview analysis, codes were latent and semantic.

Phase three: The codes were then grouped into themes. The emphasis was placed on creating themes that had the potential to answer the research question, focusing on nurses' market shelter development in the greatest depth and originality. The theme generation was multi-level.

Phase four: The themes were reviewed, and an extensive literature reading was introduced. This was to assist in placing the potential themes in the wider consideration of the literature so that I could build a strong foundation of critique. Multiple sources of literature from across different disciplines were reviewed. This was guided by the theme generation and considering how the presented phenomenon and challenges could be explained.

Phase five: Influenced by the extensive literature reading, a synopsis was written out for each potential theme. This helped me review the themes individually and together so that I could consider the narrative that was being presented. The three themes that were chosen were the ones that I felt enabled the strongest narrative to be written to answer the overall research question from three points of consideration. Three points of consideration, rather than one, were chosen because they reflected the interconnected and interdependent challenges of nurses' post-registration development.

Phase six: The write-up of the themes in the discussion chapter was completed in this phase.

3.3.9 Ethical considerations

Potential participants were approached having gained favourable ethical approval from the Nottingham University Business School Research Ethics Committee (NUBS REC) (Appendix 4). Approval was sought from the NUBS REC after communication from the Health Research Authority confirmed that the recruitment of participants was not from a single site[29], was not through the NHS and was not focusing on a 'health' question, so an NHS REC review was not required. The fact that a single site was not used for this research further meant research and development approval from NHS organisations was not required.

All information collected during this research was handled, processed and stored in accordance with the Data Protection Act 1998 and the GDPR. All information collected about participants was kept strictly confidential, stored in a secure and locked office, and on a password-protected database. Personal data (for example, email addresses) will be kept for up to 12 months after the study's end so that I can contact participants about the study's findings (unless advised that they do not wish to be contacted). All other study data will be kept securely for 7 years and disposed of securely afterwards. During this time, all precautions will be taken to maintain participant confidentiality; only I will have access to participants' personal data. This data will not be used for any other research or purpose than that stated on the participant information sheet.

The names of participants were not used directly in the analysis to ensure further confidentiality. Instead, participants were given a reference to determine what level they had been recruited for. For example, a nurse recruited for the micro level is referred to as 'micro participant 3'. An individual for the meso level is referred to as 'meso participant 5'. An individual at the macro level is referred to as 'macro participant 2'. The organisation a participant was associated with were not detailed in any way and identifying organisations or other personal aspects were removed from quotes in the semi-structured interview analysis quotes.

Individuals who expressed an interest were sent a participant information sheet (Appendix 5) and confirmation of ethical approval via email to ensure informed

[29] For example, recruitment from a single hospital Trust

consent. The purpose of the study was introduced as research to explore the challenges and difficulties surrounding nurses' post-registration development in the English NHS. All participants signed a consent form before any interviews

There was no risk of harm to the participants or myself, as the researcher identified before the research was conducted. However, as detailed in the data collection section for the meso-level interviews, ethical concerns were raised regarding the recruitment of participants. These were mitigated by suspending recruitment and restarting it when knowledge from within the organisations was gained, signalling that the pressures were reducing. Furthermore, while this research focused on nurses' post-registration development, other more distressing topics came out in interviews. For example, in the micro-level interviews, one participant disclosed experiences and diagnosis of Post-Traumatic Stress Disorder (PTSD) due to working during the COVID-19 pandemic, and another participant detailed experiences of a colleague's suicide (not related to the COVID-19 pandemic). Due to my position as a registered nurse, these types of topics in conversations are familiar to me. While they were unexpected in the context of this research, I drew on my professional background to help cope with the discussion and ensure that the participants were happy to continue. For example, when the discussion surrounding a participant's experience of PTSD, I took the opportunity to check that the participant was ok to continue the interview and reminded them that they were able to withdraw at any time. Due to my professional background, I consider that I have a duty of care to participants beyond what may be regarded as 'normal' for a researcher. This is because I am regulated by formal statutory legislation and am held accountable by a code of practice which extends beyond a clinical setting. I do not believe this makes me 'better' at research ethics; instead, it gives me a heightened sense of awareness and accountability. Despite this sense of accountability, I maintained professional boundaries with participants and utilised my skills and experience from clinical practice to mitigate against 'over-involvement' and entering a 'therapist' role (Allmark, Boote and Chambers *et al,* 2009).

3.4 Part three: Reflexivity and COVID-19 adjustments

3.4.1 Reflexivity

Reflexivity is the reflection upon the researcher's (my) position and experiences and how this could influence the construction of knowledge and research outcomes (Holloway and Galvin, 2017). Humans are inherently subjective; thus, their position can influence study outcomes (Palaganas, Sanchez and Molomtas et *al.* 2017). It is also a core component from a feminist epistemological perspective and reflexive thematic analysis to take account of researcher positionality and influence (Stanley and Wise, 1993. Braun and Clarke, 2022). Recognising researcher positionality, particularly within the data collection and analysis, can help enhance the trustworthiness and credibility of research (Holloway and Galvin, 2017). Various methods can help with this, including a field journal, which aids reflection during data collection and can be utilised within the analysis to help the researcher identify their potential influences and impact (Murphy and Dingwall, 2003). Therefore, I kept a reflective account during the research process to explore situations and experiences, which helped me reflect on my influence and possible implications.

For example, a key component of reflexivity is the 'insider-outsider' perspective (Corlett and Mavin, 2018). I am known to be a registered nurse, so I am considered an insider due to my professional background. This was emphasised to me when I conducted the interviews as participants referenced my position as a nurse and constructed responses utilising terms such as "as you will know" and "I am sure you understand this". At times, I was aware of this, and although I asked participants to clarify, there could have been times when references to my position went unnoticed. This is because I am very immersed in the language, context, and experiences to which participants often refer and, at times, may not pick up the nuances that an outsider may detect in an interview. Furthermore, I was asked about my background before some of the interviews, so it became clear that some participants wanted more information about me before talking to me.

Subsequently, my insider status may have impacted the information provided to me in the interviews (Silverman 2016). This does not make the information better or

worse, but it can be expected to be different (Murphy and Dingwall, 2003). I may also have been more sensitive to aspects of the data gathered because I am an insider, which may have gone unremarked on by an outsider. This is relevant to my research design's documentary analysis and interview components. Subsequently, I may have 'gone looking' for other elements within the data that I could connect using my pre-existing knowledge. Thus, my position as an insider impacts the themes and inferences I have developed.

Furthermore, I experienced challenging dynamics while moving between insider and outsider identities while conducting clinical nursing work during the COVID-19 pandemic. I returned to clinical work due to a sense of professional responsibility, which included working on the wards and in vaccination clinics while also carrying out my PhD. I found moving between the two environments from one day to the next unexpectedly difficult. I presented this topic to my Economic and Social Research Council PhD students' group at the University of Nottingham. The content centred on my reflections on my emotional labour and the 'whiplash' effect of moving between identities and holding both simultaneously during a pandemic alongside a PhD. The emotional and psychological exhaustion was, at times, very difficult. The presentation and set of reflections were positively received by staff and students. Some students stated that they were contesting with themselves, though not directly as nurses. For example, some peers were teachers, and their professional identity was also something they felt had challenging dynamics to contend with while completing their PhD in a pandemic.

Finally, through conducting the macro and meso interviews, I have considered the challenges that often come with this type of 'elite' interviewing. The definition of elite participants is variable (Solarino and Aguinis, 2021). Still, generally, they are individuals with whom power lies through extensive and exclusive information who make key decisions to influence and change their communities or organisations (Aguinis and Solarino, 2019. Carpenter, Geletkanyez and Sanders et *al.* 2004). The difference between interviewing elites and non-elites includes the researcher-participants power distribution and elite participants' expectations (Solarion and Aguinis, 2021).

The instances where participants wanted to know about my background before talking to me are reflective of conducting elite interviews and navigating elite participants' expectations. Research indicates that elite participants can pose gatekeeping questions to assess and evaluate an interviewer's expertise and credibility, while non-elites will not (Zuckerman, 1996). Additionally, the interview environment for accessing elites can be intimidating for a researcher to navigate and can emphasise unequal power distribution (Sin, 2003. Liu, 2018). However, due to COVID-19, all my interviews were conducted online. I felt comfortable and relaxed interviewing elites online, and this may have been because the online platform broke down some of the power dynamics. For example, I did not need to travel to their office, navigate access once there and generally be in 'their' environment. This could also have worked both ways, as the elite participants I interviewed were often working from home, and thus, being in a personal and private setting may have encouraged them to feel more relaxed and talk more openly about their opinions. It is not possible to claim this as an absolute truth, but this could have impacted the data obtained so far (Nelson, 1999).

Considering the co-construction of knowledge within a feminist epistemological stance, I acknowledge that I have influenced the phenomenon reported and the overall outcomes of this research. I have already acknowledged this as an insider. However, the influence I have over phenomenon reported is prevalent to me as the researcher, not just because I am an insider from the nursing profession. This is because selecting themes in the document analysis influences what knowledge was produced, in what format, and the analysis which will derive any significance or non-significance. This analysis then determined the direction and final themes for the semi-structured interviews. My interpretation and analysis of this information were influenced by my knowledge base and understanding of the phenomenon that may arise. This will subsequently impact upon any 'truth' reported. Therefore, I recognise that I can only construct, rather than represent, an account of the 'reality' of nurses' post-registration development. Thus, I contend that I cannot produce a single 'objective' understanding of the problems associated with the development of nursing career structures.

Regarding the power relations in the research process, I acknowledge that learning is a crucial component in the research process through which I will learn from the experiences of the participants involved and the phenomena reported. By committing myself to a feminist epistemological perspective, I accept that any knowledge produced is not rigid or opaque. It is, instead, flexible, and the bodies of knowledge that are constructed will, and should, allow for reflexivity, absorption or rebuttal of claims. Adopting a feminist epistemological perspective does mean that I cannot produce a judgement or position, as indeed I have. However, I cannot ignore that my politics of knowledge have influenced the outcome of my research.

One notable learning aspect I have taken from this is the importance of allowing people to have their voices heard. The professional voice in nursing has been criticised for being weak, which is considered to have impacted patient care and safety (Francis, 2013). I noticed throughout the interviews that people often took the opportunity to thank me for listening to them and giving them a platform to express their views and opinions. Additionally, I noticed that their interview was one of the first opportunities participants had to discuss their development in detail. Participants expressed that having this platform to talk about their development encouraged them to seek additional opportunities and ensure they gained the support to enact them. For example, in the micro-level interviews, a quote highlights that because of my presentation on this thesis at the RCN International Research Conference in 2021, a participant was compelled to have more conversations about professional development. As a result of my presentation, the participant in question wanted to be a part of this thesis research. I was recruiting for the micro-level interviews at the time. This demonstrates the impact of research on the nursing professional voice and that, because of my presentation, participants' perspectives and responses were influenced, impacting the data collected and, therefore, my findings.

While I am passionate about this topic, I did not anticipate that participants could feel listened to and empowered through participation in this research. This reflection has made me more aware of research participation's power on individuals. The act of participation gave individuals a platform they did not feel they currently had. In the

future, this awareness is something I will incorporate into other research projects, not just in a positive light, but acknowledging the power the research platform can have.

3.4.2 The influence and impact of the COVID-19 pandemic

The impact of the COVID-19 pandemic on this research was most notable in terms of recruitment and data collection for the meso-level participants. As addressed previously in the methods section, data collection was paused for six months at this level due to intense pressures on NHS organisations and their Chief Nurses. Subsequently, I was unable to secure interviews at this time. As acknowledged previously, there were ethical implications in pushing potential meso-level participants to complete interviews. Initially, I had planned to complete data collection by July 2021. Therefore, the COVID-19 pandemic significantly impacted my timeframe for completion. The ethical dilemmas and recruitment issues would not have been present had it not been for the pandemic. Recruitment of healthcare professionals is generally considered difficult; however, due to my insider status, I had the advantage of being a nurse, which made things easier. However, that was insufficient to mitigate the pandemic influence and remove the ethical problems.

Additionally, the COVID-19 pandemic may have influenced participants' responses and outlooks on nurses' post-registration development. This observation has a variety of factors. First, COVID-19 itself was not spoken of in detail by participants during interviews. A number of meso-level participants, for example, expressed relief that they got to talk about something other than COVID-19. Therefore, their responses and viewpoints may have been different without the pandemic. The interviews themselves may thus have acted as a form of outlet for participants during intense pressure. Subsequently, the pandemic may have enhanced the willingness of participants to reflect on nurses' post-registration development. The second observation is that nurses' post-registration development has had challenges for some time and that the COVID-19 pandemic (re)highlighted these issues. Consequently, the pandemic may have refocused the existing pressures and challenges for people to consider, and subsequently, the opinions and views of participants may have been sharper and

fresher for them to reflect on. For example, training and education were some of the first aspects of work that got suspended and or removed due to pandemic pressures. This brought conversations around post-registration development into the consciousness of people with greater frequency. The removal and suspension of post-registration development may have altered their perspective and reinforced and or heightened their views and opinions, which would not have happened without the pandemic. Finally, it is possible that due to the break in recruitment at the meso level, the views and opinions of participants may have altered due to a change in pressure on organisations. The first cohort of participants for the meso-level was just prior to the main vaccination rollout, and the second cohort was towards the end. This change may have altered participants' perspectives because their priorities and work experience were critically changed. This change was also within an intense, short space of time, and participants at either end of the meso-level recruitment arguably had significantly different perspectives and outlooks compared to each other. Fundamentally, all three of these aspects could have altered the data collected and, subsequently, the analysis and answering of the research question.

3.5 Chapter conclusion

This chapter has considered the methodology of this research through three core parts. First, the philosophical underpinnings of social constructionism ontology, feminist epistemology and an interpretive research paradigm. Second, the research design and methods were detailed, considering the use of a multi-method and multi-level design, alongside policy document analysis and semi-structured interviews. These were presented with a detailed account of the data sampling, collection and recruitment process, the reflexive thematic analysis process, and the ethical considerations. Finally, this chapter presented a reflexive account of this research, considering my role as an insider, the elite interviewing process, co-construction of knowledge and the power relations and learning process. A statement on how the COVID-19 pandemic impacted and changed the research course was then detailed,

considering the challenges with recruitment, and the potential influence of the pandemic on participants' responses.

Chapter 4a: Findings – Policy document analysis

4a.1 Introduction

This chapter presents three themes from the policy document analysis. The first theme explores the introduction of clinical governance and AfC.[30] Clinical governance and AfC are significant policy mandates underpinned by statutory legislation. Clinical governance presents a core aspect of governance changes enacted through central government, which has direct implications for the healthcare professions, including nursing. This theme will demonstrate how clinical governance and AfC are directly associated with post-registration development. The theme will lay out what clinical governance is, when and how it was implemented and the association of this to CPD.[31] Following this, AfC is explored in detail because it is a mechanism for operationalising and enacting the emphasis on training and development within clinical governance. Subsequently, the influence of this on post-registration development will be explored.

The second theme considers the role of workforce planning and data in relation to nurses' post-registration development. The theme considers the role of workforce planning in clinical governance and then explores workforce planning in more detail and its history in policy. Following on from this, the role of data in workforce planning is explored. Data requirements, systems and the association with quantifying nurses' 'work done' will be presented. The association of this to the idea of nursing metrics and its association with organisational governance will then be stated. The implications of workforce planning and the data deficit on nurses' post-registration development will be considered throughout the theme.

Finally, the third theme explores the role of instability in healthcare governance and policy. One of the instantly most recognisable aspects of the policy document analysis was the number of policy documents and the changes that occurred throughout the analysis period (1989-2020). Underpinning the previous two themes in this chapter are healthcare governance and policy instability. The implications of this on service

[30] The governance in healthcare is referred to as clinical governance. AfC is the current NHS grading and pay system for NHS staff, with the exception of doctors, dentists, and some senior managers.

[31] As highlighted earlier, CPD is a term often used in the policy literature to describe post-registration development

provision and nursing roles will be presented. The relationship between this and evidence-based policy-making will then be presented alongside the impact of underpinning legislation changes. Subsequently, the role of the legislative system in England will be explored, considering how this relates to healthcare governance and policy instability. The links to nurses' post-registration development will be explored throughout this theme.

4a.2 Theme one: Markets, targets, incentives, and performance: Clinical governance and Agenda for Change

4a.2.1 Clinical governance

Clinical governance as a term was first created in policy in 1997 within *The new NHS: modern, dependable* (DoH, 1997). There is not a comprehensive definition of clinical governance given in the 1997 document; however, an overview of its intentions is given:

> *"…a new system of clinical governance in NHS Trusts and primary care to ensure that clinical standards are met, and that processes are in place to ensure continuous improvement, backed by a new statutory duty for quality in NHS Trusts."* (DoH, 1997, p24)

The introduction of clinical governance was part of a broader set of healthcare governance reforms brought in under the then Labour Government, including the establishment of NHS Foundation Trusts,[32] and increased benchmarking and performance targets to assess NHS performance.[33] These two changes were at odds, with Foundation Trusts signifying greater local and organisational control, while performance measures and benchmarking brought greater national oversight. Arguably, the scene for the formal introduction of clinical governance had been set

[32] NHS Foundation Trusts were proposed in the DoH (2000) *NHS plan. A plan for investment. A plan for reform*. They were created under the 'Health and Social Care (Community Health and Standards) Act 2003', with the first ones being established in 2004.

[33] The Health Act 1999 provided a statutory duty of quality and was the first legislative base for clinical governance. It helped to introduce the Commission for Health Improvement in 2001 to assess and monitor performance in relation to clinical governance. The Health and Social Care (Community Health and Standards) Act 2003 then replaced this with the Commission of Healthcare, Audit and Inspection, later the Healthcare Commission, which was subsequently replaced by the current Care Quality Commission in 2009 under the HSCA 2008.

back in 1992 under the then Conservative administration *The Health of a Nation. A strategy for health in England* (DoH, 1992) highlighting a need to establish standards of good practice. Additionally, under the *National Health Service and Community Care Act 1990*, a statutory duty of quality was placed on NHS organisations, including newly created NHS Trusts. Therefore, clinical governance itself did not introduce new concepts but instead provided an organising and systematic approach to quantifying, measuring, and monitoring care quality in the health service.

Later, in 1998, *A First Class Service: quality in the new NHS* (DoH, 1998a) defined clinical governance as:

> *"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."* (DoH, 1998a, p. 2)

Critically, for professional development, clinical governance was directly linked to continuing CPD and clinical governance was presented as needing to be underpinned by a culture that valued lifelong learning to improve quality, with local organisations being responsible for CPD and training programmes to support staff (DoH, 1998a). Within *Working together – securing a quality workforce for the NHS* (DoH, 1998b) as part of the clinical governance mandate, the implementation of training and development plans for healthcare staff were considered to be a focal point for local organisations,[34] to help achieve the strategic policy aim to:

> *"Ensure that the NHS has a quality workforce, in the right numbers, with the right, skills, and diversity, organised in the right way, to deliver the Government's service objectives for health and social care"* (DoH, 1998b, p. 10).

In *Making a Difference Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (DoH, 1999a), nurses are centrally placed to help the NHS deliver the programme of change and modernisation and secure quality

[34] In the Health Act 1999 explanatory notes s(18) point 173, it states that NHS organisations will be required to put in place arrangements for monitoring and improving the quality of care they provide, underpinned by clinical governance, in which a programme of quality improvement to include workforce development is implemented.

improvement through clinical governance. Furthermore, a significant emphasis is placed on clinical governance's role in developing careers and CPD. AfC is highlighted as an opportunity and mechanism through which CPD can be linked to clinical governance to enable the development of a new career structure and framework (DoH, 1999a).

> *"…[in AfC]…we want people to be rewarded for the job they do. We want nurses to engage in continuing professional development linked to clinical governance to develop their knowledge and skills to meet defined patient and service needs."* (DoH, 1999a, p.33)

To monitor and assess clinical governance provisions currently, the Care Quality Commission (CQC) regulates NHS organisations. It assesses them against five key outcomes and, within these, key lines of enquiry (KLOE) (CQC, 2022a). One of the five areas is 'Effective', which includes considerations of staff skills and knowledge and 6 KLOEs, including arrangements of appraisals (CQC, 2022b). The regulatory activity by the CQC is underpinned by legislation, and staffing is one core area of the regulation.[35] The section on staffing includes the need for organisations to ensure that *"…[staff] receive appropriate support training, professional development, supervision and appraisal…".* (CQC, 2015, p.74).[36] Failure to meet the staffing components does not result in prosecution; instead, 'regulatory action other than prosecution' can be what an NHS organisation may face if in breach of that part of the regulation.[37] A freedom of information request sought by the researcher to the CQC has shown that under the HSCARA14, at the time of writing, 495 regulatory actions other than prosecution have been taken against NHS providers for failing to comply with the staffing component of the legislation.[38]

Since 2013, NHS organisations have followed the national UK Core Skills Training Framework (CSTF), which outlines the statutory and mandatory training

[35] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCARA14), Regulation 18
[36] 18(2)(a)
[37] Examples can include requirement notices, warning notices or a section 29A warning notice. If evidence surrounding regulation 18 for staffing also demonstrates a breach of another regulation, which can be prosecuted directly, then the CQC can decide to prosecute for the other offence. Fines can also be issued against organisations who have breached the regulations.
[38] Including: Impose a condition (7), Register Agreed Conditions (1), Remove a Condition (5), Requirement notice (451), Urgent imposing condition (7), Vary a condition (2), Warning notice (19).

requirements.[39] Though mandatory training is subject to organisational-specific arrangements (Skills for Health, 2021), NHS organisations will have a statutory and mandatory training policy. CQC inspections follow the CSTF to help them assess organisational performance concerning staff training.

There is limited analysis considering the role and link between clinical governance and development, for example, in relation to nursing research (Boden and Kelly, 1999. White and Taylor, 2002). However, there is a lack of substantive research that looks specifically at clinical governance and nurses' post-registration development in general. NHS organisations have Integrated Performance Reports,[40] which can provide some insight into statutory and mandatory training rates and appraisal completion. The Model Hospital database, accessible to organisations, further provides an overview of performance and benchmarking for appraisal and personal development plan completion rate and statutory and mandatory training compliance. However, access is not granted for non-NHS Commissioners, providers, and lay persons, so it is not possible to gain access to look at trends or performance regarding training and development in more detail. [41]

Policy links clinical governance with training and development, including personal development plans and appraisals, and it acknowledges AfC as a mechanism for those. Due to the lack of access to databases for analysis concerning clinical governance and training and development, a possible way to consider the operationalisation of clinical governance and its influence on post-registration development in practice is to look at AfC in greater detail.

[39] Included: Equality, diversity and human right, health, safety and welfare, NHS conflict resolution, fire safety, infection prevention and control, moving and handling, safeguarding adults, preventing radicalisation, safeguarding children, resuscitation, information governance and data security. Refresher training is between 1-3 years.

[40] Integrated performance reports highlight a series of metrics regarded as key performance indicators for an organisation. They can cover a variety of organisational activities, including the workforce.

[41] Access was requested to the Model Hospital database but was refused.

4a.2.2 Agenda for Change

AfC can be considered a potential way to operationalise and substantiate clinical governance in practice on nurses' post-registration development. AfC was introduced as a streamlining of pay and terms of conditions across multiple professions (excluding doctors and dentists) and was first proposed for the NHS in 1999 in *Agenda for Change: Modernising the NHS pay system* (DoH, 1999b). Before the AfC system, pay and terms and conditions were determined through the General Whitley Council system, which involved individual committees for the different occupational groups, each responsible for their own pay and grading system with terms and conditions of employment (DoH, 2004a). The Whitley system had been in place since the NHS was created in 1948.

The Whitley system underwent multiple modifications in the late 1980s to the mid-1990s. These included adapting the clinical grading structure for nurses, removing a collective pay bargaining approach to independent pay review bodies, and health service legislative change enabling organisations to develop their own employment terms and conditions. However, the system was widely considered inflexible and complicated, negatively impacting recruitment and staff retention (DoH, 1999b).

AfC sought to achieve a principal aim: 'equal pay for equal work' (DoH, 1999b. DoH, 2004a). In 1984, under an amendment to the Equal Pay Act, equal pay claims were allowed where the claimant felt they were undertaking work of equal value compared with (often) a higher-paid male colleague. A landmark case concerning the health professions was Enderby v Frenchay Health Authority and Secretary of State for Health (1993). A speech and language therapist submitted an equal value claim, comparing her work with clinical pharmacists and clinical psychologists. The claimant's basis was that she was the victim of sex discrimination as members of her profession, which were overwhelmingly female, were less well-paid than members of comparable professions, in which, at an equivalent professional level, there were more men than women (Enderby v Frenchay Health Authority and Secretary of State for Health, (1993)). The European Court of Justice found in favour of her claim (Enderby v Frenchay Health Authority and Secretary of State for Health (1993)), and this,

alongside the issues with the complexity of the Whitley system, influenced the decision to introduce AfC (DoH, 2004b).

Although proposed in 1999, AfC would not come into effect until 2004 and was rolled out between 2004 and 2007. AfC required a cross-nation agreement, with a number of unions and professional organisational involvement, which extended consultations and the finalisation of plans.

AfC had three core aims in its creation:

- *"Enable staff to give their best for patients, working in new ways and breaking down traditional barriers".*
- *"Pay fairly and equitably for work done, with career progression based on responsibility, competence and satisfactory performance."*
- *"Simplify and modernise conditions of service, with national core conditions and considerable local flexibility."*

(DoH, 1999b, p. 6)

A core component was introducing the Job Evaluation (JE) system under AfC. The JE system was implemented to provide a national framework on which all NHS jobs could be assessed, hoping to ensure *"equal pay for work of equal value"* (DoH, 1999b, p.9). Job profiles were created by evaluating NHS jobs, and a job evaluation score was then allocated.[42] The JE score fed into creating national job profiles, which grouped jobs with common features. For example, there was a job profile for nurses (including those in mental health, community, schools, and learning disabilities), which gave the JE breakdown and a short job description (NHS Employers, 2021). The job weighting score corresponded to the pay band allocated to a professional (DoH, 2004b). For example, nurses were (and still are) placed on band 5 on entry to the profession, which is allocated a job weight score of 326-395 (DoH, 2004b). The JE system underpinned

[42] The job evaluation score is based upon 16 considerations, which are then allocated a weighting score depending on the level: communication and relationship skills, knowledge, training and experience, analytical skills, planning and organisation skills, physical skills, responsibility – patient/client care, responsibility – policy and service, responsibility – finance and physical resources, responsibility – staff/HR/leadership, training, responsibility – information resources, responsibility – research and development, freedom to act, physical effort, mental effort, emotional effort and, working conditions (DoH, 2004b). The current version of the job evaluation scheme came out in 2018 and the 16 areas remain unchanged with the same weighting contributions (The NHS Staff Council, 2018).

the new AfC system through which staff were allocated to their new pay spine and band. The 9 pay bands each had different pay points to enable pay progression in post, provided *that "performance is satisfactory and they [staff] demonstrate the agreed knowledge and skills appropriate to that part of the pay band or range"* (DoH, 2004a, p.8). Under the JE scheme, knowledge was *"the most heavily weighted factor in the NHS job evaluation scheme and often makes a difference between one pay band and the next"* (DoH, 2004b, p.43).

Crucially, the introduction for AfC came with the Knowledge and Skills Framework (KSF) to enable progression within and between bands. The KSF was presented as a new career development framework to help enable progression through the pay points and bands. The KSF was intended to underpin personal development plans with an annual appraisal for staff to enable them to highlight where they were developing and achieving within their role, which would ultimately enable their career progression with greater ease (DoH, 2004a). The potential for increased staff productivity was further linked with using the KSF and the annual appraisal to improve links between training and service requirements, including staff retention (House of Commons Health Committee, 2007).

The KSF had 6 core dimensions intended to help staff quantify their ability to their employer. These included communication, personal and people development, health, safety and security, service improvement, quality, equality, and diversity (DoH, 2004c). The latest KSF guidance retains the same 6 core dimensions (NHS Staff Council, 2010).

Further claims were placed directly onto the scope of AfC to assist in professional development:

[AfC is a] "job evaluation-based process that harmonises reward mechanisms and improved structures for learning common learning, knowledge and skills framework, and continuing professional development." (DoH, 2004d, p.62)

[AfC will] "Improve all aspects of equal opportunity and diversity, especially in the areas of career and training opportunities" (DoH, 2004a, p.2)

"Through AfC we [nurses] now have a national NHS careers framework that provides the opportunity to break down traditional occupational boundaries, enables greater movement and transferability of skills and provides better career opportunities"
(DoH, 2006, p.13)

The final AfC agreement outlined success criteria measures, including better career development, defined as *"appraisal and personal development plans for all staff, wider access to training opportunities, more staff progressing to new and more demanding roles"* (DoH, 2004a, p.60). The general measurement approach to fulfilling these criteria was described as *"data on use of the KSF and development reviews and support for training and development"* (DoH, 2004a, p.60).

For nurses specifically, AfC stated that it would bring a new modern career structure (DoH, 1999b). In 1999, a few months after the initial AfC proposals, the DoH *Making a Difference. Strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (DoH, 1999a) document placed significant emphasis on AfC being at the core of creating a modern career framework for nurses:

"A new modern career framework is needed to help provide more satisfying and rewarding careers. We signalled our plans in AfC, which set out our proposals to modernise the NHS pay system…It will provide better career progression and fairer rewards for team working, developing new skills and taking on extended roles. It will also provide better opportunities to combine or move laterally between jobs in practice, education and research" (DoH, 1999a, p.31-32).

Furthermore, the National Audit Office (2009, p.5) highlighted that the terms and conditions of employment for nurses were used as *a "central reference point for the work to harmonise the terms and conditions for many other groups of staff"* that would be covered by AfC.

In 2018, the NHS Staff Council[43] outlined reforms to AfC, including re-organising the pay structure, including the number of bands and time points for pay increments (NHS

[43] The NHS Staff Council is the body with responsibility for the AfC pay system including undertaking negotiations of any core conditions and maintaining the AfC pay system.

Staff Council, 2018).[44] The reforms, however, did not mention anything in relation to professional development. In August 2022, the NHS Staff Council announced that it would be reviewing the national job profiles for nursing and midwifery to ensure that they reflect current nursing and midwifery practice and are fit for purpose (NHS Employers, 2023). The JE group will undertake the work, which is estimated to take 2 years to complete (NHS Employers, 2023).

Despite AfC still being present in the NHS, no specific research or other analysis was found on how, or if at all, AfC has enabled better post-registration development for nurses, as the policy set out to do. This is despite government-level awareness that implementing the KSF was quickly deemed challenging, and there was a struggle to achieve widespread use of the KSF (National Audit Office, 2009). The House of Commons Health Committee (2007) report on workforce planning highlighted that education and training cuts had affected the implementation of the KSF, and there was little evidence that opportunities to increase flexibility and efficiency of staff through training and development were being taken. The report went on to highlight that the cuts were impairing the ability of organisations to provide training identified by appraisals and personal development plans:

"We have one-third of trusts which are in debt… when you make cuts and announce redundancies, that is the last measure. There will have been a whole raft of other measures put in place to save money. Under education budgets—we know from hearing that from our members—KSF is becoming an almost impossibility." (House of Commons Health Committee, 2007. p.57)

Buchan and Ball (2010) highlight that the KSF had never been satisfactorily implemented. A factor linked to the problems with implementing the KSF was healthcare governance reforms. Specifically, the amalgamation (in 2006) of 28 strategic health authorities into 10 meant the rollout of KSF was 'side-lined' (Staines, 2007). The KSF was relaunched in 2007 to improve cooperation and interest at the managerial and board levels and to ensure that all staff members have a developmental review (Parish 2007). However, no direct evidence is available to

[44] Under the 2018 AfC reforms, band 1 was gradually phased out, leaving bands 2-9 remaining.

consider if this had a positive impact. Results from the NHS Staff Survey highlight that when the KSF was first implemented, the number of staff reporting that they had had an appraisal or a performance development plan in the previous 12 months was only 59%, and only 53% stated they had had the learning or development that was identified in the plan (Healthcare Commission, 2007).[45] This did improve in the forthcoming year, with 61% of staff reporting that they had had a development review (Healthcare Commission, 2008). However, only 42% stated it was a KSF development review, and only 51% said they had had the learning and development identified, a drop from the previous year (Healthcare Commission, 2008). The latest NHS Staff Survey results indicate that 83.5% of staff had an appraisal, annual review, development review, or KSF development review in the last 12 months (this was lower than in other years; for instance, when asked in 2019, it was 86.1%) (NHS Staff Survey, 2024).[46] Additionally, in the 2023 results, only 24.5% of staff stated that their appraisals helped them improve their job performance (NHS Staff Survey, 2024).[47]

There has been some analysis, including looking at the implications of the KSF for nurses' CPD, but not the influence or impact (Gould, Berridge and Kelly, 2007). A general review of the KSF (Institute of Employment Studies, 2010) included an early-stage overview of KSF but not specifically its impact on post-registration development (Buchan and Evans, 2007). Further analysis has looked at the impact of AfC on NHS staff, including focusing more on fairer and equal pay claim protection, but not development specifically or in detail (Buchan and Evans, 2008), assessment of nurses' practice using the KSF (McLean, Monger and Lally, 2005), critical care nurses understanding of the KSF (Stewart and Rae, 2012), and the job evaluation system utility and application (Kahya, 2006 and Kayha and Oral, 2007). Buchan and Ball (2010) provide some insight into the implementation of the KSF, including the lack of a link between the national guidelines and the establishment of the KSF and the further

[45] The 2007 NHS Staff Survey Questions did not split the responses down into professions, so it is unclear what the percentage of nurses this would indicate. This is also the case for subsequent NHS Staff Surveys. Furthermore, the 2007 survey did not ask about KSF specifically but talked generically about staff having an appraisal or form of performance development in the last 12 months and the types of learning and development available.

[46] It is important to note here that the KSF is grouped together with 'other' types of development review rather than being standalone. Therefore, it is not possible to differentiate how many staff members may have had a KSF-related development review.

[47] The questions in the NHS Staff Survey have evolved over time, so it is challenging to provide exact comparisons of responses between different years.

absence of an evaluation of its impact. Ball and Pike (2009) report on the RCN employment survey, which details a small amount about AfC and career progression. In this report, there was less agreement about positive career progression opportunities and attractiveness in 2009 compared to 2003, before AfC was brought in (Ball and Pike, 2009). The latest RCN employment survey considers nurse satisfaction with pay grades or bands. 65.6% reported their pay band was inappropriate or very inappropriate, with reasons attributed to pay bands not matching the level of risk, responsibility or accountability and that they cannot progress any further without giving up their clinical role (RCN, 2024a).[48]

However, none of the existing analyses, reports, and research explicitly focused on the overall influence and impact of AfC and its components on nurses' post-registration development. As a core policy stipulation from the Government and a dividing factor between NHS and non-NHS workers,[49] no evidence of AfCs' impact on professional development presents a significant gap in knowledge and understanding. The findings from this theme suggest that the introduction of AfC within the wider policy landscape may be impacting nurses' post-registration development. Due to the lack of current research and analysis, these components will be explored in the semi-structured interviews.

4a.3 Theme two: Workforce planning and the data deficit

4a.3.1 Workforce planning

Considering the operationalisation of AfC in relation to clinical governance and nurses' post-registration development, a critical aspect intended to enable the effective development of clinical governance, linked with nurses' development, was workforce planning and the generation of appropriate and effective data to inform decision-making. Within *A first class service: quality in the new NHS (*DoH, 1998a) and *Working together – securing a quality workforce for the NHS* (DoH, 1998b)*,* workforce planning

[48] The percentage of respondents reporting that their pay band is appropriate/very appropriate has dropped from 44% in 2015 to 22% in 2023 (RCN, 2024a)

[49] For example, primary care nurses in GP practices are not covered by AfC

was considered central. Critically, it was supposed to be underpinned by developments in clinical governance to inform it. As part of the drive to implement and operationalise clinical governance, National service frameworks (NSFs) were proposed in 1997 by the New Labour government and were intended to set standards and define service models for specific services or care groups (DoH, 1998a). Supporting programmes for introducing these were laid out to include workforce planning, education and training, personal and organisational development, and performance management (DoH, 1998a).[50] Fig.4 shows the placement of the supporting programmes, including workforce planning, in relation to the development of national service frameworks.

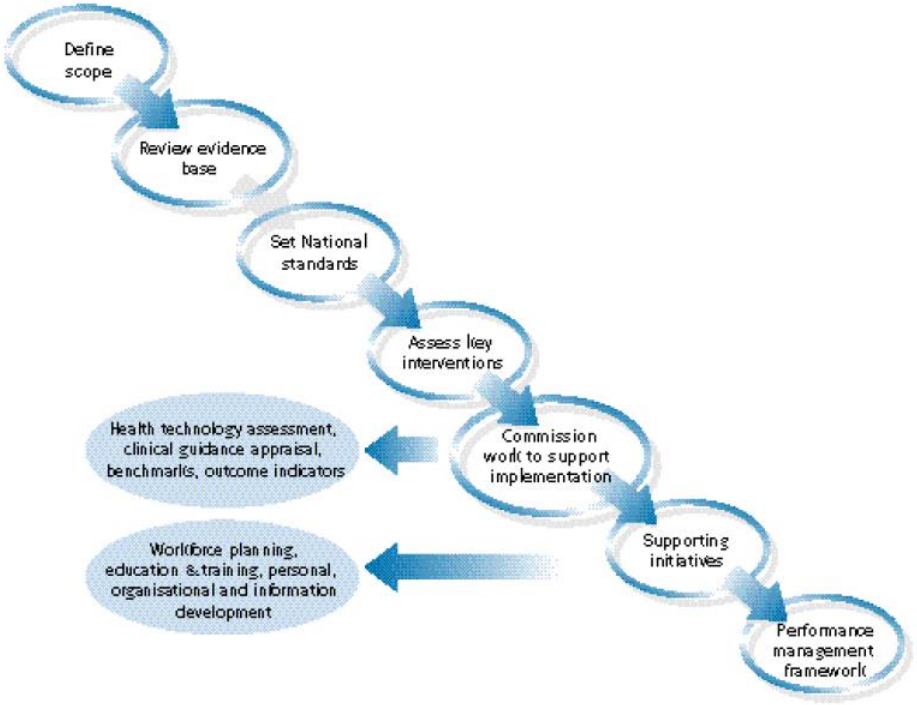

Fig.4 Development of a National Service Framework, DoH (1998a, p17)

Although workforce planning, in general, can have similar components, the practice of workforce planning will vary depending on the time horizon (short, medium or long term), lens (profession or service), and service level (national, regional or

[50] The specific NSF programme no longer exists and was discontinued with the formation of NHS England in 2013, after the introduction of the HSCA 2012. Despite no longer existing, the NSF programme and association with workforce planning, education, and training was in place for 13 years.

organisational) it is directed at. At a policy level, workforce planning is predominantly concerned with the long-term view and generation of workforce supply. At a regional and organisational level, workforce planning can take the shape of nurse-to-patient ratios, safe staffing tools, rotas and nursing establishment, and job planning. Critically, these aspects are linked, but they are fundamentally different. In general, workforce planning is how a healthcare organisation or service aims to ensure that it has the right number of nurses in the right place, at the right time, with the right skills and competencies (The King's Fund, 2023). Workforce planning is essential for nurses' post-registration development because it can help identify and plan transparent and transferable pathways and support accurate data collection (Holloway, Baker and Lumby, 2009).

Nationally, there are two main ways nurses' post-registration development can be enabled through workforce planning, which are different and have been at odds with policy. The first is through a national professional framework focused only on the profession. There have been multiple attempts at this, including *Modernising Nursing Careers* (DoH, 2006), *Towards a framework for post-registration nursing careers* (DoH, 2008a) and *Raising the bar* (HEE, 2015). These frameworks consider the profession in isolation. The other framework style for post-registration development would be through a service framework, such as cancer care (HEE, 2019). Here, the profession would be considered within the service provision alongside other professionals, including doctors. This type of patient and service needs focus sits at the core of most policy drivers, and policy indicates that workforce plans should be centred on clinical quality, be patient-centred, clinically driven, flexible, locally led and clear about roles (DoH, 2008b). The associated link between them, however, is recognised in policy as pre- and post-registration learning needs should be planned and funded to take account of patient needs and changes (DoH, 2006), and in 2015, HEE highlighted that:

> *"Guidance and standards for postgraduate development membership and fellowship should be built into service specifications to guide those commissioning services and reviewing the quality of services and education processes. It would also guide workforce planning and service development, both locally and nationally."* (HEE, 2015, p. 56)

However, at the time of writing and historically, workforce planning for nurses and the healthcare sector has been highlighted throughout national policy as an issue. Analysis has highlighted that workforce planning has been an underpinning failure to the enablement of improvements and developments in the NHS (HSCC, 2022). There were attempts in legislation in England to strengthen the statutory requirement for workforce planning. However, this was not successful (HSCC, 2022).

Workforce planning has arguably undergone repeated episodes of attention and neglect within the policy analysed. At the start of the inception of the internal market in the English NHS, workforce planning is acknowledged to be central to strengthening the ability of the health service to meet the needs of the population:

"…the ability to recruit, train and retain skilled staff may be as big a determinant of the shape and scope of health services as the overall level of public funding." DoH (1989b), p.13

However, it was highlighted in 1989 that the complexity of the planning process should not *"lead to abandoning attempts to achieve greater clarity"* (DoH, 1989b, p.8) and that demand, funding, and supply were core factors for consideration. Despite this focus, considering policy in 2019, NHS England highlights that:

"Feedback from NHS organisations stresses the sometimes confusing and disjointed approach to people issues over recent years, where workforce planning has been disconnected from service and financial planning". NHS England (2019b), p.10

Furthermore, national-level documents acknowledge that the current gap in determining workforce demand and supply has been the historic *"disconnect between service planning, financial and workforce planning" (*HEE, 2017b, p.8). This demonstrates that it has not been addressed despite the historical acknowledgement of workforce planning issues and the need for workforce plans to follow service needs.

A challenge throughout policy has been the location of responsibility for workforce planning for the workforce in general and nurses in the English NHS. Fundamentally, it is opaque, and there is a complex landscape at all healthcare system levels. Under the internal market reforms to the NHS, the mandate of responsibility for determining

workforce requirements was to delegate as much power and responsibility as possible to the local level (DoH, 1989b). NHS hospitals were *"free to employ whatever and however many staff they consider necessary…"* (DoH, 1989a, p. 25). The exception to this, however, was junior doctors, who at that time had posts for training approved by the relevant Royal College.

Workforce planning for doctors has remained a national consideration, with their post-registration training nationally commissioned in 2008 (DoH, 2008b). Within the same policy document in 2008, however, workforce planning for other professions, including nurses, was allocated to stay at a local level. It was promised that *"work will be taken forward with these professions to decide what other national professional advisory boards are required…"* (DoH, 2008b, p.35). This work did not materialise, and nursing has remained a localised focus despite policy recognising that nurses were, and remain, added to the shortage occupation list (HEE, 2015). In 2000, the DoH recognised that the workforce planning arrangements were very different for nurses and doctors and gave the reasons that nurses had significantly shorter training times, different education and training arrangements and that *"the NHS is less of a monopoly employer for these staff than medical."* (DoH, 2000, p. 16). The lack of monopoly employment of nurses by the NHS remains the case today, as many nurses work in primary care and social care and do not come under NHS working contracts.

In 1999, however, the then House of Commons Health Select Committee had already recommended that there should be a major review of workforce planning in the NHS, and the first iteration of a national entity to try and guide and support workforce planning was established (DoH, 2000), which was a notable move away from workforce planning only being a localised consideration without centralised guidance. These were known as Workforce Development Confederations (WDCs), which worked locally, first within NHS Trusts between 2000-2002, and then with the newly established Strategic Health Authorities from 2002 (DoH, 2001). These bodies were intended to have *"…clear leadership and direction to workforce planning and development."* (DoH, 2001, p18). The WDCs were supposed to work for the NHS and bring other healthcare staff employers together to develop local workforce plans. The WDCs would cease to exist by 2004 after they were merged into strategic health authorities, which the then

workforce director at the DoH voiced as regrettable (House of Commons Health Committee, 2007). In 2007, policy again highlighted that the *"…approach to workforce planning and the commissioning of education and training needs an overhaul."* (DoH, 2007, p.49). In 2012, with the introduction of the HSCA 2012, HEE was established to provide national leadership on planning and developing the workforce. In 2013, it produced the first-ever planning guidance for the NHS. In 2014, NHS England acknowledged again that demand was outstripping supply, and the need for better workforce planning would be echoed in policy again in 2016 (NHS England, 2014b. 2016).

In 2019, NHS England highlighted that having the right number of staff, including nurses, with the right skills in the right place to meet patient need has been made more difficult by the *"…historic neglect of workforce planning*" (NHS England, 2019, p.56). This comment is even though in most policies analysed since 1989, workforce planning has been mentioned in every document, alongside its importance and relevance. Therefore, it is arguable that it is not just the neglect of workforce planning as a whole that is the issue, but its appropriateness and effectiveness as well. Recent research considers the issue with workforce planning appropriate and effectiveness and nurses' post-registration development. Wallenburg *et al (*2023), p. 420, highlight that *"…the system [in England] only plans for nurses coming into the system without planning across the different structures of seniority and types of nurses."* Consequently, nurses are not considered *"…individual career-makers that require specific career pathways, but they are 'workforce' that must keep the system going"* (Wallenburg *et al,* 2023, p.420). The view of nurses within national policy is thus of a collective group and 'general cargo', not individual professional workers (Wallenburg *et al,* 2023, p.423).

4a.3.2 The data deficit

One issue that is highlighted within the policy as an underpinning challenge for conducting workforce planning is data. As a result, the problems with data generation evoke challenges to the adequacy, accuracy and timeliness of national data in the workforce. Issues with data collection for the workforce had been highlighted back in 1989, through which the internal market reforms were already producing conflict about the process for planning for the workforce and data generation:

> *"…employers will base estimates of future staffing on expectations about winning or retaining contracts…and there may be issues about who collects such [workforce] information…where it to be DHAs [District Health Authorities], there is a possibility of conflict between the DHAs role as a purchaser of services and any role as a manpower planning agency…A DHA may be seeking staffing information and, by implication, information on plans for future service developments from providers, public and private, who may simultaneously be competing for contracts from the DHA. More significantly, DHAs over time will become primarily planning/purchasing bodies who will not necessarily have the specialist skills to assess manpower demand".* (DoH, 1989b, p. 15).

In 2000, the DoH highlighted that there had been aborted attempts to agree on data requirements for workforce planning, and there were *"…major weaknesses in the information base used for workforce planning on both the supply and the demand side"* (DoH, 2000, p20). At the time, there was no national data set and separate and inconsistent databases (DoH, 2000). However, the Electronic Staff Record (ESR) would be introduced across the NHS in 2008, with the aim of establishing a national data collection point with the intended aim to help with workforce management and planning.

Despite the introduction of the ESR, data issues are highlighted as challenges for evidence-based policymaking, working planning and cost-effective care delivery (DoH, 2012a). Under the HSCA 2012, providers such as NHS Trusts were required to make available workforce planning data so that the then newly created local education training boards, the NHS Information Centre and Centre for Workforce Intelligence

could have access to *"…the data and information needed for effective workforce planning*" (DoH, 2012a, p.31). The significant reforms that the HSCA 2012 brought with it the intention to improve data quality, completeness and coverage and were supposed to support a step change in the effectiveness of workforce planning (DoH, 2013c). However, compliance with the ESR system in keeping records complete is highlighted as fragmented nationally. Although the ESR system is considered potentially the most powerful workforce planning tool available to employers, it is not taken advantage of in full (HEE, 2015). The challenges associated with the ESR extend outside the borders of healthcare organisations. The Institute of Fiscal Studies, one of the leading independent economic analysis institutes in the UK, uses the ESR to inform their analysis, which is subsequently intended to be used to improve the evidence base for policymakers concerning the recruitment, retention, and development of NHS staff (Institute for Fiscal Studies, 2023). With the ESR not being appropriately used by employers and producing incomplete data, this will lead to poor analysis and decision-making for policymakers, which creates a vicious cycle of poor policymaking.

In 2017, the need for better data to improve workforce planning was highlighted again (HEE, 2017), and in 2019, NHS England pledged to:

> *"…commission a review of NHS workforce data to ensure that the information available on the electronic staff record, NHS workforce data collections and other sources such as the Model Hospital databases, provide both local and national bodies real-time access to a single source of trusted information to guide and support both day-to-day and strategic workforce decision making".* (NHS England, 2019a, p. 88).

In 2020, NHS England would again state it would begin urgent work to improve workforce data collection at employer, system, and national levels alongside NHS Improvement and HEE (NHS England, 2020). At the time of writing, there is proposed work on the 'Future NHS Workforce Solution Transformation Programme', which is intended to replace the ESR in England and Wales, but this work is not expected to start until 2025 (NHS Business Services Authority, 2024). One of the core functions of ESR is to collect data on mandatory and statutory training. As highlighted in the previous theme, these training aspects are central to clinical governance. Thus, the

challenges with data collection, availability and utility further underpin the challenges discussed in the previous theme.

Furthermore, underpinning the challenges with data collection and workforce planning of the nursing workforce is the difficulty in defining and, more crucially, quantifying nurses 'work done'. In order to collect data and subsequently plan work and job roles for nursing to feed into workforce planning, a requirement is necessitated to understand what nurses do. Understanding this (or not) will influence the direction and development of training and education post-registration. Recent research on modern nursing work has grouped it into emotional, cognitive, physical and organisational, including quality improvement, highlighting that it is a complex narrative with many unrecognised and misunderstood aspects, including by policymakers and government (Jackson, Janet and Maben, 2021. van Schothorst-van Roekel *et al,* 2021. Wallenburg *et al,* 2023). Allen (2015, p.i) has termed the unrecognised and misunderstood aspects of nursing work as the 'invisibility of nursing work', highlighting that a better understanding of nurses' roles and work is needed to inform workforce planning and health services management. The invisibility of nursing work and the struggle to define and measure it further feeds into challenges around labour economic analysis, which is crucial to helping inform better policy decisions. Recent analysis highlighted that there has been a lack of research on the healthcare workforce, and critical areas of research needed include workforce data and analytics, and, workforce policy, planning, modelling, forecasting and analysis of future workforce needs (Walshe, Smith and Lamont *et al*, 2024).

The interconnected nature of data on the nursing workforce needs to be considered within wider labour market dynamics and interdependencies to assist in understanding the projection of staff modelling, which would impact provisions for nurses' post-registration development (The Health Foundation, 2023c). There is a significant dearth of research and analysis on labour economics in relation to nurses' professional development. Although think tanks such as the Health Foundation and Nuffield Trust have in recent years produced some labour market analysis of nursing (Health Foundation, 2021. Nuffield Trust, 2022), there remains a research and knowledge gap. A possible avenue for progress comes from a recent call from HM

Treasury on areas of research interest. Two of the identified needs within the labour market priority are to consider; what the role of human capital is in improving growth rates, and how important are different types of skills in specific sectors are, and, why rates of employer-provided training have fallen and what the economic impact of this is (HM, Treasury, 2024). These two areas of focus could be applied to nursing and may provide an avenue to explore nurses' post-registration development that could have a direct line into government decision-making. However, at the present time, due to the insufficient research on the nursing labour market and its dynamics, which makes both understanding the supply and demand modelling for the workforce and care more challenging, the understanding of nurses' post-registration development remains opaquer and more difficult to analyse.

Overall, the findings in this theme present that the neglect of appropriate and effective working planning, alongside the lack of adequate data on the nursing workforce and development, negatively impacts nurses' post-registration development.

4a.4 Theme three: Healthcare policy and governance instability

Encompassing the challenges of clinical governance, AfC, workforce planning and data is the instability of healthcare governance and policy in the NHS. This instability underpins both previous themes discussed. Additionally, one of the decisions to undertake analysis in the first theme on AfC was that it is one of the very few national policies that has withstood changes in policy, including serving multiple Government administrations. The clinical governance landscape through which quality was made a specific priority has also been part of the macro environment through which reforms have been repeatedly pursued (Leatherman and Sutherland, 2008).

During the analysis, through each government administration, there was consistency in remaking and producing new policies and legislation for healthcare governance. No government administration was immune from this scenario, and each administration demonstrated changes in approaches and emphasis. The 47 documents analysed were over 31 years, and more had to be discounted through exclusion criteria for narrowing focus due to the volume identified and time restraints being present.

This observation within policies of the repeated changes in the NHS and healthcare governance generally was already highlighted in 1996:

"The NHS has experienced a process of substantial change over the last few years, beginning with the management reforms launched by Working for Patients. This coincided with the significant developments in health policy introduced by The Health of the Nation, the Community Care Reforms, The Patient's Charter, the Clinical Effectiveness Initiative and the movement towards a primary care-led NHS. The service has come a long way in a short time." (DoH, 1996, Forward)

Indeed, in 1999, it was acknowledged that one of the reasons that AfC was brought in was because the pay system and terms of conditions of work had not kept pace with the changes within the system more broadly (DoH, 1999b). The healthcare professions, including nurses, were not separate from these changes, and there are repeated comments throughout the policy analysis that spoke of the need to change roles, skill mix, job design, and work organisation.

"…nurses' roles and responsibilities will continue to change in line with health reforms…" (DoH, 2006, p10)

Despite nursing work roles and work being repeatedly changed due to health reforms because these changes were being left to employers and local organisations to manifest, concerns were raised in policy about the impacts not being evaluated or fully understood. Thus, there are problems with implementation and managing change, which will not be aided by repeated governance structure and focus changes.

"Rapid, locally driven modifications in the shape and functions of the nursing and midwifery workforce are already under way, including new roles, role substitution, and delegation of tasks and responsibilities. These may be valuable innovations, but they raise serious concerns about public protection when poorly implemented and not monitored or evaluated. As the RCN and UNISON told us, skill mix reviews to help organizations have the right staff with the right skills in the right place at the right time should always be quality driven. Regulation and education are struggling to keep pace with these changes." (DoH, 2010b, p.60)

Fundamentally, there is a tendency to create solutions by implementing something new rather than tackling the root causes of the issues. The result is a lack of legacy combined with a persistent need to adapt and transform. Traynor (2013) has acknowledged the relentless series of reorganisations the NHS has undergone to address failings in its original system design. These reorganisations impact the nursing profession, including role expansion and debates surrounding substituting medical work. One way to illustrate repeated changes impacting nurses' post-registration development is regarding workforce planning. Some of the challenges in relation to workforce planning were discussed in the previous theme. However, arguably, one of the main factors that has impeded attempts at improving workforce planning is the constant reorganisation and relocation of accountability for this process, alongside a repeated push and pull between local, regional and central responsibility and oversight. As highlighted in the previous section, but in more detail here, the repeated changes to workforce planning were acknowledged within policy. However, despite this observation, the persistent changes have continued, creating reform fatigue. These repeated changes in workforce planning led to problems with accountability and transparency around nurses' workforce development. This created greater fragmentation, and nothing is embedded for consistent periods, as there is a persistent remaking of national bodies, with no consistency or opportunity to plan long-term. The result is very reactive rather than proactive in terms of workforce development.

An underpinning structural arrangement that has contributed to the challenges with the instability, accountability and transparency for workforce planning, is the separation of funding and responsibility for training and research at the inception of the internal market reforms. In *Funding and Contracts for Hospital Services: Working paper 2* (DoH, 1989c), a concern is highlighted that the general (running) cost of hospitals contains the cost of training staff.[51] Therefore, to avoid both training and research being cut back, *"…it is necessary to remove their costs from pricing decisions"* (DoH, 1989c, p. 16). What this means was that there were concerns that if the funding for training and research were left internally to hospitals, then they risked being absorbed into general costings. This would leave funding for training unprotected.

[51] Including considerations of demand and supply

While referring to medical post-graduate training, *Working Paper 2* stated that *"Hospitals must not cut back on post-graduate training in order to achieve immediate cost redundancies, if the long-term effect would be a poorer standard of service"* (DoH, 1989c, p.19). Additionally, *Working Paper 2* proposed that nurses' post-registration development could be covered by a similar mechanism to that of doctors. The proposed solution was to have direct funding being allocated to hospitals from regions, and Regional Health Authorities (RHAs) to contract with individual hospitals to provide training programmes (DoH, 1989a). RHAs were considered to the place to determine the supply of the nursing workforce.[52] The justification for this was that individual hospitals were not going to be able to *"…estimate the total future manpower requirements for the nursing workforce"* (DoH, 1989c, p. 20).

The concerns raised in *Working Paper 2* around training and education being cut back in pricing decisions, prompted the created of *Working Paper 10*, considering the education and training of the workforce (DoH, 1989b). However, despite the acknowledgement that there was a potential issue with the cut back of training and research, there is no formal commitment to decisions made, leaving a lack of guidance and transparency about how organisations should respond.

> *"In light of these statements [in working paper 2], an extensive series of informal discussions has been held with NHS Management and many of the professional and training interests concerned. Much of what follows reflects those discussions, although the parties involved are not necessarily committed to the conclusions reached."* (DoH, 1989b, p. 2)

What was concluded however, was that the funding should come directly from RHAs (DoH, 1989b). Critically, this change, although addressing concerns on the surface, removed the consideration of workforce supply with demand and from alongside service provision. This subsequently created separation of roles within the health service, which (with hindsight) created fragmentation and issues with accountability and transparency. The practice of conducting workforce planning had been made harder by the changing identities of purchaser and commissioner identities in the

[52] Within the supply component, working paper 2 determines this as including training, which also encompasses post-registration development

English NHS which disrupted the relationship for determining effective workforce planning.[53]As the supply component and funding was placed with RHAs, the commissioning body at that time, their reconfigurations and reforms directly influenced the provision of workforce planning, training and education. Consequently, the demand and supply components of workforce planning remained largely separate, if conducted at all, at a local and regional level. National workforce supply planning for nurses became more prominent with the creation of HEE in 2012. However, HEE only focused on supply components of the nursing workforce, rather than demand, which remained at the local level.

The concerns around separation and fragmentation of roles within the health service were predicted in the 'Rubber Windmill' a simulation exercise of an internal market for the NHS (East Anglian Regional Health Authority [EARHA], 1990). The exercise purpose was to simulate an internal market and explore its workings (EARHA, 1990). While the simulation exercise did not mention workforce specifically, it did consider the wider structural arrangements that affect the training, development and planning for the workforce, as highlighted in Working Papers 2 and 10. The simulation exercise further indicated that service development would be compromised (EARHA, 1990), which workforce planning is a part of, and which would subsequently be impacted.

> *"The separation of roles within the health service creates the possibility of fragmentation, which each consistent organisation acting unilaterally…Purchasers and providers attempted to discuss service development, but it was unclear who should take the initiative…it was seldom clear to outside organisations where the decision making power lay."* (EARHA, 1990, p. 10)

Issues of accountability were demonstrated further when the simulation exercise also identified that there was *"…no adequate framework within which the disparate stake-holders within the 'market' can be held accountable for health and quality outcomes."*

[53] The original intention from the policy analysis highlighting the challenges and changes with the accountability and transparency of workforce planning was to create a comprehensive timeline, showing the changes to location of workforce planning for nursing. However, subsequent analysis and conversation with subject matter experts including Rob Smith the former Director of Workforce Planning and Intelligence at HEE, revealed that this was a far bigger, and more challenging project than originally thought. Archive analysis alongside oral history data collection is needed to provide an accurate and comprehensive time lime which this PhD does not have the scope for as currently, the information is not available elsewhere. Subsequently, due the significance and importance, but a notable gap in understanding of workforce planning, this will be a project post PhD completion.

(EARHA, 1990, p. 11). The EARHA (1990) simulation exercise went on to indicate that all providers needed good information systems, stability to plan ahead, and NHS Trusts were particularly vulnerable to changes in financial position and national resource allocation.[54]

Healthcare governance instability creates a ground for more significant political interference, as various administrations, with leadership and internal policy changes, used the NHS as a platform for short-term political gains. Leatherman and Suntherland (2008) highlighted that the NHS is a continuing battleground for politicians, and Paton (2016) refers to the influence of politics on health policy reform as England's permanent revolution. The causes of healthcare governance instability are multi-faceted and impact various system components, including the workforce. The irony, however, is that the political interference fostered greater healthcare governance instability, often because short-term pursuits overlooked long-term health; for example, the cycle of change is restarted as people seek to address recurring problems. Issues surrounding quality of care, patient safety, resource allocation and financial stability, innovation and adaptation, public trust and confidence, long-term planning and strategy were all impacted by healthcare governance instability and workforce planning.

Although any healthcare system is susceptible to political interference (Paton, 2016), the NHS is potentially more at risk due to it being publicly funded and provided. Health and healthcare can never be removed from political influence; thus, this is not a case for considering an alternative healthcare model. Shifts in governments and political ideologies will alter policy directions, which can, for example, produce resource constraints as limited resources can create tensions between different healthcare priorities, resulting in debates and governance changes (Leatherman and Sutherland, 2008).

[54] The King's Fund published discussion papers in 2007 and 2009 on other windmill simulations, considering future health care reforms in England (Harvey, Liddell, and McMahon 2007) and the NHS response to the financial storm (Harvey, Liddell, and McMahon, 2009). There was some mention of workforce in these publications, including concerns about reforms resulting in a major disinvestment of staff with a greater reliance on cheaper and unqualified staff (Harvey *et al,* 2007) and, that financial challenges required a redesign of the workforce for specific clinical pathways and changes in the skill mix within professions, alongside a cut or freeze in pay and pensions (Harvey *et al*, 2009).

Furthermore, effective healthcare governance relies on evidence-based decision-making; however, political interference can produce bias and pressure to make decisions based on an alignment with a political ideology rather than evidence-based decisions (Paton, 2016). The issue of political interference is underpinned by the short timeframe that political cycles tend to operate within and the turbulence that can exist within a government administration, as politicians are often overly concerned with short-term impacts rather than long-term goals (Leatherman and Sutherland, 2008). This turbulence coincides with the complexity of the healthcare system itself. Increasingly, more research is applying complexity theory to health and social care, where interactions between system elements are often adaptive and dynamic and have unpredictable outcomes (Carroll, Collins and McKenzie *et al.,* 2023). At the time of writing, complexity theory has not been applied to the NHS workforce, though the workforce is conceivably a complex system within another complex system. The NHS is a mosaic organisation with many stakeholders, departments, and service providers, connecting non-state actors. The intricate nature of the system makes it challenging to implement consistent and stable governance, which is also influenced by external pressures and influences.

For example, public expectations, media scrutiny, technological advances, and changing demographics require or influence the NHS to shapeshift and adapt its governance and strategies. Therefore, reforms and changes can be created from non-political forces but also instigated by them; for example, the Mid Staffordshire Trust scandal resulted in the Francis report and instigated major changes to directions and focus within policy. For example, the DoH (2012b) vision and strategy for nurses *Compassion in Practice* shifted away from the education and training development of the profession onto values and behaviours. The development of the 6Cs strategy was developed from this, and appraisals were intended to be based on these.[55] As a result, values and behaviours were viewed as part of professional development. One of the responses to the Francis report was to create a tougher inspection regime by the CQC and move away from 'light touch generalist regulation' (DoH, 2015b). This included

[55] The 6Cs were intended to 'reinforce' the profession and underpin nursing practice: care, compassion, competence, communication, courage, and commitment.

introducing ‘Ofsted style’ ratings and special measures regime and promoting enhanced regulatory legislation and powers for the CQC. The HSCA 2008 (Regulated Activities) Regulations 2014, discussed in a previous theme regarding clinical governance, is an example.

However, like healthcare governance instability evoking more political interference and vice versa, additional regulation and bureaucracy brought in to address problems and issues can also create challenges for maintaining stable governance practices. This can create a cycle of policy and legislation changes that can significantly impact.

To give a more specific example, the internal market principles are consistently being remade and re-focused through various government administrations, which impact policy and legislation development. An example from these findings is *Liberating the NHS* (DoH, 2010c), the policy which laid the foundations and principles for developing the HCSA 2012. Timmins (2012) highlights that *Liberating the NHS* was created in record time, only 60 days after the formation of the new Government. Critique at the time raised concerns that the reforms were going too far, too fast, and felt to be undermined by a desire by the new coalition government to avoid Labour's mistake of failing to be bold when entering government (Timmins, 2012). The ‘Lansley reforms’[56] and the HSCA 2012 would later be considered by Conservative ministers themselves as *“our biggest mistake in Government”* (Timmins, 2018, p. 3). This is a lesson in individual ministers' impact on the healthcare governance landscape. *Liberating the NHS* and the HSCA 2012 are examples of the association between legislation and policy.

One of the challenges that encompasses healthcare governance and policy instability is the creation and implementation of the legislation that foregrounds them. One of the critical reasons to consider the policy and legislative systems and foundations underpinning the health system and nurses’ post-registration development is because, within the timeframe of the document analysis undertaken, competition is the main regulatory tool to control and manage the health system, either through policy mandates, or embedded in legislation. As a result, understanding the system

[56] Andrew Lansley was the Secretary of State for Health at the time of the introduction of the white paper *Liberating the NHS* and the HSCA 2012

through which they are scrutinised to enable competition is core to understanding where challenges and issues may arise.

Policy and legislation, although different, are intertwined. Legislation and policy are both forms of governance and play a core role in a country's legal and regulatory framework (Harris, 2016). Considering policy, without considering the legislation and context that surrounds it would be a failure to recognise the multi-level and systemic functioning of the healthcare landscape. There are two core types of legislation: primary and secondary (Harris, 2016). Primary legislation is the process of creating the main laws, and in England, this is usually proposed by the Government but must have approval from both the House of Commons and the House of Lords (UK Parliament, 2024). For example, the HSCA 2012 is a primary legislation. Secondary legislation, also known as delegated legislation, is often made by ministers or other bodies under powers given to them by an Act of Parliament. Secondary legislation is used to 'fill in' details of primary legislation and provides the practical details of the implementation and administration for enforcement and operation in everyday life. For example, in the first theme, the regulation for helping to operationalise clinical governance and regulation of healthcare organisations was highlighted in relation to staff training and development,[57] this is a form of delegated legislation.

The problems surrounding the HSCA 2012 and the Act itself were previously highlighted in this theme as dysfunctional and hindered trying to establish the more integrated care it was supposed to enable (Timmins, 2018). In 2019, NHS England (2019a) acknowledged that developments in policy, in this case, the *Long Term Plan*, which called for more integrated and partnership working, were incompatible with the current legislation mandate of the HSCA 2012. This arguably laid the foundation for introducing the Health and Care Act 2022, which removed the competition mandate on the NHS from primary legislation.

"Parliament and the Government have both asked the NHS to make consensus proposals for how primary legislation might be adjusted to better support delivery of the agreed changes set out in this LTP [Long Term Plan] …our view is that

[57] Health and Care Act 2008 (Regulated Activities) Regulations 2014 (HCARA14), Regulation 18

amendment to the primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability. We recommend changes to…remove the overly rigid competition and procurement regime applied to the NHS". (NHS England, 2019a, p.10)

However, it is not just primary legislation creation that can face issues and subsequent challenges from policy; there are also problems with the delegated legislation system in the UK Parliament. Delegated legislation makes up the majority of the legislation and process of law-making in Parliament. It is considered crucial to the effective operation of government and affects every aspect of the public and private spheres, including healthcare (Hansard Society, 2014). In 2014, the Hansard Society published a report highlighting the problems with the delegated legislation process in the UK Parliament. The system of dealing with this legislation has, over the years, been referred to as unsatisfactory, preposterous, and inadequate, yet it has seen limited reform (Hansard Society, 2014). Internally, the problems with the delegated legislation process and the security of Parliament have been established (Cabinet Office, 2015). In 2021, the Hansard Society launched a review of delegated legislation, considering it one of our time's most significant constitutional challenges, raising concerns about democratic accountability (Hansard Society, 2021a).

A specific healthcare example regarding delegated legislation which raises concerns about further instability is the rise of the 'power of precedent'. As the HSCA 2012 was being superseded by the Health and Care Act 2022, concerns over the delegated powers within the legislation were acknowledged concerning the power to transfer functions between health and care arm's length bodies, based on precedent: justified because there were similar powers, or precedent, in the Public Bodies Act 2011 (Hansard Society, 2021a). However, safeguards in the Public Bodies Act 2011 include a strengthened scrutiny procedure, which is not reflected in the Health and Care Act 2022 (Hansard Society, 2021b). Under this delegated legislation, power could be transferred between health bodies without scrutiny. This paves the way for alterations

to, for example, accountability for workforce planning[58] without consultation, thus creating fertile ground for more changes without appropriate scrutiny (Hansard Society, 2021b). Despite concerns raised by the Hansard Society and the Department being questioned on these proposals (Hansard Society, 2021b), the power to transfer functions between bodies remains in the Act without enhanced protections.

Arguably, healthcare policy and governance instability can contribute to increased fragmentation and a lack of accountability and transparency for nurses' post-registration development. The challenges with the instability of the governance landscape are underpinned by problems within the UK Parliamentary system of policy and legislation development and scrutiny, which then fuel the instability of governance and policy further. These issues of primary and delegated legislation development and scrutiny are the root cause of some of the challenges that nurses' post-registration development faces. While these processes may seem far removed, they are part of the wider web of systemic influence on the profession. No research or analysis was found that focused on the interconnected nature of the Parliamentary system on nurses' post-registration development to draw on here for further analysis. Thus, it remains a research and knowledge gap.

4a.5 Chapter conclusion

The first theme explored the impact of clinical governance and AfC on nurses' post-registration development. The findings indicate that while post-registration training and education were directly linked to clinical governance, no research or analysis exists to explore this in detail. Central to clinical governance, the findings highlighted AfC as a mechanism through which a new career development framework was to enable nurses' post-registration development. In policy, AfC is expressed as a reward mechanism and a flexible framework that will break down traditional barriers to career progression and enable the transferability of skills. The findings showed that, at the time of writing, no research or analysis could explicitly consider the role of

[58] Examples of relevant bodies defined in the Act which could influence the workforce planning landscape include HEE and NHS England. Though HEE has now been absorbed into NHS England, there is nothing to suggest that another body could be created nationally and the accountability transferred.

clinical governance and AfC on nurses' post-registration development. Thus, these components will be explored in more detail in the subsequent semi-structured interviews.

The second theme considered the role of workforce planning and data on nurses' post-registration development. Workforce planning is associated with service planning and nurses' education training and development. However, throughout policy, there is a recognised failure of workforce planning and an underpinning challenge to try and achieve improvements and developments in the NHS. Despite the persistent recognition in policy that workforce planning is an issue, there is a persistent issue with a lack of demand planning. Thus, this theme states that it is not just the lack of workforce planning that is problematic but its effectiveness and appropriateness. Underpinning these issues are problems with data generation and systems, including a lack of an agreed national data requirement for workforce planning. The ESR is considered problematic, including compliance issues, which nationally impact workforce data fragmentation. Associated with this is the problem of defining nurses' 'work done', the invisible aspects of nursing work and the policy drive for nursing metrics. Fundamentally, nurses' post-registration development is hindered by a lack of workforce planning and deficits in workforce data.

Finally, the third theme explored the impact of healthcare governance and policy instability on nurses' post-registration development. The persistent changes in healthcare governance and instability create a lack of legacy in the healthcare system. The repeated re-organisations impact the accountability and transparency around nurses' post-registration development. Underpinning this is the persistent political interference, which results in the NHS being England's permanent revolution. The legislative system in England is associated with this, and this theme considers challenges with both primary and secondary legislation. This includes the issue of the 'power of precedent', which enables national governance changes without appropriate scrutiny. Critically, the instability creates an unstable environment where nurses' post-registration development is trying to be enacted.

Chapter 4b: Findings – Macro interviews

4b.1 Introduction

This chapter explores three themes from the macro-level interviews. First, a consideration of the influence of AfC which was identified in the document analysis as a core policy mandate for enabling professional development. However, there was no research or analysis to explore this proposition at the time of writing, therefore, AfC became part of the semi-structured interview guide for the macro interviews. Two core aspects of the AfC analysis are discussed here. The first is funding, which considers the money and mechanisms associated with funding and how they are linked with AfC and nurses' post-registration development. The second aspect explores the utility of AfC and its restrictive and inflexible nature in relation to nurses' post-registration development.

The second theme in this chapter explores the lack of current data on the impact of nurses' post-registration development, particularly in relation to economic 'value'. These issues are subsequently underpinned by data sharing and systems challenges, alongside workforce planning, a critical issue highlighted in the document analysis. The relationships of these to the 'old power' (government) follows, considering the requirements to have the correct language (data) to navigate the national landscape and influence decision-makers in relation to nurses' post-registration development.

The final theme considers the instability of the political and healthcare system, particularly in relation to persistent policy changes. This extends the document analysis, which considered the influential role of healthcare governance and mechanisms on nurses' post-registration development. This theme then explores issues surrounding the short-termism of processes, systems and funding and how this affects national organisational memory and partnership working. Finally, how these are associated with creating and emphasising fragmentation of nurses' post-registration development and between national, regional and local organisations will be stated.

4b.2 Theme one: It's not all about the money, but it helps: Agenda for Change and nurses' post-registration development.

4b.2.1 Funding: Money and mechanisms

The education and training budget cuts identified in the document analysis were linked to problems with AfC, the KSF and other financial and budgetary considerations in the interview data. Every macro-level participant brought up issues with finance and funding, highlighting participants' shared experiences across organisations. Participants considered that the wider healthcare governance system was impacted by government-level decisions to try and reduce public expenditure and introduce austerity measures, which had a knock-on effect on the ability to implement a policy like AfC, meaning it could not achieve its intended outcomes.

"I think it [problems with funding for CPD and AfC] was part of wider budget cuts.... you could trace it back to other budget cuts around the time, but I think it was to do with government austerity." (Macro Participant 3)

Alongside the budget cuts, participants reflected that at a government level, the size of the profession and the output of labour costs were influencing factors when considering AfC. Participants considered that the economic value of nursing was not recognised and, therefore, was seen as a cost burden to the economy. The challenge was then about how to move beyond considering nurses as pay brackets and their economic viability. This was expressed as although nursing could, on the surface, be politically valued, the expression of political value did not translate into investment.

"When we start talking about nursing, I think politically there's a challenge in that as one of the largest health and care collective workforce, we then start looking at costs. There's a challenge around the size of the profession, and then politically and societally, the costs of that to any government or any economy are large." (Macro Participant 6).

"I think politically it's, nursing is great, but it isn't necessarily valued in terms of its monetary value." (Macro Participant 4)

However, participants highlighted not just the funding amount as an issue for enabling nurses' post-registration development. Even if the money was available, the funding

mechanisms, including issues around who controlled it and how it was distributed and managed, were raised as barriers. Participants considered that more time had to be allocated to manage the process for funding rather than getting the development output for professional development from the funding itself. The commissioning process within England was subsequently highlighted as fragmented and complex. As the commissioning process is the means for assessing needs, planning, prioritising and monitoring the health service, the fragmentation and complexity can cause geographical variation in nurses' post-registration development.

"We've got a commissioning process that is so complex. England isn't that big, yet there are nine regions within England; when you split them down, each has some of their own funding streams and governance streams for that funding, which is managed in different ways, and we see a variance in that. There's a difference in how that CPD money is getting across, how that CPD is allocated, and what is supported. You spend a lot of time trying to manage the process rather than necessarily getting the output." (Macro Participant 2)

Participants further raised that alongside funding restraints and problems with the management process, caveats on what funding could be spent on meant that both employers and individual nurses could lose out. This further restricted development opportunities that AfC could enable, and the ability to innovate to meet the demands of a dynamic and frequently changing healthcare service was considered to be diminished.

"There are barriers around how employers are able to spend that money and caveats around that. Maybe some of the development that nurses want or employers want nurses to have, the funding won't necessarily cover that. Then it puts them in that position where they spend it on something they don't necessarily want and isn't useful for both sides." (Macro Participant 5)

Some macro-level participants could also reflect on the influence of AfC on a practical level, as they had previously held Chief Nurse positions within NHS organisations. Participants stated that employers highlighted concerns about what AfC would do to the pay bill for organisations and educational and training costs. As a result,

participants reflected they were under increasing pressure to make cuts or be restrictive with development and training opportunities.

"There were some terse, off-the-record conversations at work…what are you doing for the pay bill? You are ratcheting up costs; are you going to reduce the nursing workforce to meet those costs, or how are we going to get extra work in to do it through contracts? There was a huge anxiety about what it [AfC] would do to the pay bill and the cost of education development and training. Because it's not just paying for the education and training; it's the backfill. And how does that rachet up?" (Macro Participant 8)

An impact of this concern and requirement to be conservative with the allocation of funds was that macro participants considered that the NHS was more focused on financial income and outputs rather than thinking about the skill sets and knowledge needed for the health service and the nursing profession. In the end, participants expressed that AfC, acts as a tool for cost management rather than enhancing nurses' post-registration development. AfC, as a cost management tool, was again associated with health spending cuts and principles of economic management.

"Towards the latter part of the 90s into the 2000s, funding constraints kicked in, and then we headed into austerity. So it [AfC] becomes a tool, becomes you know we can't afford it, and actually, AfC is then about how do you control cost." (Macro Participant 2)

One way that AfC was considered to be a tool for cost management was through a process known as down banding. This is when a job description is re-written so it can be evaluated at an AfC band lower than previously. Participants gave examples of this happening nationally when there was a restructuring of services, often to try and make efficiency savings. As a result, participants reflected that the health service was often at risk of not being run and developed according to patient need but rather run by budget.

"I have been mentoring a clinical consultant nurse. When I talk to her about trying to get her role re-graded and re-evaluated, it is all about affordability…that role might be an 8b, but we can't afford an 8b, so we will make it an 8a. Just work it within the

affordable envelope that we have financially, and still run the service. That doesn't suggest to me a devout process about skill set and knowledge involved in developing a service. That sounds like a service run by budget." (Macro Participant 8)

However, overall, macro participants stated that AfC did not come up in national bodies or government-level conversations. Participants at this level did not feel that AfC was brought into conversations that would affect nurses' potential progression or development needs. This included not factoring into discussions around the association between retention and development. There was an overarching view from participants that because AfC was not factored into conversations associated with development, it would end up lower down on a list of priorities because it was not already there, rendering it nullified in relation to nurses' post-registration development.

"If there was an issue and the solution was a new type of worker or role, nobody [at the national level] would stop to think about AfC and the KSF. You would just develop the solution to the problem. What is it that we need to do? Everybody would agree and sign that off, and then someone would put through a job evaluation matched to the terms and conditions. It goes through a process and comes out the other end as a grade; therefore, you look at affordability. It is very mechanistic rather than holistic." (Macro Participant 7)

4b.2.2 Utility: Restrictive and inflexible

Although the financing associated with AfC appeared to act as a barrier, even if money was more readily available, participants highlighted other issues as problematic to enabling nurses' post-registration development. The additional salient factor from the interviews that the document analysis was not able to identify was that despite the policy intention of AfC to enable greater flexibility of jobs and roles, participants indicated that AfC was, in fact, restrictive, inflexible and capped nurses' post-registration development. This outcome, therefore, counters the AfC policy rhetoric of a flexible and responsive workforce for service needs.

"You don't have any flexibility [with AfC]; it's such a blunt instrument for such a wide, broad-based profession. Then we have this one pay banding. I think it has taken away our ability to articulate how unique our contribution is and to have discussions with the government around how we retain nurses and create career opportunities." (Macro Participant 4)

One way this was expressed was that AfC does not enable or reward an individual's level of practice. Participants reflected that the levels of practice are not considered with the more significant impact of experience. As a result, an individual's level of practice and greater experience level do not equate to moving 'up'. Participants considered that nurses are often forced to change roles to receive a higher pay band.

"We have to look at our knowledge and our levels of practice rather than bands because that does constrain people; people cannot move… some of those people within band 5 are highly skilled, highly trained individuals. But they are contained in their banding and sit at the top of that banding for a long time, with no progression. So it effectively caps their careers and their development. It's essential that we look at nurses, not as [AfC] bands of finance. It is essential that we look at levels of practice." (Macro Participant 1)

An issue concerning the flexibility of AfC was repeatedly brought up among participants in practical terms. This included establishing hybrid roles between the different pillars of nursing practice: clinical, education, management, and research. Participants commented that AfC could not recognise complexity, with issues around hybrid role development and cross-sector working. An example of this was given in relation to developing clinical academic careers, a hybrid role for nurses in research and clinical practice. Creating, maintaining, and developing links with universities was considered a particular barrier to clinical academic careers, and participants reflected that this impacted the credibility of the role and profession. Participants reflected that although national policy repeatedly pushed for nurses to have these flexible roles and focus within their work, the underpinning mechanisms to try and enact this, including AfC, did not enable this. Therefore, participants considered that AfC had not enabled greater movement and transferability of skills to enhance career opportunities.

"We need people who can work fluidly across education and practice, but AfC hinders that because it is just terms and conditions. Going forward, I don't think we will have credibility as a profession if we just keep employing people from practice and making them into academics. Career pathways need to allow fluid movement across practice and education, and AfC doesn't aid that." (Macro Participant 7).

Furthermore, there were issues in recognising the different types of nursing roles, with the management of budgets given precedence over other aspects of work in determining pay band allocation. Participants reflected that this was associated with the emphasis on the healthcare service being run and considered around budgets and affordability, as well as the importance of finance and budget control given precedence in banding status. Participants highlighted that the practical things hindered the creation of a different dynamic paradigm in developing the future workforce, and the issues are anchored to terms and conditions of employment. There was a general disagreement that the aim of AfC to harmonise reward mechanisms had not been achieved.

"If you look at AfC, it values the number of people you lead and the amount of budget you hold, which for a CNS [clinical nurse specialist] isn't the case. You might have one person, you might have a budget of 50 grand versus a ward manager, who might have 4 wards and cover £5 million. So it [AfC] creates these tension points within the nursing structure because the band equivalency is based on the size of the things you run, not the impact you have." (Macro Participant 2)

Participants reflected the cost-containing funding challenges as contributing to the restrictive nature of AfC in terms of furthering nurses' development. As a result of the restrictiveness and lack of flexibility, participants expressed that AfC does not positively influence the development of nurses, resulting in it simply becoming a set of terms and conditions of service.

"From a professional development aspect, I think managers can use it as a bit of a blocker; you don't quite meet this thing, so you can't go up a pay scale. It is very focused on terms and conditions rather than on professional development." (Macro Participant 7)

Participants repeatedly expressed that AfC lost its development focus early on, was reductionist, considered blunt and procedural, and incapable of holistically approaching the nursing workforce. Despite the emphasis in AfC policy surrounding the KSF, participants did not feel that this had the impact intended to help quantify nurses' abilities. As a result, participants expressed that it had not had the impact desired regarding contributing to developing a careers framework. Fundamentally, AfC was viewed as unresponsive to development and, in the long term, has done a disservice to the nursing profession.

"I don't see it [AfC] as a development tool. It's something that you map against for a job, and it will tell you yes or no and if you can have it at that level. It becomes a sausage factory where you have a band 5, 6, 7, and I would argue we should stop talking about people in terms of bands rather than roles because I think bands are very labelling…it is a bit like a pick and mix…you will have so many of these bands and what does that say about the profession?" (Macro Participant 4).

"There is a very managerialist approach with AfC as you must prove that you have jumped through flaming hoops to get your next promotion because we expect you to do X, Y and Z. It became [a] very, detailed transactional[ly] orientated process, which I think in the longer term did us a disservice." (Macro Participant 8)

The funding provision and mechanisms, alongside the utility and inflexible nature of AfC, are interconnected. An overarching but also underpinning issue that was reflected in relation to both elements was the demonstrating value and impact of nurses' post-registration development. The provision of data and the type of data were consistently highlighted in association with the problems for AfC, but also more broadly for nurses' career development.

4b.3 Theme two: The old power and data

The government was referred to as the *'old power'* (Macro Participant 6), a top-down hierarchy led by a government that influenced the direction of the profession, which placed an emphasis on data, particularly economic data for evidence. Participants expressed that data considerations were an underpinning failure nationally that embedded challenges regarding the strengthening of nurses' post-registration development. Broadly, participants expressed problems with acknowledging the value and impact of post-registration development and training, which subsequently impacted political buy-in and policy development.

"…things that are good ideas, but don't necessarily have an evidence base or traction in the real world…it's like pulling a lever that's not attached to anything, and a lot of that happens in policy. Certainly, as a civil servant, or as a minister or Prime Minister, you pull a policy lever, and it's not attached to anything, nothing's gonna happen…those policy disconnections are profound…unless your policy lever is connected to something, which the HSCA 2012 disconnected because then the department was not running the NHS." (Macro Participant 8)

The challenge of data was expressed particularly in relation to economic terms and being able to convey value in relation to return on investment and how this fitted more generally with the positive societal impact of post-registration training and development. The ability to talk in this economic language was considered necessary for influencing and trying to gain status, thus resulting in change.

"If I went off and were meeting with SpAds [Special Advisors] or Number 10 [Prime Minister's office] and we were able to firmly say by not investing in this area there is harm and risk to the population that needs to be looked at and being able to talk in economic terms…we need that evidence. It is part of the old power structure that the Treasury will immediately want to know: 'What's the return on investment?' 'If you want to invest X million in post-registration education and training, how will that benefit society?' There is always an economic element." (Macro Participant 6)

One of the ways that expressing this value had been removed, which impacted that ability to show quantifiable value, was the abolition of the English National Board

(ENB) for Nursing, Midwifery and Health Visiting, which was responsible for providing or approving post-registration training courses for nurses. Courses were specific to a clinical area; for example, ENB 100 for adult intensive care was nationally standardised, recognised across organisations and was aligned to meet the UK Central Council for Nursing, Midwifery and Health Visiting, the then regulator of nurses and precursor to the NMC, content and standards.[59] With the responsibility for training and development now falling to employers and without national blueprints, participants reflected that the monetary argument for post-registration training and development had become more prominent. Without the expression of value in economic terms for impact, employers could argue against proof of value. Participants considered that while the ENB did have faults and a degree of flexibility and freedom had been gained from its removal, the 'baby had been thrown out with the bath water' and left confusion, resulting in more significant geographical fragmentation of development.

"…it [ENB] made it unarguable, if you as an employer want to run an intensive care unit, you need a nurse with Y. It was very clear what the skill mix and workforce shape should be like from a professional point of view. Since then, employers have been able to argue, what value does it really add? Why should I pay for Y? Then it comes back to funding and flow of money". (Macro participant 8)

Data availability, particularly regarding economic impact, led participants to feel that there were challenges around transparency regarding nurses' post-registration development. However, this was further expressed in terms of course provision and trends, which were felt to be significantly easier to understand for pre-registration nurse education. The predominant issue with this type of data availability participants reflected, was due to commissioning arrangements and post-registration being employer-led without a collection nationally.

"It would be interesting to see how many courses were being commissioned and changes over time. I've never seen data like that. Universities know what they provide and the changes over time. The interesting thing is how little I have to do with the

[59] The ENB was abolished in 2002, along with the UK Central Council for Nursing, Midwifery and Health Visiting when they the NMC was established. The intention was that the functions of the UK Central Council for Nursing, Midwifery and Health Visiting and ENB would be streamlined into one organisation.

intricacies of CPD compared to pre-registration. Even if I had that data, it may not change the way I do my job because commissioning decisions are taken by employers and universities respond to those requests. The information for CPD nationally is much harder to get hold of; we have to rely on soft feedback on provision and problems, but we can't always resolve them." (Macro Participant 3)

However, participants also considered that although the absence of the 'right' type of impact data was limited, challenges were also present around the storage, accessibility and sharing of data at a national level. Issues around benchmarking between NHS organisations and the lack of ability for employers to compare themselves with others for CPD were raised. NHS Digital and Model Hospital were provided as examples of some provisions. Still, they were for mandatory and statutory training, which participants stated was not post-registration training and development but the safety critical aspects of service provision. Participants considered that the different data types available, for example, population need, service provision, pay and workforce development, were all interconnected. However, it was highlighted that there was a lack of workforce planning to link these together, including a deficit of a long-term outlook, drawing in the 'academic' components of how to do workforce planning and specialist insight and consideration of how commissioning will interlink with this.

"…the separation between the academic components, with the service saying this is what we need in year one, two, three, four and the commissioning that wraps around that to say we're going to commission X decimates the workforce." (Macro Participant 4)

Participants further highlighted that at a national level, disconnection and fragmentation between the different components were underpinned by a lack of sustained focus on workforce planning strategy and policy over the decades. Without a consistent workforce plan that was regularly reviewed, participants expressed that this did impact nurses' post-registration development.

"We haven't had a national workforce strategy for over a decade, which leaves us in a really difficult position both professionally and from a service level perspective. I think that there is a really serious issue here, which is the effect of lack of workforce

planning, having a demonstrable effect on the profession's development." (Macro Participant 2)

Despite the lack of appropriate workforce planning, which has resulted in the absence of a clear understanding of the number of nurses needed for the health service, participants expressed that nurses are often spoken of nationally in terms of numbers. This was particularly considered prevalent in manifestos and policy. For example, the target of 50,000 more nurses in the Conservative government manifesto in 2019 was associated with political game-playing (The Conservative and Unionist Party Manifesto, 2019). One of the underpinning reasons for this was thought to be that headlines and targets in relation to the numbers in the nursing profession are easily quantifiable, and a political game can be orchestrated to make it easier to gain public support. Post-registration development, however, was considered harder to explain and would not achieve the same political presence and impact that could attract and hold the public's attention.

> *"…it is about government priorities and what makes headlines. You don't see election promises around CPD, but you do around numbers of nurses, it's just a more political area. Because of staff shortages, people can count those and point at them and say there are 40,000 vacancies; it makes headlines, and people are uncomfortable with it; that's why governments have targets for nurses. It is more difficult for people to understand post-registration education."* (Macro participant 3)

Participants also used the example of the 50,000 more nurses promise to highlight the disconnect between workforce numbers, linking that with the importance of patient safety and care, reducing staff burnout, improving morale, and ultimately aiding retention. Participants considered that if post-registration development were nationally seen (politically) to assist in meeting the manifesto commitment, there would be greater emphasis on post-registration development nationally. However, because the association is not politically acknowledged and associated with the 50,000 target, it is not a priority.

"All of the focus is on bringing in 50,000 nurses to meet the government manifesto. It's about bums on seats, and I feel there is a disconnect between let's get 50,000 nurses because it is good for patient care, good for staff, good for experience and reduces burnout. It doesn't feel like that is what we are trying to achieve in conversions. It's very much you need more nurses to meet that manifesto commitment. The 50,000 is emotive, nurses promote the heartstrings." (Macro Participant 5)

Participants also reflected that the focus on the number of nurses was expressed through AfC, which the previous theme focused on and interlinked with workforce planning problems. It was considered that there is a deficit in understanding or mobilising policy in relation to demand on the service, and thus, how nurses and their numbers are associated with that. Participants considered that for a nursing post-registration development strategy to be successful, it would need to be connected to other priorities, including retention and staff experience.

"There is no focus on what the service actually needs. If you look at the workforce, it should be around what you need to deliver care to patients. You shouldn't be looking at I need six band 5s to be able to deliver the care; those band 5s may not have the appropriate knowledge and skills behind them, so it is irrespective if you have six or twenty-six, the care may not be delivered. My big message is to look at levels of practice, look what is actually needed for service delivery, rather than how many numbers are out there". (Macro Participant 1)

The challenge with a focus on the number of nurses was expressed further by participants in relation to governments across the spectrum, not understanding nursing or nursing work. This relates to the problems surrounding data availability and impact-related outcomes discussed in the previous theme. Participants reflected that the value of nursing fell to the interpretation of not only a government administration but also individual ministers within that, which could also be gendered. Participants expressed that individual ministers' views on nurses and nursing impacted policy direction. There was a broad consensus among participants that political figures' individual interpretations and beliefs of nursing and nurses' post-registration development influenced action in policy, which impacted the profession.

"It's really important from a political point of view to have the argument that nursing is a safety-critical profession. But the value of nursing…and it was worse with conservative ministers than others, their view was either from the Daily Mail or from Carry On films, or even one Secretary of State's mother from the 1950s. It shocks ministers to think that a lot of women in nursing enjoy a high degree of social mobility because of their role in the profession and development." (Macro Participant 8)

Participants then highlighted that in relation to the individual drivers from ministers affecting policy outcomes, this was associated with problems trying to establish national nursing career pathways. A particular example was *Modernising Nursing Careers* (DoH, 2006). One of the factors that participants felt contributed to challenges with establishing the post-registration career pathways from this policy was in relation to which political party was in power, who the nursing leaders at the time were, and if the value or impact of pathways were not established, then it would not gain traction and be implemented.

"…it depends on who our nursing leaders are at the time and which government is in parliament. The CNOs [Chief Nursing Officers] are often held up to be the most senior nurses in the country but their role is at the whim of government officials, and they have to be very yes people. If a minister doesn't see the value in career pathways, they think it is a waste of money and money is tight, so they will just push them [CNOs] to focus on something else. CNOs are at the behest of the government. The power of politics in decision-making about career pathways is really strong." (Macro Participant 7)

Overall, participants considered that because of the emphasis on a particular type of data and the need to speak in a language that (as previously highlighted) the Treasury would respond to, nursing organisations and nursing leaders nationally must play the political system as a game. The old power architecture was considered to enable (or not) the nursing profession's ability to make changes.

"…a lot of stuff the profession has done is very old power architecture. It's led by the government at the top of that power architecture. They tell us what to do, and we

have to focus on how we get the old power architecture to allow us to do things. We need to have that evidence base of impact; whenever we try to make policy changes, the old power structure will want to know the [investment] return." (Marco Participant 6)

Participants reflected that playing the political game requires a language. Subsequently, when national bodies lobby for change, they have to play with the 'old power', which requires the language to go with it, as the data talks. Participants at this level unanimously believed that data was paramount for a profession seeking more significant influence at a national level. Participants consensually agreed that nursing as a profession had less bargaining power without this type of language and recognising its role in government and policy decisions. As a result, the government had greater control and influence over the profession because it had a weaker position to enter into negotiations.

"…if we are lobbying and trying to push for this [investment in CPD] there needs to be a process that shows that it has impact, that it is not just an additional monetary gift. Our policy advisors will say what is the evidence, what is the impact, because that is what they [the government] is going to come back and say to you. That is the way of politics. If you take them stories, that is not clear statistical evidence, there is not economic work there and there needs to be." (Macro Participant 1)

As a result of the challenges highlighted in this theme, nurses' post-registration development nationally is viewed as an economic entity. Participants felt that the default position around post-registration development conversations was always monetary. Another reason for the *Modernising Nursing Careers* (DoH, 2006) framework not becoming established was that participants felt that there had been a vast underestimation of the number of people needed to train and the subsequent funding required. Nursing, viewed as a matter of economics, was influenced by individual government ministers' views on nursing and the collective approach to considering the value of career frameworks and the underpinning economic model being utilised. Tensions were expressed regarding dissonance between funding models

for a healthcare system and desired health and system outcome levels, which impacted the nursing profession.

"I think a conversation is to be had with the government and the public on what do we need to run a health service, what sort of GDP [Gross Domestic Product] would we need to fund it. The former [name of minister role] said he wants Scandinavian-level outcomes on Singapore-level inputs. And then to say focus on tech options that will give us the efficiencies to make this square away in a Singaporean way, it's fanciful Conservative economics. In a meeting with the [Government official name] it's 'When are we going to deploy AI?' Seriously. But we're not doing dressing ulcers on Friday because there's no nurse, and you want to deploy hundreds of millions of pounds worth of AI; the level of dissonance is absurd." (Macro Participant 2)

Without the economic data to 'talk' for the profession for post-registration development, participants expressed that this often led to a lack of investment and funding availability. Participants consistently cited the lack of funding and investment as an issue. They expressed that attempts have been made to alter this, including, for example, the move by HEE to introduce an individual CPD allowance for nurses in the NHS. However, the overall picture was expressed as fragmented due to commissioning and funding mechanisms. This fragmentation, with money and mechanisms, was expressed in relation to AfC, as discussed in the previous theme. This theme has enabled an exploration of what aspects may further underpin some of the challenges with AfC while enhancing the broader picture that influences nurses' post-registration development.

4b.4 Theme three: Blink and you will miss it: short-termism and instability.

An undercurrent that was felt to make the challenges with impact, data generation and availability and the political game playing with the 'old power' was the instability of the political and healthcare system. This brought with it a 'short-termism' of policy, which extends the discussion in the document analysis on the instability of healthcare governance and mechanisms underpinning those political and policy systems and

structures. This subsequently strengthens the argument that the broader processes within a political economic system influence nurses' post-registration development.

Participants expressed that there was a fundamental short-termism of not only policy but also of process, systems and funding. The role of working within national-level organisations was felt to represent crisis management. Participants reflected on needing to react quickly and then react again to whatever policy initiative, driven by budgets and funding, a government was dictating. This included trying to stay updated on changes, which evolved rapidly. Transient systems and processes which were conducted annually, were acknowledged to impact down to the front line, which further impinged action on embedding and developing post-registration development.

"…if you take post-registration career pathways, it's just around dealing with workforce gaps and finding alternative solutions to the workforce, it's not about professional development. We just become crisis managers in this system, and by the system, I mean policymakers, whether that is HEE, Government, the NHS, or NHSI, everything is driven by money. People are trying to respond as quickly as they can, but it's very crisis-managed." (Macro Participant 7)

The crisis management was felt to be influenced by a repeated cycle of, and within governments, changes in political landscapes and views around spending. There were subsequently highlighted as challenges to what could be established and developed for nurses' post-registration development. For example, an issue expressed on how *Modernising Nursing Careers* (DoH, 2006) as a policy was not established in full was because the government administration changed soon after it was developed. Participants acknowledged that getting a policy beyond one administration into the next and ensuring it was still seen as beneficial was very difficult. This was also felt to be a more significant challenge because there was a lack of learning from ministers about what had come before, and therefore, those who did remain in place who worked with the government and played a political game with ministers to enable the transition of learning within the system to be carried over.

"With Modernising Nursing Careers, the administration changed in 2010. From a policy perspective, getting policies beyond one administration into the next one,

thinking it is still a good idea is very difficult. Then you have the conversations where the minister would come up and say, 'We need to do x' Are you sure the last lot did that and this happened? 'oh, we can't do that then'. But I could have the conversation saying this really needs developing because we got some traction with this, and you could make it much better. As a civil servant, you have to play these cards very carefully." (Macro Participant 8)

Participants also emphasised that the constant government reforms affected national organisational memory, resulting in a lack of stability and a lost sense of purpose over post-registration development. The document analysis highlighted the repetitive changes to workforce planning as an issue. In these interviews, participants considered that these challenges further impacted any delivery structure because the repetitive changes meant a potential breakdown in understanding and trust within and between organisations.

"Over the last few years, there has been constant reorganisation and loss of organisational memory, particularly in more arm's length bodies. It will change, there will be another reform, then people are either recycled into different roles or whoever you are dealing with changes and then it starts all over again…it's not just understanding nursing but also understanding the financial systems behind what is happening and building up the trust you need to for it [post-registration development] to happen." (Macro Participant 4)

As a result, one of the challenges that the lack of organisational memory evokes, alongside the instability of policy, was that this created a problem with partnership working nationally. Participants felt there needed to be greater alignment between organisations to discuss the outcomes and overall what they, focusing on the nursing profession, wanted to achieve. Issues related to 'jockeying' of position and importance were felt to feed into the problem and diminished the strength and direction of action for improving nurses' post-registration development. For example, different organisations could be looking at career frameworks and levels of practice. However, because they do not work together, there is a time lag between them, which results in multiple accounts of the same issue but no unified voice or direction on the matter, ultimately impacting delivery attempts. Thus, overall, there is a lack of systems thinking

and effective networks at the national level, which participants considered to be a restraint on unified action.

"Are we genuinely working as a system and understanding how we play stronger together? I'll confidently say we are not…I think we are far from being in the best place and allowing us to genuinely understand what needs to be done. We need a common narrative, but also, you can create visions, and policy and frameworks, but we don't implement them because we don't do the systems bit. We need the systems approach to bring all these various partners together to truly implement, and I think we have fallen down on that. Then we look five, ten years back and say we haven't delivered on things…we shouldn't be surprised". (Macro Participant 6)

The lack of stability and direction of post-registration development was fundamentally considered to evoke greater geographical fragmentation of nurses' post-registration development. One way this was expressed was the increasing division between national and local organisations, with the national being the steer and support and the local level being responsible. Participants highlighted that there were many different stakeholders, which evoked the need for a high volume of negotiation and time. Due to the lack of partnership working and networks within the national landscape, one of the issues this further presents in relation to the division between local and national is an accountability issue around ownership of nurses' post-registration development, with no one nationally taking it on.

"It's always the challenge between national steer and support with local responsibility to make happen what they need for their patients. With the Lansley reforms[60] the intention was to give more regional systems ownership and not to have one body controlling everything, but we go round in circles, because the more we fragment, post-registration development becomes more disparate. You do need a conductor, so to me is one of the causes, it's the balance between devolved

[60] The Lansley reforms are often used to refer to the introduction of the HSCA 2012. As highlighted previously, Andrew Lansley was the Secretary of State for Health in the Conservative and Liberal Democrat coalition government from 2010 to 2012 and was a core proponent of the Act's introduction. The health reforms that came with this Act were part of the broader direction planned in the 2010 white paper *Liberating the NHS* (DHSC, 2010d).

responsibility but the ability to oversee and make sure there is consistency of outcomes." (Macro Participant 4)

This was expressed even though there had been a shift in the national landscape, acknowledging that, for example, CPD was essential and needed national investment and ownership.

"…nationally in the last few years, the message about the importance of CPD is coming through more clearly, and the government was criticised for CPD cuts, and they are much more explicit about talking about the benefits of CPD now. But a lot of CPD conversations are focused locally because it is a local market, whereas pre-registration is more responsive to national directives and is more explicitly shaped by targets for growth. So, although the national HEE office that works on post-registration may say there is national direction and conservations with regional offices, ultimately, it is driven by employers. There is a disconnect." (Macro Participant 3)

Alongside the lack of partnership working and networks nationally, participants also expressed that the top was crowded, with multiple state and non-state actors, whom, as highlighted previously, all have slightly different positions and goals, creating a politics of action due to multiple priorities. This also influenced the challenge of accountability and responsibility. Although this thesis focuses on the NHS, participants highlighted that one of the challenges that nurses within the NHS will face with regard to their post-registration development is the status of nurses working in other parts of the healthcare system, including social and primary care. The document analysis highlighted that the NHS is not a monopoly employer of nurses, and this difference with medicine, which is planned nationally in structure was acknowledged to influence nurses' post-registration development in the NHS. This is alongside the fact that medical career structures cross devolved nations' borders. Unlike medicine, nurses' post-registration development does not have cross-border continuity despite the profession's professional bodies and regulatory legislation being UK-wide.

"Progress comes down a lot to the devolved nations' governments and the acknowledge of importance, we lobby UK wide, but the governments address it in

different ways, so you have four structures working in one UK country, that has a real knock-on effect. Then England doesn't have recognised CPD time, but they have got new funding from HEE the £1000 a year, but that only touches the NHS, a lot of our nursing workforce works outside the NHS in different places and structures. The difference in the countries creates a different ability of nurses to access education, learning and development, so the nurses themselves have a different expectation about what is available to them". (Macro Participant 1)

Alongside the challenges of a lack of national networks and partnership working, participants considered that fragmentation issues went deeper into the structure of the healthcare system itself, which has impacted the ability of national and local systems to work together. Aspects of the internal market and competition focus that have been the underpinning principles for healthcare governance in the English NHS were considered a particular problem. In the previous theme, it was highlighted that individual ministers' views of the nursing profession could negatively drive decisions on policy for post-registration development. Entrenching this issue further is that the individual power on decisions could drive more instability because if ideas and plans have not been considered systemically, there is less scrutiny of policy ideas. This could impact their appropriateness, implementation and effectiveness. Participants highlighted that only recently has a form of policy testing been established, which includes considerations of benefits and measurements of success to try and reduce the impact of individual ministers making decisions quickly based on personal opinions and lack of data.

However, it was not just policy that was highlighted as being impacted. As discussed in the document analysis, the process of legislative scrutiny is an issue, and individual minister's actions can have profound impacts through this as well. For example, participants supported the notion that the legislative process for orchestrating healthcare commissioning decisions could be traced to the fragmentation and instability challenges with post-registration nursing development. The HSCA (2012) and the creation of HEE were given as a particular example:

"…the HSCA 2012 was scrutinised closely in the Lords…although the bill was authored by Andrew Lansley in the Commons, so the Commons gave it very little sight. The

Lords gave it a huge amount of debate, and it happened anyway. So there is a political system there to be discussed. I talked to one minister about HEE, and he was like 'oh what is that?'…you've just created it as part of the HSCA 2012, which you have passed, 'oh I didn't see that one really'. The Lords have that detail, but the Commons and the MP who became the minister didn't. But a lot of that was generated by the [minister role] at the time from his own thinking, discussions, and personal network rather than there being a real drive to say, 'This is what we need to fix. What should we do to get the evidence of what will make a difference?'." (Macro Participant 8)

The HSCA 2012 was highlighted previously as an example of individual minister and parliamentary legislative process problems with creating policy. What the HSCA 2012 did additionally was enshrine competition with a statutory footing into the healthcare governance system, which had previously only been a policy focus, albeit a strong one. Although the HSCA 2012 has now been superseded by the Health and Care Act 2022, which has removed competition as a statutory mandate, it was still in place for a decade, which has had implications for partnership working between organisations. Competition was felt to have a negative impact on establishing and developing nurses' post-registration development because stakeholders were working in a competitive, not collaborative, environment.

"…silo working never works, and one of the biggest downfalls of working in healthcare or policy or the NHS is the competition. We see competition between hospitals and stakeholders, but at the end of the day, we have one output: to make patient care better, more efficient and more effective. Working in a silo just means it is like a race, a race to see who can get there first". (Macro Participant 1)

Prior to the HSCA 2012, issues with the healthcare governance structure historically were also highlighted regarding establishing better relationships between local and national systems and reducing fragmentation for the benefit of nurses' post-registration development. Examples of changes in commissioning structures were given, including foundation trust development versus non-foundation trusts and the nature of organisational sovereignty. This meant that national steer and support would have less impact with a foundation trust than a non-foundation trust establishment.

"[a challenge of trying to manage the process of funding for post-registration development] …it's a subsidiary of the market…the issue is individual organisational sovereignty. Foundation trusts versus non-foundation trusts. A foundation trust is an independent organisation based on its financial and national statutory position so it can do what it wants. In fact, I really can't tell it what to do. They would be legally obliged or obligated to tell me to bugger off. Non-foundation trusts do have to follow instructions; people generally play ball." (Macro Participant 2)

Overall, participants considered that national policy sets the culture and the framework for action in relation to nurses' post-registration development; however, things that are done have to be met through commissioning. Subsequently, if a commissioner decided something regarding, for example, a particular career framework, that happened because that is where the balance of power lies within this healthcare system in relation to nurses' post-registration development. Furthermore, due to fragmentation and instability, national policy directives may not always take because people are at different stages of development. This means the policy can land too simplified or too high a level and be too vague and broad to do anything meaningful.

"Policy does not always take because it doesn't take into account regional or local variations, or where people may in terms of timelines. People may only just be thinking about post-registration education; some people may have a really robust experience strategy that they have embedded over a number of years. So writing policies can be challenging because you might say get involved with these stakeholders or do this. For those people who are really established, that feels like we are teaching them to suck eggs, whereas, for people that might be on the other end of the spectrum who haven't done much, that policy might be too high level, vague or broad to be able to do anything that feels meaningful." (Macro Participant 5)

The instability and fragmentation result in national and local priorities not always connecting. Consequently, policy does not filter down well to the regional, local and organisational levels, which impacts implementation. The instability and short-termism of the healthcare governance and policy environment underpin these problems, which are also underpinned by a lack of the 'right type' of data and language

to inform policy and negotiate with politics, disconnecting it from appropriate strategy creation for nurses' post-registration development. This issue will subsequently impact the ability of AfC as a framework to succeed. This is because the lack of data and persistent changes in policy underpin the challenges with funding and AfC being inflexible and restrictive.

4b.5 Chapter conclusion

In this chapter, three themes from the macro-level interviews have been explored. First, concerning AfC, funding challenges were related to broader government decisions, including introducing austerity measures. Subsequently, the labour cost of the nursing profession received greater scrutiny, and politically, nursing was not considered highly valued in monetary terms. The commissioning structures for the NHS were reflected as fragmented and complicated, which impaired post-registration development that was trying to be enacted through AfC. However, AfC was acknowledged to be a cost-management tool in organisations. Down-banding was an example of how the AfC framework could be used against nurses and their development. Critically, AfC was not spoken of nationally nor featured in education and training conversations. AfC was further considered restrictive and inflexible, which goes against the policy intention for AfC to enable greater job and role flexibility. Establishing hybrid roles and working cross-sector was not regarded as well-organised, and AfC was not thought to be able to recognise the complexity of nursing work. Management aspects in AfC are given precedence over other pillars of nursing practice. Subsequently, AfC was thought to be blunt, procedural, and unresponsive to development needs. These issues constrained the viability of AfC as a career development framework.

Alongside the challenges with AfC, data considerations nationally surrounding the impact and value of nurses' post-registration development were also considered problematic. The economic lens was viewed as pivotal to expressing the 'right' value and impact to influence national conversations to steer nurses' development. However, this type of data was not considered to be readily available. The

commissioning arrangements and fragmentation of the national system were viewed to impair data generation and sharing. This impacted workforce planning, including understanding the demand for services. A lack of a consistent workforce strategy and challenges with workforce planning were also attributed to impairing nurses' post-registration development. Despite this, nurses were considered to be spoken of regularly in terms of numbers at a national level. Yet, this was often disconnected from wider system issues, including patent safety and staff retention. Without the 'right' type of economic language, nursing as a profession was viewed as having less bargaining power than the 'old power' (government). This impairs the profession's ability to seek greater national influence to improve post-registration development.

Finally, the persistent changes of national policy were considered an undercurrent to the challenges with impact, data generation and availability, and playing the political game with the 'old power'. Crisis management in national organisations, due to the consistent changes in policy and healthcare governance structures, was attributed to a creation of a lack of organisational memory. This impaired the ability to build effective national networks and establish partnership working to improve nurses' post-registration development. A lack of effective networks and partnership working was further considered to diminish efforts to enhance nurses' post-registration development. Underpinning the lack of networks and partnership working was the internal market structure of the NHS in England. This included challenges with the HSCA 2012. Fundamentally, the fragmentation in the system and policy instability were considered to impair the ability of policy to transcend from national to regional and local levels. This impacts policy implementation and creates structural barriers to improving nurses' post-registration development, including impairing the ability of AfC to work as intended.

Chapter 4c: Findings – Meso interviews

4c.1 Introduction

This chapter explores three themes from the meso-level interviews. First, it considers the role that organisational governance, including systems and processes, plays in orchestrating nurses' post-registration development. This section will also consider how organisational governance challenges relate to implementing and managing AfC at an organisational level. Then challenges within the AfC system and process at the organisational level will be considered in relation to impairing nurses' post-registration development. Consequently, this builds on the analysis of AfC in the previous two chapters.

The second theme explores effective networks and partnership working. While these considerations were raised in the macro-level interviews, they were stronger and more prominent in participants' interpretations of challenges associated with nurses' post-registration development at this level. Changes in commissioning structures and moving to an ICS structure are explored, followed by relationships with higher education institutions. Effective networks and partnership working are then viewed, considering persistent policy changes and how they impact nurses' registration development. How these challenges relate to a lack of transparency and accountability for nurses' post-registration development will be presented. Finally, the lack of nursing voice and consideration of nurses at a systems level, both regionally and nationally, is stated.

The final theme considers the underpinning role of clinical governance and data on this chapter's two previous themes. The role of data generation and management is considered, including the utility of the ESR. The implications of data generation and management on workforce planning are then explored. Alongside this, clinical governance and its relationship to education and training at an organisational level are stated, and how this impacts nurses' post-registration development. The presence of targets and the role of statutory and mandatory training are then presented and related to the requirement to monitor organisations and the impact of this on nurses' post-registration development.

4c.2 Theme one: Organisational governance: systems and process

All participants highlighted challenges surrounding organisational governance systems and processes, which they considered to have impacted nurses' post-registration development. Around half of the participants within this level of interviews stated they had the portfolio for nurses' post-registration development. However, others reported that they did not and that the portfolio was based within the Human Resources [HR] system. Participants reflected that not having the portfolio for training and development made it harder to make changes and provide organisational leadership for nurses' post-registration development.

"When I was at [name of Trust], I didn't realise for a long while that it was quite unusual that I had a whole lot of that money, and as the Assistant Director of Nursing, I could decide how that money was spent [on development] and nobody would challenge me. It didn't occur to me that other peoples were actually within HR, and they had to fight for that money… and because there's not a lot of money, and organisations want to keep the money inside the organisation, there is a risk that specialist training courses won't be funded." (Meso Participant 6)

Participants stated that if they did not have the portfolio for nurses' post-registration development, they had made efforts to get it moved into their remit due to concerns based on patient safety. Participants highlighted that one of the reasons that it was separate and sometimes hard to move was that post-registration development was often associated with learning and development, which were often dominated by statutory and mandatory training which sat within HR. Participants considered that the statutory and mandatory training and education programmes were not post-registration development. If they were managed together, there was a risk that professional education would get overlooked. Fundamentally, participants considered that without the control, they would have limited power to safeguard the profession's future.

"At [Trust name] pre-reg, post-reg was in the Chief Nurse portfolio. Here at [Trust name], it's not. I think it's unsafe and made the case for it to move. I don't have professional oversight over what is commissioned, so we have a Deputy Director of

Training and Education who doesn't want to share. So there is very little professional input into it, so he'll go out to the educators in the divisions to say what you want. They could ask for basket weaving, and I would have no impact on that. I strongly believe that we are accountable for the development of pre-reg and post-reg. The model I'm operating in doesn't work." (Meso Participant 9)

Additionally, participants considered that one of the challenges of having the training portfolio outside their control was that non-clinicians often had greater power to influence what nurses had access to. This was considered problematic because, according to participants, non-clinicians did not understand the nursing role and work and, subsequently, what post-registration development was required. Some participants had experienced both ways of working regarding the location of the portfolio of nurses' post-registration development. It was highlighted that separate portfolios was not an issue if the non-clinical Trust leadership worked in partnership with the clinical leadership. However, participants stated that the division between these two aspects was often not bridged effectively, which impaired nurses' post-registration development.

"[one of the biggest problems is] non-clinicians having a say on what clinicians should do. This is not how it plays out across all trusts; it's been very different for me in other trusts. In this Trust you've got administrative staff saying what clinicians should have and need. So [they are] playing a key role in deciding what clinicians require." (Meso Participant 7)

Alongside the location of the portfolio challenge, the funding amount and mechanisms, both outside and within an organisation, were cited as barriers to further improving nurses' post-registration development. Participants highlighted that national funding had been reduced,[61] its sources were often segregated, and internal education teams could struggle to understand the access processes and criteria. This impacted an organisation's ability to effectively translate the funding to nurse development. Furthermore, due to reduced funding and segregation of sources, participants considered that organisations needed effective corporate governance

[61] For example, the budget for professional development through HEE was significantly reduced, falling from £205m per year in 2015-16 to £83.5m in 2018-19 (RCN, 2019).

strength, including financial planning and management. However, participants considered this was not always apparent, and poor corporate governance could contribute to more significant challenges in enabling development opportunities.

"I don't think organisations have put enough money aside to say this is how much it's going to cost us to pay for learning beyond registration. We don't get that funding pot so much anymore, and organisations haven't done that [put money aside]." (Meso Participant 5)

One of the ways that organisations had attempted to get around funding challenges was to become internally self-sufficient for training and development rather than commission , for example, a university. Participants gave examples of where they have developed their own internal courses, which were accredited by a university, which meant they protected development opportunities for nurses from external influences, including national political change.

"We have the capacity and capability to be creative, so some of our courses we've had accredited with universities, that gives us an edge that you don't have in a general hospital. This is probably the best Trust I've ever worked in for career and professional development because we can react. The national funding is being cut; you must jump through so many hoops to access it; the process is complicated, confusing, and time-consuming. Here, we're moving towards a situation [of being] self-sufficient for CPD because we've got the ability to deliver it in-house, so our nurses won't be disadvantaged. For me, as a Chief Nurse, that is the only sustainable way forward, so you're not relying on other partners, the national funding, the politics to deliver what you need." (Meso Participant 1)

However, participants considered that larger university hospitals had the capacity and capability to be creative and respond to demand for development,[62] whereas smaller general hospitals struggled to enable this. Participants acknowledge that this could be due to financial ability, individual leadership and organisational culture. This division between organisations created greater geographical fragmentation and inequality in

[62] University hospitals are speciality trusts with significant involvement in research and education. In England, there are 42 specialist Trusts out of a total of 215 Trusts (University Hospital Association, 2024)

nurses' post-registration development. Thus, national governance systems could create inequality and disparity at an organisational level. Therefore, participants highlighted that it was not just funding that was imperative to improving nurses' post-registration development but the overall organisational development system, which included clear strategic planning, transparent and motivated leadership, and an organisational culture that embraced learning.

"What makes a difference to your post-registration development is how much your employer, especially if they are not a large NHS provider, values your development and is willing to invest in it." (Meso Participant 3)

Throughout the interviews, the broader systems and processes encompassing organisational governance were associated with the challenges regarding implementing and managing AfC. Therefore, to illustrate examples of how organisational governance processes affected policy implementation, enablement, and nurses' post-registration development, the remaining organisational governance challenges will be viewed through the lens of AfC.

4c.2.1 Implementation and management: Agenda for Change

Participants gave accounts of the broader organisational governance issues that compounded challenges in enabling AfC to act as a development framework. Further, participants reflected on specific problems with the AfC process and system at an organisational level that inhibited nurses' post-registration development progress. Overall, building on the previous findings from the document analysis and the macro-level interviews, participants at this level supported the previous views that AfC was not beneficial for nurses' post-registration development.

Participants expressed problems with core organisational governance challenges in enacting AfC as a development framework, including nursing establishment and uplift.[63] However, participants highlighted that the process of establishment and uplift

[63] The nursing establishment is the number of registered nurses, nursing associates and healthcare assistants who work in a ward, department, or team. The establishment number reflects the dependency and acuity of the patients

varies across different organisations, and study leave must be included within the uplift calculation, affecting the ability to release staff for development opportunities. As study leave is considered part of the leave uplift within the nursing establishment, there is often no protected study time in job planning for nurses. Participants expressed that the impact of this was that training and development were often not seen as part of the nurses' role.

"When we calculate establishments, we consider study leave, maternity leave, and sickness absence, and different organisations use a different percentage. The RCN would advocate, I think, 24% that you consider in your establishment to uplift and enable study time. Other organisations I've worked in have said 19%, and that significantly impacts how a workforce is established. So if you've got a unit that is under-established and is functioning at a 19% uplift instead of a 24% uplift, you're already scuppered because you can only allow maybe one person at a time to go on a course. Whereas in another organisation, you got a 24% uplift on an establishment, and you've got a healthy establishment and a lack of vacancies." (Meso Participant 8)

Furthermore, participants stated that alleviating the staff release problem was challenging, not just because of staff numbers but also the financial ability to account for increased staff release within budgets. Participants reflected that accounting for protected time within an organisation's job planning would increase the demand for the establishment in that area. Participants acknowledged that would make a ward budget more expensive, making it hard to justify financially.

"Having the financial ability to over-establish would be the key piece. If you can over-establish by 20%, [actually], you don't even need 20%; if you could over-establish budgets by 6% across the board to allow release, that would be fantastic. Currently, we've got release built into budgets, but because you can only establish to the point of the budget by the time you had in sickness and various other mandatory pieces, it doesn't work out." (Meso Participant 4)

being cared for. Each establishment must include an 'uplift' which is to allow for the management of planned and unplanned leave, including study leave. Uplift is also referred to as headroom.

Participants acknowledged that while there were national guidelines for nursing establishment and uplift recommendations,[64] there was no national statutory standard; they were locally set. This means that an individual organisation's finances and culture around development could influence the release of staff. Participants reflected that this also meant enabling internal consistency for nurses' post-registration development across departments was a challenge.

"…uplifts in terms of rosters and release are not nationally set; they're locally set. So we know that some of the recommendations around percentage uplift, and the safe nursing care tool, but that depends very much on the local organisation's financial situation as to whether that is able to be enacted. And across organisations that may be different depending on whether you work in critical care versus ED, versus general medical." (Meso Participant 10)

Additionally, staff release time had competing interests other than training and development. Participants highlighted that post-registration development had to contend with an organisation's other foci, including international staff recruitment and mentoring student nurses. While important, this often meant that post-registration development did not get the focus it needed.

"A lot of our release time here is going much more into mentoring overseas nurses and students as opposed to investing it with what we've got." (Meso Participant 5)

Alongside the challenges of uplift and nursing establishment, participants acknowledged that one of the problems with enabling professional development was addressing service needs simultaneously. Although interlinked, participants acknowledged that professional and service needs did not always match. This was even though participants stated that through AfC, an individual's appraisal is built into a service area's training needs analysis, which is then fed through to divisional and finally into organisational-wide training needs. An organisation will then consider the priorities being identified, what financially they can commission, and what courses and training have the most relevance, for example, in relation to national policy.

[64] For example, The National Quality Board (2018) gives an example of uplift at 22.2% for adult inpatient wards in acute hospitals.

"Staff have an appraisal…and I can cope with a large number saying I want to do a masters in health leadership because then I can scale it up and go to university because I can get a really good price. What I can't do is have 10 people doing 10 different things. So what's diminished is that individual personal development plan because what I have to do is take it up to service level, and then it goes up to divisional level and then organisation level. But then I might have staff who go. I don't really want to do that, but if that's my only option to develop, I'll go with it." (Meso Participant 11)

The financial challenges and commissioning of courses from training needs analysis were exacerbated by the short-term horizon of the financial year organisations must work within. Participants highlighted that the position that organisations often find themselves in is that last-minute funding means they are frequently only able to meet critical business requirements rather than plan for and develop progressive nursing roles and jobs to improve nurses' post-registration development. As described in the previous section, some organisations tried to alleviate this by becoming self-sufficient. However, the majority were not able to do this.

"One of the problems is there is no ability to forward plan, so from an organisational point of view, it's all year-on-year funding, and it's very last minute. So whilst organisations can get stuff to fit in training needs analysis, can put forward that business criticals every year, you're balancing the tension of how much funding is coming, where is it coming from? What's the critical delivery? And then that becomes the plan for the next year. Then the money over the last three to four years has been stripped down so badly that it only allowed organisations to focus on really business critical delivery, not wider career development and CPD." (Meso Participant 2)

Leadership and organisation governance were further acknowledged as imperative when service demands and delivery were under increasing pressure. Participants highlighted that strong leadership was essential to helping to protect time for training when there was not, for example, protected time embedded in working contracts. However, leadership strength was organisationally dependent, and participants felt that the variation in leadership attitudes towards training could lead to more

significant organisational and geographical variations in nurses' post-registration development.

I think it's really difficult when you've got to balance service delivery. It is really difficult because when the operational pressures are on, training is one of the first things to go. And having the leadership that recognises how important training is and, therefore, protecting that training time is key. So in terms of who the leaders are in post and at what level, their functioning at what training they've had, what's their experience around training, I think that's really important." (Meso Participant 8)

Overall, participants reflected that there were a multitude of organisational processes and systems that meant implementing the intention of AfC as a developmental framework was challenging. However, participants could also reflect on specific challenges with the AfC system and processes that impeded nurses' post-registration development. A reason that participants expressed problems with the AfC process being beneficial for nurses' post-registration development was through the appraisal process. The AfC framework considers appraisals critical to enhancing nurses' post-registration development. Participants highlighted that the appraisal systems, processes, and documentation differed across organisations. Participants drew attention to the variability and inconsistency of the appraisal process and considered that training and development were often not connected to the process.

"Every single trust has got its [appraisal system] interpreted differently. Every Trust has different appraisal documentation, and there's only one bit on revalidation. Some of them have attached it to [development] levels. For example, when you can get to a certain point and you need to show xyz, you go to the next stage. But a lot of them have not even bothered doing that. You were meant to have a conversation with the individual through appraisal and through one-on-ones. So it wasn't just an annual thing, but you are meant to do that, and then say, yes, this person can move up an increment point. In the whole time I've ever seen, it's never been enacted." (Macro Participant 7)

As highlighted in the document analysis, the KSF was intended to connect training and development to the appraisal process. Participants emphasised that the KSF was either

not integrated with the appraisal process, or if it was, it was not used consistently. Additionally, participants expressed that while some of the challenges with AfC were because funding for development had diminished, removing the ENB also meant there was no clear line to quantifying development, which presented challenges with equity of access to development. Participants considered that the impact of this was that training and development became a desirable rather than essential component of job descriptions. Thus, AfC within organisations was often only considered a pay grading system. This aligns with the macro participants' view of AfC as simply terms and conditions of service rather than a developmental framework.

"When AfC came out, you had the KSF, and you did appraisals against this framework. Now it's just a pay grade. I don't think it has anything to do with development; it has lost that functionality. [Previously] you had things that were embedded into job descriptions, and you couldn't get a senior staff nurse post in critical care unless you got the equivalent ENB programme. And that did mean that it was linked to development. I think now because you can't put those in job descriptions and the funding for CPD is so slight, nobody has access to it, therefore it's discriminatory if you put that as a requirement. So it then lost that [development] because people had to be inclusive of making sure that everybody had access to things." (Meso Participant 10)

Another challenge participants highlighted with appraisals, and AfC was that they heavily relied on their mid-senior levels leadership, such as ward and division leaders, for their completion. From appraisals, the mid-senior level leadership must populate training plans, which are negotiated at the board level for approval and funding. Participants acknowledged that the appraisal process could be positive if their mid-senior level leadership were well-trained and engaged. However, if they are not well trained, for example, in appraisals and training plan development, the appropriate and effective use of service training plans could be affected. Participants reflected that then, at an organisational level, the direction of nurses' post-registration development could be affected. Furthermore, overall appraisal management and service plan development were then managed within HR, which participants felt contributed to a disconnect and a lack of shared understanding around professional and service needs.

As acknowledged in the previous section on organisational governance, depending on where the portfolio for training and education sat, this was crucial for determining the progress of nurses' post-registration development.

"I rely on our senior nurse leadership team to be really scanning and looking at what service changes are coming and what's likely to be driven at an organisational level in terms of clinical pathways to then work out how we develop the staff. [example of Trust pathway training] that development [came] within from the senior nurses, they know their workforce, they know how they work with their medical teams, where the gaps are going to come." (Meso Participant 11)

One of the core challenges with the operationalisation of AfC at an organisational level was banding panels. Banding panels are part of the job evaluation system within each NHS organisation. The document analysis highlighted that the job evaluation system was a core part of the AfC policy to help ensure 'equal pay for equal work of equal value' (DoH, 1999). Within this process, the job weight score is how a nurse is allocated to their respective pay spine and band, and these scores are determined through banding panels. However, participants expressed that banding panels are often very rigid and constrictive regarding job specifications and do not have consistent governance across organisations. Furthermore, participants reflected that the process struggled to enable flexibility and respond to, for example, clinical career progression. This was acknowledged previously in the macro-level interviews and was reinforced by the meso participants, who expressed that the bandings were predominantly management-focused. One of the reasons participants gave for problems with the rigidity of banding panels is that they often consist of only HR personnel and do not have clinicians in their membership. Some participants explained that although they, as clinicians, could challenge a job-matching outcome from the banding panels, the job-matching outcome was specific about what could be challenged, as the panels reflect national job profiles.

"I think it [AfC] is restrictive, and one reason is to get anything through banding panels, the criteria are interpreted differently in organisations, but it's so rigid about what must be in a job spec to tick the box for a certain band. It doesn't allow much flexibility. And if you're not managing people and a budget, getting a job banded

higher is very hard. You must have certain triggers in a job to get it to score adequately to get it up a band. So if you have got an innovative role that might be leading something from specialism professionally, but that person isn't managing a budget or people, it's quite complicated to get it to a level that it would be banded higher if you wanted to attract that professional leadership." (Macro Participant 2)

Finally, alongside the experience of some of the macro participants, participants at this level also said that the practice of 'down banding' of nurses continues. Participants considered that this was because nurses' banding was used as a management tool for financial reasons. Participants thought that keeping the number of nurses on higher bands down was also used to try and keep the makeup of the workforce more organisationally palatable. Therefore, while service finance was a huge driver, participants thought that AfC could also help manage organisational relationships, but to the detriment of nurses' post-registration development.

"…[the reason for down banding is] the makeup of the workforce. It doesn't land well to have really high bands at all in the organisation, and it just cheeses a lot of people off, so sometimes it's not worth going down that road. [down banding] It keeps the peace, doesn't devalue what other people feel that they're doing." (Meso Participant 7)

4c.3 Theme two: Networks and partnership working

Underpinning the previous theme on organisational governance, participants expressed challenges associated with effective networks and partnerships working at an organisational and national level. While the organisational culture and governance were influential, participants thought that due to the move towards systems-based healthcare, ICSs and a greater focus on integrated care across a geographical area, the system's (ICS) culture regarding nurses' post-registration development was significant. Participants thought that Chief Nurses needed to consider and understand the ICS's influences on their organisation and what they could and could not get for development. Participants acknowledged that because there was, for example, now a system (ICS) wide allocation of funding, there could be competing interests between

the system, staff groups and organisational priorities, which meant tensions could exist when trying to gain funding for nurses' post-registration development.

"…our speciality needs might not be a system priority…if you're in an ICS where the focus is population health, or reducing hospital admission, [there can be a] real tension and competition for funding for workforce development. And you've got healthcare scientists, pharmacists, etc, and that's not even counting non-registered staff, to consider as well. CPD funding is critical because money enables development and opportunity, doesn't it? But understanding your system if you are a lead to do with education, certainly in organisations now you absolutely have to understand what's going on in a system." (Meso Participant 2)

Furthermore, the partnership between an NHS provider and higher education institutions [HEIs] was recognised to be crucial to improving nurses' post-registration development. Participants said that due to initial nurse training and most post-registration courses being in HEIs, the partnership and collaborative practices, at an individual organisation level and within an ICS, were central to improving nurses' post-registration development. Participants gave examples of how, for example, the relationship with universities was important for clinical academic career development, but building and maintaining that partnership could be challenging.

"The highly important thing is the relationship with universities, its building that relationship. So for example, [with] nurse consultants[65] it was meant to be that you recruited them between the university and yourself, 50/50. That's a really important relationship for clinical academic careers. It's about that relationship understanding what's needed, what's the gap? So university is hugely important. Research massively important. The relationship between the [university] learning and development department and the nursing directorate is hugely important. And if there's too much of a gap then it doesn't work." (Meso Participant 7)

Participants then highlighted that the organisation's size would influence the partnership with and reliance on HEIs for course and development provision. Smaller

[65] Nurse consultants are nurses that practice at a consultant level, having progressed from an advanced level. All consultant level registered nurses are supposed to demonstrate doctoral level capabilities, using and embedding research in their role. There is no formal standardisation for entry to this level of practice.

organisations were considered to be at a financial disadvantage when it came to negotiations with universities, which participants said could increase geographical variation and fragmentation in providing nurses' post-registration development.

"…[development] depends on the size of your organisation. Previously at [Trust name] we could consider getting accreditation with the university for [a] post reg qualification that we knew staff wanted. But at [Trust name] the pot of money I have isn't enough within one speciality that I can really develop something internally. I'm really dependent on the universities and other providers of post reg training and development…but for me to operationalize it, and to make any CPD realistic and achievable, one of the real limiting factors is that university modules cost a fair bit. We can do quite a lot to negotiate, but you have some limit if you're not a big organisation." (Meso Participant 11)

Despite challenges, participants were hopeful about the prospect and future of ICSs and collaborative working regarding improving nurses' post-registration development but reflected it was too early to tell what the impact would be. Some participants considered that smaller organisations may benefit from being with an ICS, because they will have access to bigger teaching Trusts, which means they could give staff more access to development opportunities. However, concerns were raised that training and development may not be a priority.

"…it [ICS] should strengthen it and eliminate some of the inequalities that exist with access to courses and funding. In reality, whether it delivers that, I can't see it doing it in the early days [be]cause it won't be a priority at the moment, the priorities are how do you balance the books? how do you get patients out of hospital so that you can continue to treat more? I think it [post-registration development] will be a long way down the agenda." (Meso Participant 9)

The national commissioning system for post-registration development was associated with the relationship with universities. Whilst the move to STPs[66] and now ICSs were highlighted to potentially alleviate some of the difficulties; the previous commissioning structures were acknowledged to be a challenge for organisations to get what they

[66] The precursor geographical healthcare governance system set up before ICSs

needed. For example, a participant expressed the need to access training courses quickly due to becoming an acute and community organisation. However, the commissioning process was long and impaired their ability to give staff the training they needed.

"…we were an acute organisation three years ago, and now [an] acute and community. We needed community qualifications, but we didn't have them, so we had to go through bidding rounds, which takes about a year to get the money out. We needed them quicker… [and we needed] the ability to commission locally [lists local universities]. Whilst the concept was right nationally to get value for money, and they did, you didn't have local flexibility and I think that's where the neglect came. I think there was that they tried to central command something that needed to be done locally." (Meso Participant 4)

Participants considered that one of the challenges that made partnership working and network development more difficult was consistent national policy changes. These repeated changes were highlighted as one of the reasons why the *Modernising Nursing Careers* (DoH, 2006) policy could not be established at an organisational level. Participants stated that *Modernising Nursing Careers* required the establishment of frameworks and reconfigurations of organisational management, but it was not operationalised appropriately because other constant policy changes had to be addressed organisationally simultaneously. Furthermore, participants considered that the instability nationally of regular governance and policy changes meant that organisations had to react repeatedly rather than have a stable landscape from which to plan for long-term training and development opportunities, which a policy like *Modernising Nursing Careers* needed.

"…it's policy on the hoof. It depends who happens to be pulling ministers' strings at that moment that may not be the national leadership team…. if I had a pound for every national policy document that's come out in my career I could retire today. Leadership moves on; political imperatives move on. Also, it's really, really difficult with Modernising Nursing Careers to put all those pieces of the jigsaw together because something else comes along." (Meso Participant 1)

Additionally, recent mergers, such as the HEE move into NHS England, presented further uncertainty for organisations. Participants stated that no direction was available to organisations and systems about how the merger may affect their ability to provide post-registration development and where accountability lay. The lack of communication and systems thinking was also related to local accountability problems regarding national policy implementation. Participants stated that another reason *Modernising Nursing Careers* did not have the desired impact was because there was no national oversight holding NHS providers to account for the delivery of the policy.

"I remember Modernising Nursing Careers, and to an extent we adopted it here. [But] as a Director of Nursing I have never been held to account to delivery of any of it. I would have expected someone to say, have you put Modernising Nursing Careers in? Can you demonstrate how that's worked… [If] there was] consistent oversight, that might galvanise everybody to say we need to do this piece of work as opposed to I can choose not to…there are things that should be governed and things that you can be left independently to do. But if you've got a national directive or guidance, say Modernising Nursing Careers, but anybody can not choose to [do it], it's not worth the paper it's written on." (Meso Participant 5)

Fundamentally, participants did not feel that nurses' post-registration development was owned nationally, and this was felt at a local and organisational level, with issues of accountability, transparency, and policy consistency. Participants expressed that they did not feel supported by national bodies to have conversations at an organisational level to ensure that roles and development opportunities were maximised. The introduction of the Professional Nurse Advocate[67] role was highlighted as an example of how a national directive aimed at post-registration development for nurses was implemented with limited direction at an organisational level. Participants thought that this lack of guidance impeded connections with organisational financial, strategy and HR systems, making it harder to establish recognition of the importance of development.

[67] Professional Nurse Advocates are registered nurses who are trained to facilitate restorative clinical supervision for colleagues and teams. The programme was introduced in England in March 2021 and is a level 7 accredited programme that includes academic assessment, poster presentations, and competency portfolios. Participants need line manager approval to be released for training, which is based in a HEI (NHS England, 2024c)

"There needs to be something [nationally] that supports me saying no, don't do that. Careers are really important; they play a really important role, but I'm on my own speaking, and I've got nothing that backs me up." (Meso Participant 7)

Additionally, participants considered that the constant changes to healthcare governance were cyclical politically, affecting funding and policy to progress nurses' post-registration development. Participants said this weakened links between national and local organisations, including non-state actors like NHS England and HEE (as was), and professional nursing leadership such as the RCN. The weakened links impaired communication and partnership working and were stated by participants to further fragment policy and national direction, moving between national and organisational domains.

"I think where things fail are where they're not working in tandem with what's happening nationally or where something comes down, and everybody looks in says that makes absolutely no sense to what I am doing and therefore because it doesn't fit with what I'm doing. I would say the biggest thing that will make any national framework deliverable locally is that engagement early on with the key critical professional bodies locally…otherwise, things just happen ad hoc and not altogether." (Meso Participant 3)

A reason attributed to the fragmentation of policy implementation and commissioning structures was a lack of nursing voice and consideration of nurses at a systems level, both regionally and nationally. Participants considered that policy development often neglected to consider how the nursing profession could contribute, affecting the systems' ability to work well for nurses' post-registration development. An example given was about public health and the need to consider the wider nursing profession, not just specialist public health roles, to enhance population health. However, participants highlighted that without a national blueprint, for example, on ICS governance of nurses' post-registration development, it was more challenging for systems and, thus, organisations to develop policy effectively and appropriately.

"…policy is usually about nursing as a workforce, and we need more nurses rather than focusing on nursing work. I've just come out of an ICS steering group, and it

strikes me that if the ICS papers [are] all about population health, then where is the developing [of] policy which sets how nursing contributes to improving population health? Not just the traditional public health nursing and school nursing, but how do we mobilise the entire nursing workforce [including in the acute sector], and how do we ensure that training enables nurses to focus on working in an integrated way?" (Meso Participant 6)

Finally, participants acknowledged that how healthcare was organised nationally affected the lack of nursing voice at a system level. Participants reflected that as Chief Nurses, their focus was on patient care, quality, and service delivery, and these issues were prioritised because they were areas of legal responsibility for Chief Nurses. As a result, participants thought that collaborative working for post-registration development was always going to be more complex when there was a statutory emphasis on organisational responsibility and accountability, which subsequently encouraged silo working.

"if you're a Director of Nursing in a big provider Trust, your focus is on delivery, etc, and that takes precedence because the legal frameworks make that your responsibility…I think everything we achieve [for development] is despite that [the healthcare governance arrangement], so I think it's difficult because we all have our own statutory organisational, purpose, function and deliverables that have to take precedence… If I don't do a bit of my ICS role, it's not great, and it doesn't help collaboration, it doesn't help relationships, but there's no penalty, and that's the same across the board. I think collaboration is always hard where the statutory pull back into silos is even harder." (Meso Participant 3)

4c.4 Theme three: Metrics and reporting: Clinical governance and data

Appropriate and effective data systems, workforce planning, and clinical governance influenced organisational governance, including AfC, networks, and partnership working. Participants highlighted that data creation and sharing were part of the challenge of establishing relationships and networks with universities. Data sharing and collection challenges created difficulties with understanding nurses' post-

registration development requirements and outcomes, which subsequently affected strategy development.

"…it's difficult to get information out of them [universities], even if it's that you seconded or you have said so many people can go into a programme of study you don't know if they've turned up. That type of information is difficult to get hold of, and I think because the funding pots are segregated, it's a logistical nightmare. Even to control it and then produce a report that says this is what came in, what we've used, what's gone out, I really do think that there's very little to inform. It [data] all feels very messy, and not tangible that you can go, there, that's where the issue really lies." (Meso Participant 5)

On an internal level, participants highlighted that some organisations had not taken the time to invest in the generation of workforce data and that inadequate workforce data systems contributed to organisational challenges when planning for nurses' post-registration development. The ESR was repeatedly highlighted as a barrier to understanding the nursing workforce appropriately. It was associated with problems in establishing partnership working and data sharing nationally, which participants considered contributed to poor policy decisions.

"The hard data is supposed to be on ESR…that is one of the most difficult to navigate databases on the planet. ESR was supposed to be a national system that, when you moved between trusts, you could take stuff with you and have it recognised. I don't think ESR has been a success…even just pulling data from our own ESR system is really hard. I can see why it wouldn't be shared nationally. It would need a PhD in astrophysics just to get it out." (Meso Participant 1)

Participants highlighted that the ESR required extensive manual coordination and structuring within an organisation, which took time and resources away from staff development. Challenges with the ESR included problems with how often people appeared on the system and what data was included in the system, such as job role and educational attainment level. Thus, participants reflected that it was harder to plan education and training because the data was not transparent and appropriate.

"ESR coding is really variable. Some NHS organisations have highly functioning workforce departments with workforce data importers, while others don't; it's hit and miss…the coding for nursing is not great either, so the codes don't accurately reflect the different roles. And then we have multiple job titles and roles…You need a much simpler, straightforward coding….then It's easier to know where you're going if you know what the job you're after is called…But it's not obvious what training you need for that role or what you need when you get in…you need accurate, simple, straightforward data, then you can map people's progress." (Meso Participant 6)

Participants further commented that within an organisation, the ESR system would not always link up with other parts of the internal development process, including the training and appraisal process. Participants stated that as the ESR has evolved, various segments have been bolted onto it, often without considering how the whole system would work together. Thus, participants considered that there was a lack of systems thinking within a system.

"Most systems across all trusts are really poor. They don't talk to each other, so ESR doesn't necessarily talk to your training platform, your CPD person who allocates the CPD. It doesn't talk to appraisals…none of it talks to each other." (Meso Participant 7)

Additionally, participants highlighted that the challenges with ESR at an organisational level fed into problems with understanding a national picture to help with, for example, workforce planning. Participants acknowledged that although some of the workforce planning processes had improved, they did not feel there was sufficient specialist knowledge and expertise at an organisational level to produce insights into service demand. Challenges with data used for workforce planning were also brought up in relation to vacancy rates and retention, a lack of a coordinated systems approach in the planning process at a local and national level and having to plan a workforce within tight financial constraints. Participants further considered there was a lack of guidance and support nationally and regionally to help organisations do workforce planning appropriately. Participants then said that as there was a variation in how organisations used and reported data on ESR, there was variation in what got uploaded at a local and then national level, impacting national workforce planning considerations. Critically, participants did not think the ESR was useful for planning

nurses' post-registration development. As a result, training needs analysis was more emphasised at an organisational level for post-registration development requirements.

"I don't think we do proper workforce planning that says this is the demand, this is the need. How do we find the money to make it happen. We start from the point of the money." (Meso Participant 3)

Associated with the challenges of data generation, sharing, workforce planning, and professional education was clinical governance. The document analysis highlighted that education and workforce planning were supposed to underpin the clinical governance cycle. Participants stated that the process of gaining training needs analysis from appraisals and, for example, avoidable harm incidents, did create a portfolio and direction of action for organisations about training and education.

"…we've got a couple of safety themes that have emerged through our clinical governance processes. They become the trust's top quality and safety priorities [and] I will be interfacing with the clinical governance team to look at delivering education in relation to those…every year there's a trust training needs analysis that goes down to matrons and ward sisters. They populate with their essential training needs… if it's a core theme like patient handovers, etc, which have been identified as potentially causing more delays, for example, that then becomes a trust priority and a programme of education is put in place in partnership with divisions. But then the department needs to own the action to implement the improvement and monitor their outcome[s]." (Meso Participant 2)

However, participants felt that the education that came through the clinical governance cycle had more of a baseline patient safety focus rather than professional development. As a result, there was often an increase in monitoring and mandatory and statutory training. Participants considered that due to this increase, the nursing establishment and uplift allowances meant that they could not release staff to undertake more substantial post-registration development as there was more mandated or statutory training. This consideration of nursing establishment and uplift ties into the first theme consideration of an organisation's ability to enable AfC as a development framework.

"Carter says we should have 25% headroom.[68] Which allows for annual leave, study leave, etc. But at [Trust name], I think it's 21. At [Trust name], it was 22. And to be fair, even at 22, the amount of mandatory stuff exceeds the 2% you're given before you start giving somebody proper CPD." (Meso Participant 9)

Fundamentally, participants considered that professional development was different to mandatory training. However, the monitoring, both internally and nationally for mandated and statutory training, was what was audited and had metrics at an organisational level. As highlighted in the document analysis, statutory and mandated training were included within CQC inspections and had legislation underpinning them. Thus, participants reflected that this type of training took precedence over post-registration development as a failure to comply with mandated training could mean penalties for an organisation. As a result, participants considered that the national mandates around statutory and mandatory training within organisational governance were restrictive in enabling post-registration development.

"…we have mandatory stuff that we are monitored against. So we have metrics at board, for example, around what training and development is mandatory and the percentages of staff that have achieved so we are held to account on the on that. Any training that is not mandatory, then it becomes the issue." (Meso Participant. 8)

However, participants highlighted that targets against training and development could be beneficial, such as benchmarking against other organisations. Participants acknowledged that benchmarking could help develop an organisation as they could learn what Trusts may be doing to help with geographical standardisation and cross-organisational learning. Some participants felt that the benefit of benchmarking was to break down the organisational silos that inhibited partnership working. Despite this, participants considered that targets around training and development were only

[68] As highlighted earlier in the chapter, headroom is also known as uplift. Carter refers to the independent report for the DoH by Lord Carter (Carter Report, 2016), which highlighted the variations in headroom (uplift) allowances in NHS Trusts (18.5% to 27%). Headroom (uplift) is the planned unavailability of staff and is a budgeted allowance to cover, among other things, study leave. NHS organisations can use headroom as a key performance indicator and set targets for it in staff roster policies. The Carter Report did not actually specify 25% as the definitive number for headroom. The report overall was about reducing unwarranted variation in productivity and efficiency, with staffing identified as a core component of this, and the headroom variation was stated as a problem (Carter Report, 2016). The National Quality Board (NQB) (2018) gives 22.2.% as an example but acknowledges that uplift is calculated on a local basis. Critically, the NQB (2018) guidance p. 14. for uplift (headroom) states, *"estimates for study leave should include mandatory and elements of core/job-specific training…".*

beneficial if meaningful outputs could help them determine good practices for professional development.

"There are targets against everything to do with training and development. I don't like it if we're beaten over the head with it. Because that's all commissioners and people who have given us the money do. They just see an amount of money and a target, and they think you haven't done this. So they use it quite punitively. Whereas I like a target to say that trust over there has managed to achieve 80%, why haven't we? [The] CQC looks at them, our board looks at them, the committee's look at them. Targets are good for benchmarking [and] getting people on board and on side."
(Meso Participant 7)

Additionally, participants highlighted that monitoring around training and development could become more restrictive due to financial constraints. Participants stated that when there are, for example, limited resources, funding will be allocated to training and development that an organisation will be regulated and monitored on.

"…courses cost money. I've got 6,500 nurses. Therefore [you] have to make a decision on where your business-critical areas are in to deliver a safe service…at the end of the day when you've got CQC saying that 50% of your critical care nurses have to have an accredited critical care course, then your hands are tied when it comes to what you do with the finite resource that you are allocated…equity between the system the medics have and the non-medics would be a big step forward but that's never going to happen because of the cost." (Meso Participant 1)

Finally, the year-on-year funding challenge[69] that participants previously highlighted in the first theme of this chapter as an example of organisations often only being able to meet business-critical requirements for training, which was also considered to contribute to organisations being penalised by auditors. This was when national funding was made available for nurses' post-registration development but could not

[69] The NHS financial year is from April 1st to March 31st, and the funding is set for a particular year by the central government. At the time of data collection, development funding came from HEE, which was allocated funds from the central government on a yearly basis. HEE has now merged into NHS England. While development funds now come from NHS England, the allocation to organisations is still on a yearly basis. The timeframe for receiving confirmation of development funding amount and retuning plans is two months (NHS England, 2023a).

be spent because long-term planning and commissioning for development had not been enabled due to the short financial cycle.

"…when you don't find out about money until June, and you gotta get rid of it by April, then it is very reactive. Whereas if we'd known that this is a three-year settlement, it could benefit impact development. Because it is governmental money, HEE can't say roll it over or protect it. They will turn a blind eye for an organiser to do it, but then the organisation is penalised by the auditors. So you're in a rock and a hard place. That's the difference with medics because they've had that stability. I think if there was stability in the system and you knew what you were going forward into, then that [would] enable you to make the impact. If you think about triangulating patient experience, patient risk, staff experience [and] desire, then developing [that] into something about learning and what's going to impact on patients, that takes time." (Meso Participant 10)

Furthermore, participants highlighted that alongside financial penalties, there were also financial incentives that placed organisations under pressure. An example was given regarding taking undergraduate students for training placements, where organisations are given money for every student they take.[70] This example was in relation to the 50,000 extra nurses' government announcement (Conservative and Unionist Party Manifesto, 2019), which participants felt was done with a lack of consideration of demand planning and how it would affect them at an organisational level to increase placement capacity. As organisations often face financial restraint, they would take the students. However, participants noted that this placed extra stress on staff and could restrict their time for development. Participants considered that the financial challenges, monitoring, financial and system stability and difficulties with establishments and uplift were some of the barriers that existed when trying to create

[70] This refers to education and training tariffs, which were introduced in 2013 for clinical placements (including nursing) and medical training placements. A clinical tariff payment provides an annual contribution (reflective of a full time equivalent) rather than an individual student. Full tariff payment is paid for every 40.8 weeks of placement activity. Therefore, a week of placement activity should be 37.5 hours) to the funding of placement coordination and practice-based learning. There is no equality of tariff funds between medical and nursing training. In the latest guidance published in 2023, the tariff for clinical placements (undergraduate nursing) is £5,343. For medical undergraduate placements, it is £32,552. Unlike nursing, medicine also receives a tariff for postgraduate training, at £12,632. Medical postgraduate study leave is also funded, at £812. Nursing does not receive an allocation. (DHSC, 2023).

a more equitable professional development system between the medical profession and nurses.

4c.5 Chapter conclusion

In this chapter, three themes from the meso-level interviews have been explored. First, organisational governance was considered a core factor influencing nurses' post-registration development. The loci of responsibility for post-registration development could lie outside the control of the Chief Nurse, which inhibited appropriate and effective development. National funding reductions and fragmentation were cited as challenges, and organisations tried to become self-sufficient to shield themselves from external influences, which often impaired their ability to plan development long-term. Organisational governance was also attributed to challenges in operationalising AfC at an organisational level. Restrictions around uplift and nursing establishments, combined with financial constraints, a lack of protected study time, competing service delivery needs, and variations in organisational culture, were all attributed to affecting the AfC aim to enable development. However, the AfC policy and framework were also acknowledged to be rigid and could not respond holistically to nursing professional development. Challenges included banding panels and appraisals, which participants considered had lost a development focus.

An aspect that was considered to make organisational governance challenges more difficult was networks and partnerships working at a local, regional, and national level. These were often fragmented, underdeveloped and restricted by national healthcare governance arrangements. Additionally, repeated policy changes and unstable foundations from governance and financial cycles impair an organisation's ability to plan development long-term and establish effective networks, with, for example, HEIs. This was compounded further by a lack of national ownership of nurses' post-registration development, creating problems with accountability and consistency of policy and implementing initiatives at an organisational level.

Finally, in trying to overcome governance challenges, fragmented networks and partnership working were inhibited by a lack of data and poor data systems. Data

generation was considered crucial to workforce planning and strategy development, such as influencing training needs analysis to support clinical governance. However, data systems such as the ESR were consistently cited as poor, impairing workforce planning, and clinical governance was focused on statutory and mandatory training, not post-registration development. Due to legislative and monitoring requirements, financial penalties and incentives, organisations would be further restricted in how much time and resources they could give to progress nurses' post-registration development appropriately and effectively.

Chapter 4d: Findings – Mirco interviews

4d.1 Introduction

This chapter presents three themes from the micro level. First, it explores the influence of AfC on nurses' post-registration development, which builds on the previous two chapter's findings. The management focus of AfC is considered, in terms of how it can act as a disincentive for post-registration development alongside the restrictive nature of AfC. This theme also includes challenges with the appraisal process linked to AfC and the wider influencing factors within clinical governance on education and training. Subsequently, the state of post-registration being interpreted as a luxury item for nursing is presented.

The second theme considers the central role that people in management roles play in enabling (or not) post-registration development. The prominence of line manager's views and attitudes towards post-registration development is discussed. The implications of this are reflected in considering how an individual's exposure, personality, and ability to navigate processes determine how well and how much development opportunities are facilitated. Further considerations about the consequences of this are then presented, including equity of access and gender stereotyping for post-registration development.

Finally, the third theme explores the impact of the lack of post-registration development on the nurses themselves. Consideration is given to a lack of pathways and guidance at an organisational level and the role that organisational strategic thinking plays. The presence of increasing short-term opportunities and the instability of roles are then presented. Data and evidence generation are considered alongside the challenges with role and opportunity development, including the relationship to workforce planning. Lastly, the recognition of the role that politics and the national context can play on nurses' post-registration development is stated.

4d.2 Theme one: The desert island luxury item is training and development

The views of participants at this level echoed and expanded upon the previous levels of interviews regarding AfC and its impact on nurses' post-registration development. Throughout the interviews, nurses across NHS organisations, bandings, specialities, experience levels, and geographic regions expressed that AfC did not aid their professional development; instead, it acted as a barrier. Furthermore, participants expressed that they did not feel or realise that CPD was associated with AfC. This view was again expressed across all experience levels, from those newly qualified to those with very senior-level experience and bandings.

"I think it's [AfC] used against us. That banding can't do that because that's x banding. I'm not a fan of how it's used [and at] the conference[71] *when you said about it being linked to CPD, I had no idea, and I would never have guessed, and I would have said it was a tool to prevent CPD. It blew my mind. I've had so many conversations because of your presentation. And everyone's like, argh, get the pitchforks out now. I am so fascinated it is supposed to be an enabler. I don't think it's the people. I think it's the system…the system is such that…it feels like people will throw a band and say, well, you can't do that because that's that band. You can't apply for that cause that's that band. [How] can you pigeonhole this many people within a profession to those bands?"* (Micro Participant 23)

One of the ways that participants expressed that AfC could impair development was that the AfC increases were often centred around management roles and responsibilities rather than recognising clinical experience or specialism. One of the few exceptions to this was around advanced clinical practice, through which participants considered it possible to be recognised at a higher AfC band while remaining clinical. As a result, many participants reflected that AfC acted as a disincentive to post-registration development, and at higher AfC bands, the 'nursing' element of the job sometimes felt lost. A reduction in patient contact and clinical focus

[71] I presented the analysis on AfC and nurses' post-registration development at the RCN International Research Conference in 2021. The reflexivity section of the methodology chapter explores this participant's response in more detail.

were highlighted in relation to this. Thus, participants thought they had limited options for development.

"I think it didn't take very long at all before you realised in your mind it [AfC] doesn't recognise experience …you have a glass ceiling around if you want more seniority and responsibility, and you do end up being forced into [the] management line… I don't think it changed anything from the old grading, and in some ways, it [AfC has] made it more difficult." (Micro participant 1)

Furthermore, participants at this level frequently expressed that nurses were spoken of as bands rather than their role or profession, which relates to the macro-level participants' view of AfC as restrictive. Participants expressed that this translated as AfC being nothing more than a triangular hierarchy, which places the majority of nurses at the base and ultimately feels derogatory.

"…you're only a band 5; you can't do this and this. I might only be a band 5, but it's quite derogatory to certain people. Especially if you've got a career in nursing and you've been a band 5 nurse for 10, 20, sometimes 30 years, but you're happy doing that role for someone to turn around and say, well, you're only a band 5. It's derogatory, and it happens quite frequently." (Micro Participant 22)

Participants repeatedly expressed that AfC contributed to the number of nurses and their band being prioritised over experience level when, for example, determining recruitment and skill mix. Incidences of downbanding were highlighted, as all previous levels of interviews have indicated, with a finance focus and lack of value placed on the role felt to be the root causes. Participants also reflected that the banding panel's job evaluation systems were focused on getting the numbers 'right', and because the process is often based within HR, they [HR] would not consider job requirements outside the banding framework. This reflects the experience of meso-level participants. Furthermore, the focus on numbers was expressed within the macro-level interviews, indicating that the AfC framework and system are viewed from the outside as being focused on numbers and internally by those working within the system.

"I think if you're a manager and have a very experienced nurse retired, you're going to replace them with a newly qualified band 5 because they are kind of [ten a] penny. You're not going to replace them with another nurse with 25 years of experience, but we will still have 10 nurses, still have the same number; it just won't be the same quality. It's a numbers game. I think that's intentional." (Micro Participant 9)

The lack of association expressed by participants between AfC and professional development and the focus on numbers reiterates macro-level participants' views that AfC is a set of terms and conditions focused on pay rather than skills and experience. Thus, not only is AfC at a national and policy level associated with issues around flexibility and versatility, but nurses working within the AfC system also expressed that AfC cannot facilitate and reflect the complexity of the nursing profession. Participants stated that they considered AfC and the banding system to create barriers to development rather than facilitate it.

"…there used to be training with the coroner [about] recordkeeping. Fantastic, a whole day, it was band 6 and above only. Why? So they've got restrictions on that, which will also affect your development. You can't gain additional skills to have opportunities if it's 'you can't do that because that's not your band'. Then how are you supposed to develop?" (Micro Participant 4)

Alongside the meso participants highlighting the differences with AfC bandings between organisations, participants at this level expressed confusion about mapping their skills and experiences across organisations when, for example, roles were banded differently. For instance, participants stated that in some organisations, ward managers could be a band 6, while in others, they would be a 7, or what would be considered a band 8a was also organisationally dependent. As a result, participants expressed that from a professional development perspective, what needed to be achieved or experienced was very different, leaving them confused about what they needed to focus on. Thus, AfC was not considered a consistent system that enabled continuity in improving post-registration development. Additionally, participants emphasised frustration that the equality between professions and AfC bandings was not apparent, even within the same organisation. Therefore, participants didn't feel that AfC was a fair system that rewarded skills and experience.

"…the expectations at the grade for nursing are very different to different professions also on AfC. For example, I'm a 7, but my colleagues who are allied health professionals and would probably have less responsibility than me are 8as. If we talk about pure management, they are line managing 15 people; I'm line managing 50 people. I am responsible for the whole unit, the budget, and the response to it, and they all come to me with questions, can I do this etc. And you sit there and think, hold on, why am I a grade lower? It's not a great tool for nursing because I think it devalued nursing a lot in terms of remuneration." (Micro Participant 3)

A central part of the AfC framework that participants highlighted repeatedly as being essential but also held the most variability was the appraisal process. Appraisals were considered to set the tone for career development possibilities and opportunities. They were pivotal at a local level, where there was limited national guidance for career frameworks and post-registration development. The majority view was that there were persistent issues with the appraisal process, which included if they happened, who did them, and what the process consisted of.

"…how we talk about post-reg development within appraisals is hit and miss. I think that's where perhaps the quality of what we do is a bit hit-and-miss. And [your appraisal] depends on who you're sitting in front of, how they will think about how they support you, and what opportunities there might be. Because there are no defined pathways or what a pathway could look like. I think that's [the appraisal] a really crucial point for nurses because you're setting that tone for possibilities and opportunities and what nursing is and can be." (Micro Participant 6)

Participants considered that appraisals could be very beneficial if done correctly and if other existing structures and systems were genuinely related to that appraisal (like accessing funding and time release). There needed to be a governance process that was transparent and supportive. Participants considered that unless appraisals were connected to the wider systems that enable actions to be enacted, they lost their function and purpose. Challenges with accessing funding and time release, including study leave, to undertake post-registration development were repeatedly brought up as issues that participants considered to impact recruitment and retention in the profession. For example, participants highlighted that they would be told they could

request whatever they wanted for development but would not get funding for it, making them feel that appraisals were just a tick-box exercise. As a result, participants considered that this contributed to a feeling that nurses were just viewed as numbers, which has been reflected throughout the previous levels of analysis.

"[Without the structures in place], all people see is I will be a band 5 nurse forever. What are my managers doing to invest in me to progress to band 6? What do I need to do? So your appraisal process, things such as investment from the trust, all comes down to resources for how you will be able to progress. I think there's an element of disillusionment because there isn't that framework, and I don't think that level of support is there. They [nurses] are just seen as numbers on a page." (Micro Participant 26)

Additionally, participants indicated an awareness that impacting the outcome of their appraisals was the central focus of clinical governance. Participants reflected that most of their study leave, or days, got used up by mandatory and statutory training requirements. Participants stated that this type of training was the safety-critical, service requirements, not post-registration development. However, participants reflected that these two components, the mandatory and statutory and post-registration development, were often viewed at an organisational level as the same. This conflation supports the view held by the meso participants and the challenges they had getting the two differentiated.

"I looked at the course catalogue on our website's learning and development section. I didn't really see anything there other than the standard development training, the training we have to do, the mandatory training." (Micro Participant 2)

Participants highlighted an aspect associated with the conflation of post-registration development and mandatory training outside their organisation: the revalidation process with the NMC.[72] Within this process, mandatory training hours count as CPD, which many participants disagreed with. Participants stated that doing all their

[72] Revalidation is a process every registered nurse undertakes every 3 years to remain on the professional register and be allowed to practice. Within this process, is a requirement for a set number of CPD hours. Currently, the CPD requirement is 35 hours over 3 years. Mandatory training is given as one of the approved activities for achieving the 35 hours set by the Nursing and Midwifery Council.

mandatory training over the 3 years revalidation cycle would cover their CPD requirement. Participants considered that this contributed to a feeling that 'true' post-registration development would get missed or ignored by an organisation because their professional regulator allowed mandatory training as CPD.

"…what people think is post-registration development, showing how to use a pump or doing an IV package, that's not really development; that's just allowing you to do your job. You need to be looking at development on a bigger level, deepening that knowledge base, and I think that is missed." (Mirco Participant 5)

Furthermore, participants highlighted that not only is their development affected by the focus on mandatory and statutory training but also roles directly related to development within their organisations. For example, smaller NHS Trusts with practice development nurses (PDNs) were acknowledged to have greater difficulty providing more substantial development outside the service and safety-critical mandatory and statutory training. This was attributed to staffing levels, workload, and rules around the backfill of staff.

"We're a small District General Hospital with a PDN that only works two days a week. How is that PDN supposed to do any meaningful development? Because you almost need a PDN for mandatory stuff. She basically ends up doing the medication sessions because, by the time she's everyone done, there's a new raft of people to do; how can she do everything else? And you can't get support from her to cover. The matrons are so busy with everything else. Technically, you're not even allowed to replace people on maternity leave. So how are you supposed to get extra staffing to cover a ward for an hour of a Wednesday afternoon to produce teaching? It's almost impossible." (Micro Participant 10)

As with the focus on mandatory and statutory training, many participants expressed frustration that they did not have any protected time for post-registration development, which reduced the impact of appraisals. Thus, CPD was often seen as an extra burden, increasing their stress and contributing to feelings of burnout. Fundamentally, participants considered that AfC contributed to a lack of focus on

proper post-registration development, augmenting the erosion of a nurse's professional identity, as nurses were seen as bands, not educated professionals.

"…[the problem] is that you're a band. That's mostly what it [AfC] comes down to, and there's enough issue with professional identity anyway, but I think you're this you're that is probably the biggest thing that comes out of it." (Micro Participant 23)

The overall impact of the AfC framework, problems with appraisals, the absorption of study leave and days with mandatory and statutory training, and a lack of protected time was that nurses' post-registration development was considered a luxury. The undercurrent to this was that participants repeatedly highlighted that 'proper' post-registration development was seen as an add-on to their role rather than an integrated component. Participants further highlighted that because development and training were seen as a luxury, they were often the first things to be removed when service pressures mounted, which presented safety concerns if not reestablished quickly. This was due to staff not having the opportunity to strengthen and develop their capabilities to benefit patient care.

"…I think we need managers and leaders that are going to support their staff. It needs to be part of the culture that staff development is normal, to be encouraged rather than something that's a special treat. Somebody once said to a manager of mine, why do you need to go on a course? Are you telling me you can't do your job? I've come across that a couple of times. Within the last 20 years, I've come across the question of why you need to do this. To do that? And the bottom line is safety. Apart from obviously keeping staff and them being motivated, it's safety. If we don't develop, how can we be safe?" (Micro Participant 16)

4d.3 Theme two: Middle Earth management, the kingpin makers

As highlighted in the previous theme, one of the central aspects of an appropriate and effective appraisal process was who conducted it. Managers, particularly line managers, as opposed to general management, were considered by all participants to be very influential in nurses' post-registration development. Line managers were

considered gatekeepers, as they held the metaphorical keys to access, such as time and funding, because they were the first port of call for staff seeking opportunities. For instance, an example was given about a nurse working on a stroke unit who wanted to do a diabetes course to help broaden their knowledge but was having access problems through their ward manager because, in the manager's view, it was not considered stroke care.[73] Participants also highlighted that it was not just the formal access to study leave or funding but also accessing 'on the job' opportunities for further development. For example, a participant identified the desire within an appraisal to care for more patients with brain injuries within an intensive care setting. However, this was not facilitated due to management's lack of coordination and communication.

"I think it's difficult for them [plans from appraisals] to be implemented because you just have that with one of the band sevens. For example, I said I'd like to take more neuro [brain injury] patients because I'm interested in that. And they were like, yeah, that's fine. We'll definitely do that. But then, when you come on shift, nothing happens. It might not be them that's doing the allocations, so I think communication between the band sevens or matrons should be better." (Micro Participant 12)

Furthermore, managers were seen as crucial to enabling staff to try and access development opportunities within working hours if, for example, trying to gain study leave was not possible. Many participants expressed that this often had to be negotiated with their managers because they did not have protected time that they could utilise. Much of the 'line–manager–nurse' relationship was indicated by participants to be based around the idea of negotiation because there were no or limited external mechanisms in place that could act as a blueprint for a nurse's post-registration development. Line managers thus had to act as that advocate, which participants did not always feel was apparent or encouraged.

"…my research manager has really acted like a mentor, given me loads of different options, has shown me different things I've not really considered in my career. That's been important because she's supported me in using my working hours to do different stuff. So you do a lot outside of work, but at some point, you have to stop and

[73] Even though diabetes is a major risk factor for stroke (National Institute for Health and Care Excellence, 2023)

actually get your manager's support to do things within your working hours. Whether you can develop yourself within those hours is a bit hit-and-miss. It depends on who you speak to about it. Some of my managers are really supportive, but some, I wouldn't even broach the topic because it's not worth having." (Micro Participant 24)

Additionally, participants highlighted that the attitude of line managers to career and post-registration development was profoundly influential. Many participants highlighted that if their manager valued education and viewed it as important for staff development and patient safety, they would be more inclined to be proactive and discuss ideas and ways to enable opportunities for staff. For example, a nurse who was a line manager highlighted that because they recognised how important education was, they would sometimes run a shift short or would step in in place of that staff member to enable them to go on training because they knew the value it would bring to the ward area in the long term. However, participants often expressed that they received ambivalent or derogatory comments and attitudes from line and senior management about their career progress or ambitions.

"When I did my scholarships, I was very junior, and I had two matrons during that time. When I returned, I was given protected time to spread my learning into service improvement. During that time, these two separate matrons who were enabling me to have that time and were involved in the project independently said to me what it is like being up the arse of the Chief Nurse? I was a band 5, and for a Band 8a to be saying that to me made me question what I was doing, how am I perceived, and should I step away from the work? I think I'm doing the right thing for the hospital, my career, and everybody; why am I getting this feedback? It's difficult to balance wanting to do well, to do things for the greater good and not wanting to be seen as sticking my head above the parapet because it will get chopped off." (Micro Participant 15)

Another attitude that participants highlighted as challenging was the underlying assumption that if they were trained, they would leave. Throughout this level of interviews, participants highlighted a lack of consideration or acknowledgement of the link between retention and development. This attitude was considered by participants to undermine efforts to develop and encourage post-registration development.

Participants reflected that what influenced this was that nurses' post-registration development was often considered within a silo, with a lack of consideration of the wider healthcare system and the role that nurses played within it. Some participants hoped this attitude might be alleviated by emphasising systems thinking, such as through ICSs and viewing staff within that system rather than just within their organisation or practice area.

"I've been lucky in the organisations and with the managers that they've allowed me to develop. Whereas I know some people feel that they are not enabled to develop, and it's seen as a loss to a team if somebody then goes up. I suppose the benefit of the ICS way of thinking is that if they are retained within your ICS structure, it doesn't matter where they work as you still got them delivering whatever that may be."

(Micro Participant 11)

However, participants were aware, either from their own experience of being a manager or observing management, that there was often insufficient training and development for those taking on management roles. Appraisal training was often considered not present, and though some organisations did provide training, this was not common. Additionally, some participants highlighted that because management was seen as one of the few ways to advance careers, managers were often in their roles because that was the only option available to them rather than because it was something they wanted to do. Participants reflected that this contributed to an attitude of apathy towards the development and training of staff, particularly within the appraisal process.

"…that's [the appraisal] dependent on how good the appraiser is, and where their heads at. Because you can get the Ward Sister, that's like you won't be able to do that course for another five years, you can't do that, you can't do this. Whereas my approach to appraisals is because of my own experiences, I know where our Chief Nurse is at because I know what money's in the pot, say, what would you like to do? You can have the most beautiful appraisal process that guides people into developing themselves, yet it comes down to the individual doing the appraisal and where they're at...It comes down to people enabling and the ability to enable." (Micro Participant 17)

Nonetheless, participants did highlight that ward managers, for example, often had very high workloads, with more staff to manage than was appropriate to enable an effective appraisal process. Furthermore, participants acknowledged that managers were under significant pressure to focus on and maintain staffing levels. For example, practice area staff numbers were repeatedly considered a significant barrier to managers feeling they could facilitate other staff development or nurses pushing forward for development opportunities because they knew staffing levels were an issue.

"The problem is you are relying on people more senior to you to give you that [career] advice, who have got an ulterior motive they want you in the job. It's all well and good for me to go to my manager and say I want master's funding to do advanced practice. I know that there's no one in my department to take over my role, so she's going to be influenced by that. Of course she is, I would be." (Micro Participant 10)

The phenomenon of 'fortune favours the brave' resulted from the pivotal role that middle and senior management played in nurses' post-registration development. For example, more senior participants indicated that they had been able to develop and access opportunities because they pushed and were generally considered extroverted or tenacious, which, for example, improved their networking opportunities. While many participants highlighted that it was important for nurses to take responsibility for their post-registration development, generally, participants considered how well someone knew the system, the people in it, and how well they could navigate both aspects dictated their development. For example, one participant described post-registration development as being influenced by the *"hidden curriculum"* (Micro Participant 5), in which knowing the right people, what processes you needed and where to go dictated success.

"… it was hit the ground running; get on with the job. You don't have time to meet up with your matron for appraisals. So, I never had one. You had to really beg if you wanted to be put on a course…[and doctors had] these case scenarios [training], and they would always laugh as there was me, this one scruffy nurse that would turn up at the back. But it was fascinating…but the oncology nurses weren't even on the list.

Even me, who turned up every month, wasn't on the list. I would be nagging the consultant every time being, like, can you add my email to the thread? They never did. I always found it out by asking someone else, 'Is this teaching on?'." (Micro Participant 7)

Furthermore, participants stated that alongside the necessity to push for development constantly, they had advanced their careers or knew of options due to chance or exposure. For example, participants described their success within and getting into infection prevention as down to luck, more than judgment or anything written down. Participants considered post-registration development as something they stumbled upon rather than having any structure or guidance, and it often felt opportunistic, not formal or guided. This exposure was also related to knowing what roles were possible as a nurse. For example, participants stated that they only knew that nurses could be involved in research because they saw nurses doing research in their clinical area, which inspired them to explore it as a career option. Participants indicated that there needed to be greater emphasis on identifying talent from within an organisation, not just people identifying themselves, because participants generally considered that the louder someone shouted, the higher the chance of success in gaining post-registration development. Subsequently, participants reflected on the importance of role models and organisational talent management as central to enabling and improving post-registration development.

"…if you wanted to go down the management route, that was fairly clear cut. But for anything else beyond that? No. And it really depends on people pushing themselves forward, seeking out opportunities and speaking to people…when I moved into academia, it was just because I contacted someone at the university…and out of that conversation I had an interview, so it was very much on the fly, you know, just lucky charms really, rather than anything more structured." (Micro Participant 19)

Participants also expressed that the opaque process for post-registration development and the influence of management as gatekeepers impacted the equality of access to opportunities. Internationally trained nurses and those from minority backgrounds were highlighted as being disadvantaged. Another access issue for post-registration development was participants stating that women often needed more flexibility in

their careers due to childcare. Some participants highlighted that family dictated their careers and post-registration development. Although the female-dominated workforce was considered an influential factor for careers, this was made more challenging by a lack of pathways and transparency. Many participants expressed that childcare, for example, was a restriction, but this did not remove the issue that existing organisational structures made it more challenging. For example, participants stated that it was difficult to plan long-term development alongside childcare if you didn't know what to plan and organise for because there was no guidance or pathway to help.

"I've got kids, and I've been granted the benefit of fixed shifts. As a band 5, I know full well that if I move beyond a 5, I lose that. So [for] development in later life, there's not much encouragement because there are a lot of people on my ward that have been nursing for a long time. And they're really knowledgeable, and they could move their way up quite easily but can't because of childcare issues and having that stability because shifts are obviously all over the place. So I see it [post-registration development opportunities] favours the young and the childless." (Micro Participant 20)

Finally, in relation to the flexibility and childcare challenges, participants highlighted that they had experienced gender stereotype norms regarding post-registration development. Participants reflected that women would be perceived as bossy or demanding for asking or being ambitious in their careers, but this would be different for men. Both male and female participants at this interview level indicated that men tended to benefit more with post-registration development as a result. Some male participants also stated that they had advantages with career progression, particularly in terms of progressing quicker, and that management potentially played a role in this when, for example, recruiting for roles.

"I feel that as a male nurse, I've had easier access, and I've been offered career progression at every stage. I think being a male nurse has been a benefit for me, and I do feel that is wrong because a lot of my female colleagues said well, it took me 5 years to become a district nurse, and It took me 2, and I do feel this is a bit controversial but…I went into job interviews and I'm of the opinion some manager

subconsciously think the young female nurse is probably going to go off and have children. I do feel it might have been advantageous to me. I'd like to think my performance at interview would be the reason to give somebody a job. But I see a lot of my female colleagues taking longer to progress up the grades. I do feel that aspect is there." (Micro Participant 27)

4d.4 Theme three: I wandered lonely as a cloud

The overall impact highlighted by participants due to the challenges they have experienced with post-registration development was that they experienced being aimless and disappointed, not only at an organisational level but also nationally as a profession. This view was expressed by graduates and direct entrants to nursing. The lack of pathways and guidance was considered to affect confidence and motivation in pursuing post-registration development, which ultimately negatively influences retention.

"[When there is not investment in post-registration development and training] It can make you feel aimless or, why am I doing this? I have a lot of friends who don't work in healthcare or in nursing and seeing their regular career paths they know where they're going. It's a very much built into their workplace culture that they'll have pay rises, have plans for where they're going, what's going on and then I [am] just like ohh, we'll see what happens if I do this, and applying for things, trying to find out information. It's a bit disappointing." (Mirco Participant 14)

The lack of pathways and guidance expressed by participants was acknowledged to be an issue at the organisational and national levels. At the organisational level, participants expressed that there was often a dichotomy between the promise and reality of post-registration development. Participants considered that there was a lack of information to guide conversations about development. It was often a case of development only becoming available when someone left a role, so while the theory of what is available may be present, there are often no posts. Preceptorship challenges were also highlighted, and some participants stated that although they were given a preceptorship, the quality was variable, with a lack of mentoring. Sometimes, they

were left to find mentors themselves and were provided with limited or (at times) no structured training and development sessions.

"I think actions speak louder than words, and there's far too many words. The challenge [is being] given the time to do it…and accessing it [CPD] as well. It's not easy, it's not clear, it's not standardised. And different areas [internally] will do different things…[and] I think the problem is we do preceptorships post-registration, but they're not enforced. So, because we don't [have] do it, [the] quality is variable. So what's the incentive? Why would you?" (Micro Participant 3)

Participants considered a lack of organisational support underpinned the dichotomy between promise and reality. Participants considered a lack of organisational strategic thinking around nurses' post-registration development a contributing factor to this challenge. While participants highlighted that Trust variations on development opportunities would be affected by their funding focus, they also stated that other internal structural and strategic deficits impair post-registration development. For example, challenges with a lack of succession planning for specialist roles in cancer services were highlighted, and there was a lack of consideration given to what that would mean for the provision of services. Furthermore, participants stated that if opportunities were not available for nurses once they had undertaken, for example, a development course or a secondment, it could lead to people feeling disenfranchised and demoralised. Fundamentally, participants considered there needed to be more system thinking at an organisational level around nurses' post-registration development.

"Sometimes there is a bit of a disconnect…so there's a flipside to training people to do loads of great stuff and developing them if that is what they want to do. They need to be supported in it [afterwards], because if you just train them and don't do anything with them and they just sit there, then they become disenfranchised. It gets demoralising." (Micro Participant 5)

Furthermore, participants highlighted that at an organisational level, development opportunities were becoming increasingly short-term. Participants reflected that this contributed to a sense of instability in post-registration development, as there was a

lack of longer-term posts. This sense of instability increased unease about not knowing what might be next regarding further development or career opportunities. While participants acknowledged that trying a new role was very valuable, for example, with secondments, many commented that this was becoming the dominant method of career development, which did not always yield permanent progression.

"…everything's a bit sort of bitty and bobs. I'm on a 6-month contract and we've rolled it a couple of times now, but there's an awful lot of that now. So there aren't quite so many jobs for life. A lot of things are, you can always test the water with certain things, but it's only for six months, and then you're not quite sure what's going to happen. We are still struggling with [working] contracts." (Micro Participant 18)

Alongside challenges with the instability of jobs or working contracts, participants highlighted that instability and significant service changes affected their post-registration development. Participants considered that a system-based perspective was not often taken on how governance changes would influence staff development. For example, a hospital merger highlighted that line management was allocated double their previous responsibility, which resulted in them being unable to focus on staff development. As the previous theme highlighted the significance of line management, participants considered that organisational changes that impaired this relationship hindered nurses' post-registration development.

"Our Trust has merged with another Trust. We used to have one matron who oversaw us. Now we have a matron that oversees two trusts, two wards, and a team of CNS [clinical nurse specialists], so there isn't somebody around…premerger, you'd go upstairs and have a chat with the matron. Now, she could be anywhere. I don't have that one-to-one support any more it is gone. [Previously] the matron was incredible, talked a lot about development and was proactive. But since we have merged Trusts, that's gone." (Micro Participant 8)

Reflecting views from meso-level participants, a reason that participants considered that development opportunities were not as well established within their organisation was a lack of data to evidence the impact of workforce initiatives on, for example,

patient safety and service provision. As the first theme in this chapter showed that AfC and post-registration development were a luxury item for nurses, the lack of data and evidence at an organisational level was considered to contribute to this issue. Participants expressed that there was a disconnect between service initiatives, evaluation, data generation and workforce implications at an organisational level. As a result, participants thought there was a lack of a full cycle of quality improvement on development opportunities considering the outcomes on services. The lack of insight and understanding generated was considered to contribute to a lack of investment in development opportunities for nurses. An example given was around clinical academic role development, which was not evaluated or considered organisation-wide, and there was a lack of interest expressed from senior management in working in partnership with the person trying to implement the role to consider the impact.

"…it [referring to setting up a clinical academic initiative] was happening but never acknowledged and never evaluated. The impact was never evaluated. But looking back, it's really mad that that was the case because it did have real benefits, and I used to talk about them a lot, but there was never an 'okay, we need to support these roles'. How do we build a bit of a framework for them? To be blunt, no one was interested. Nobody within my organisation, even within the service. There was never strategic thinking around it, or this is happening, so what? It *was never recognised by the organisation as a role. Nobody ever came to talk to me about what I thought the benefits were of it."* (Micro Participant 6)

The lack of data on workforce development was further considered by participants to influence the ability of organisations to carry out appropriate workforce planning, a challenge also confirmed by meso participants. Participants acknowledged that developing existing roles or creating new ones was challenging without the data to illustrate potential or current impact. An example of trying to get a Trust Board to recognise ACP roles was given. In this case, the need to attend meetings with senior board members was highlighted, and they would only be heard if they had the right types of data to have conversations at the board level, particularly regarding cost savings. As a result, participants acknowledged a greater need to navigate organisational politics to try and establish new roles or develop career pathways. In

the policy analysis and the macro-level interviews, the focus and requirement for data and the right type of data language were considered significant when discussing post-registration development. Here, participants working on the front line confirmed and reflected on the significance of having the right type of data back through their experiences in progressing post-registration development.

"My band 8a has been hard fought because my Trust didn't know what my job role was, so we had to fight for our contracts and get them paid as band 8s rather than 7s. [For getting a ACP role recognised] Me and my colleague did presentations to the board and the clinical directors that we infiltrated from a talk to discuss [the role] with the Director of Nursing. [Making it] sound like a cost-effective option for them in terms of retaining staff, improving the patient journey, and improving patient safety. We tried to get ourselves heard; it was about politics [and] power. Being in a district general hospital [there is a lot of], we've always done it this way attitude, hierarchy, and a lot of the boards have been there for a long time, and that doesn't promote change well." (Micro Participant 13)

Participants considered that improved partnerships working with higher education institutions (HEIs) could improve data generation and evaluation cycles to enhance nurses' post-registration development. Clinical academics and joint strategy development with HEIs were considered mechanisms to improve partnership working. However, the participants unanimously considered the national voice and policy direction around post-registration development weak. Participants stated that the lack of national steer and strength of professional voice from national organisations contributed to a lack of incentive at an organisational level to support post-registration development, which impaired organisational strategy and investment. Challenges with implementing national policy initiatives at a local level were highlighted, including PNAs, which meso-level participants also expressed. At this level, participants considered that the lack of direction and guidance about implementing the PNA role created issues around the standardisation of governance of the role at an organisational level. The problems with the standardisation of governance were considered to lead to inconsistent and fragmented development of the role.

Participants highlighted this ultimately impacted the nurses as PNAs and those they were trying to support.

"…the professional nurse advocate programme [from] NHS England has been problematic because there's been no higher-up guidance or direction. They said this programme is marvellous, this is what we're going to be doing…restorative supervision and quality etc. But there was no direction about how we're doing that in practice. I think this is across the board, not just us. I think somebody at a trust started doing some stuff with it, and most people are now looking to them and using them as a benchmark. But there was just, we've got all these places, all free. Anything that's free, organisations will jump on the bandwagon to get people on. Without really knowing how to implement that or roll it out…some places have protected time; some aren't allowing protected time. Some people have got x hours, some people haven't, and some organisations have got a permanent person just doing that role and doing it full-time, but we're not having that. So you just bumble around." (Micro Participant 21)

Additionally, participants recognised the politics and the role that national policy played in what they experienced within their work and in their post-registration development. Participants desired an increase in the strength and prominence of nurses on a national platform, as they thought that if nurses were seen more in politics and government, it would add value to their profession. Fundamentally, they considered this would help post-registration development because nurses would have more presence in decision-making spheres. As a result, participants expressed that this would mean education would be more highly valued and more effective policies would be developed. Furthermore, national policies not directly related to post-registration development were recognised to impair access to training and development opportunities and staff wellbeing, including targets. Participants recognised the interconnected issues at an organisational level that affected training and development opportunities, including staff shortages. However, participants were also cognisant that there was a lack of long-term thinking about the impact of restricting development opportunities, including on patient care and staff retention.

"… [I notice the effect with] the 4-hour waiting times, but you have no staff, and you've got two doctors out of 6 on a night shift or something stupid like that, and the waiting time is like triple the amount it should be. Then you feel it cause everyone's stressed and everyone is trying to adhere to a time that is not based on the current staffing pressures that you are faced with… and then [a] barrier is whether my department would release me [for development] …a person got a really good job at NHS England for six months, [her department] released her and then called her back because of the acute staff shortages. But then it's sort of just kicking the can down the road because people are trying to develop and get better so they can deliver gold-standard patient care. [But] You're not allowing people the time to go off, [to] be better and do better, [and] that also affects retention, and it's getting worse." (Micro Participant 25)

As a result of the lack of national direction, many participants considered that they had to invent their own post-registration careers, with limited support. However, the lack of pathways nationally was considered a double-edged sword. From the previous theme, it was acknowledged that career flexibility, including the ability to move specialisms, was important and highly valued across sectors. Participants further expressed that the stringent and stricter medical model for careers was not wanted, but they recognised its value in developing coherent career pathways. Nonetheless, participants believed there needed to be a more significant national steer for post-registration development, including career pathways. This was because there needed to be more extensive networks, levers of action, and evidence attached and connected system-wide for effective development opportunities. While participants recognised that there are beneficial local initiatives for career development, these were geographically dependent. Therefore, only certain nurses would benefit, and crucially, there was only so much possible at a local or regional level.

"I think it [post registration development] does need national steer. I think it needs a strategy behind it. I think that what's lacking, I think it must have national steer for it to be an all singing all, dancing pathway. For example, the medics have their career pathway laid out for them, and they get on and get off at different junctures, and that's nationally set. That cannot be a regional, local decision because the pathway

must go across England; it has to go everywhere to be a true pathway. Nursing career development opportunities must come from the national level. We've tried to do it locally and it's not worked. You can only do so much. You need it all to be linked up, to have those bigger networks and those levers; you need the national leverage." (Micro Participant 15)

Fundamentally, participants considered that the healthcare system and national direction had an enabling role in empowering nurses and creating an environment with appropriate infrastructure for post-registration development. Participants considered the balance of power for nurses to forge their development too heavily weighted in favour of those in line management and organisational culture. While individual responsibility was considered crucial, the national policy and political arena and how this affected organisational strategy and change were also acknowledged as central to improving nurses' post-registration development.

"…if you [the government] want us to continue to develop, change, innovate, that requires effort and a structure to allow us to do that. In terms of training and development, it's getting that acceptance that this is absolutely essential if we want the workforce that we need. There are things we personally can do about that, but there are things that require an infrastructure and environment in which that will thrive, and I don't think we've got that right. And it's recognising that some of the people who have the biggest influence on that will not have an incentive to push it forward. So you're potentially putting the power in the wrong hands for it to change. If we want people to go on to training and development, then we need the power to come from other than the line manager. If we want nurses to feel empowered to push their development forward, we need to make sure they're clear about that right from the beginning, about all the opportunities available to them." (Micro Participant 19)

4d.5 Chapter conclusion

The AfC framework was considered to contribute to an erosion of the professional identity of a nurse due to the banding system and nurses subsequently being considered as numbers. Thus, AfC devalues nursing through a reductionist approach

to nursing work. Additionally, the inconsistent use of AfC across organisations was highlighted to increase confusion and a lack of clarity over what post-registration development was required for roles. Furthermore, appraisals were considered central to progression, but their quality and quantity were inconsistent and frequently did not enable development. Challenges around navigating release and study time, alongside the focus on mandatory and statutory training, underpinned this. Fundamentally, post-registration development was viewed as an add-on luxury rather than a central part of the nursing role.

Underpinning AfC challenges was the strength of line management in enabling training and development. Line managers were considered gatekeepers. However, issues with manager training and attitudes towards education were acknowledged to be influential. As a result, post-registration development was often viewed in a silo and considered heavily influenced by individual drive, luck, and exposure. This was expressed to impact equity of access to opportunities and progression. Flexibility of careers and opportunities was considered important; however, men benefitted more from gendered norms around career development and progression.

The overall impact of a lack of post-registration development resulted in feelings of disappointment and frustration. The disconnect between the promise and reality of post-registration development opportunities was considered to be affected by poor organisational strategic thinking and left many feeling disenfranchised. Increasing instability in development opportunities was further highlighted, underpinned by a lack of data and evidence on the impact of nurses' development on patient and service delivery. Policy and politics were acknowledged to influence experiences of post-registration development, which was further impaired by a weak national voice and steer in progressing effective policy at an organisational level. Finally, the need for more long-term systems thinking at a national and organisational level was attributed to improving post-registration development and empowering the nursing profession.

Chapter 5: Discussion

5.1 Introduction

This discussion is structured into three main themes through which all the levels of analysis have been interwoven. Each theme is based on considering the findings from each data chapter and exploring a thread that ran through all of them. These three themes will be discussed in relation to their impact on nurses' post-registration development, drawing on a range of literature sources to gain a holistic perspective. These core themes will subsequently be augmented by considering how they have impacted the development of nurses' market shelter and how Light's (1991, 1995, 2010) countervailing powers framework is associated with this in accordance with the theoretical framework employed in this thesis. The augmentation of each theme with Light's framework is utilised to present an answer to the research question from each theme. The research question explores why nurses in England do not have a stronger market shelter through post-registration development and career frameworks despite post-Fordist reforms.

First, policy instability will be addressed, and how this has created an unstable environment from which nurses can develop. Second, a lack of appropriate economic data from which nurses can speak to the bases of power to enable development will be explored. Finally, a discussion on the juridification of practice placed centrally, where increasing formal legal requirements of work and processes through clinical governance have restricted and restrained nurses' post-registration development.

To conclude, this chapter presents these three core themes through the analogy of building a house to articulate how these components, while individual, are also interconnected and influence each other. The house itself is the market shelter. The instability is the environment in which the house is trying to be built. The data represents the building materials available to build the house. Finally, juridification acts as the process of governance to control and monitor the house build.

5.2 Theme one: Market shelters and instability: change is the only constant

5.2.1 Findings overview

The notion of instability exists throughout the levels of analysis presented in the findings. Every government administration contributes to changes in healthcare policy and governance. Healthcare services are relentlessly re-organised, causing repeated reallocations of responsibility and accountability for core system processes. Alongside this, reforms and changes are not thoroughly evaluated and thus understood nationally, contributing to poor decision-making and increasing instability. The policy landscape is subsequently characterised by persistent political intervention to try and address problems that the instability creates. The interconnected nature of policy and legislation demonstrates the multi-level and systemic landscape in which the NHS operates. This highlights that additional regulation and bureaucracy can create further instability rather than maintain stable governance practices, which impedes nurses' post-registration development.

Due to national policy and political instability, crisis management within national organisations is prevalent, causing a lack of organisational memory, which impedes the development of trust and partnership working. The analysis further indicated that the national picture was crowded, with multiple state and non-state actors creating manifold and often uncoordinated priorities and unclear accountability. The HSCA 2012 was highlighted in the analysis as an example of how individual political actors can evoke legislative and policy change at speed, founded on individual decisions and a lack of data. Subsequently, the power of an individual can impact an entire profession, such as nursing. The macro-level analysis highlighted that the repercussions of the instability of policy and governance can create policy implementation issues, as organisations will be at different stages of development. Thus, policy can be too abstract, simple, broad, or vague to have a meaningful impact on the areas it is trying to influence.

Within the meso-level analysis, instability caused challenges for long-term planning within local organisations. Persistent national policy changes meant that organisations had to consistently react and alter organisational direction, reflecting crisis

management akin to the macro-level analysis of working within national organisations. The short-termism of the financial year was also highlighted to coincide with policy and governance instability, which (combined) impeded partnership working between local and national organisations, increasing fragmentation of nurses' post-registration development. The accountability issue highlighted in the macro-level analysis was echoed in the meso-level analysis, with a lack of ownership around nurses' post-registration development nationally identified as affecting transparency and consistency of policy at an organisational level. Ultimately, due to the instability of policy and governance, often only business-critical components could be addressed by organisations. To try and mitigate this, some local organisations are turning inwards, trying to become self-sufficient for nurses' post-registration development, aiming to shield themselves from the instability.

Finally, the repercussions of instability nationally and at an organisational level were reflected within the micro-level analysis. Accounts of nurses' individual annual professional appraisal process demonstrated that often only statutory and mandatory training was done. The challenges that the meso analysis highlighted around frequent changes in organisational direction and strategy due to policy and governance instability were reflected in the micro analysis, with development opportunities becoming increasingly short-term. The short-termism of opportunities was foregrounded by limited organisational support, a deficit in strategic thinking, and issues related to a lack of succession planning of services. The instability of policy and governance of services were further acknowledged to impact nurses' post-registration, with a lack of a system-based perspective on how governance changes would impact staff development. Fundamentally, the impact of instability was felt to influence post-registration development as it was subsequently only enabled through luck and exposure, with the process often opaque and managers acting as gatekeepers, which could impair the quality and equality of access to opportunities.

5.2.2 Placebo policies and the responsiveness trap

As the findings in the previous chapters identified, the repercussions of the instability of policy and governance create policy implementation issues, with policy being too abstract, simple, broad, or vague to have a meaningful impact. The result is actually a 'policy vacuum' because, whilst there is a lot of policy, it does not consist of tangible mechanisms to evoke meaningful and effective action for nurses' post-registration development. A way to frame this is through a consideration of 'placebo policies', which are policies produced in part, or substantially 'for show'; thus policy making is driven by a desire for the government to demonstrate it is 'doing something' to address a problem (McConnell, 2020). Aspects that can make policy initiatives more inclined to placebo elements include complex and wicked policy problems, the emergence of media scandals, public sector organisational underperformance and reform seeking to join up and rationalise service delivery as examples, and appointments of 'tzars' to key policy areas (McConnell, 2020). NHS policy has arguably encompassed these elements, combined or separately, at different times. For example, research has highlighted that demand management in the NHS is a wicked problem, partly due to interlocking issues and constraints and no overall resolution, only partial and time-limited solutions (Pawson, Greenhalgh and Brennan, 2016). Placebo policies can result in symbolic and weak policy responses (McConnell, 2010), which the findings identified.

Aspects that contribute to placebo policies are persistent changes in policy through policy expansion and dismantling (Tosun and Schnepf, 2012). Expansion is through introducing new or intensifying existing policy, while dismantling is when policy or parts have been revoked without replacement (Knill, Schulze and Tosun, 2012). Additional views on policy change can be considered through changes in policy density and intensity (Knill and Tosun, 2020). Density encompasses the breadth and extensiveness of governmental intervention, while intensity is the level and scope of policy intervention (Knill and Tosun, 2020). Multiple direction changes in policy are prevalent in the findings, through variations in focus and the persistent increasing number of policies, while simultaneously dismantling policy aspects without replacement or a clear indicator of reallocated responsibility, such as workforce

planning. The coalition of policy change directions is not normally considered likely, as its coordination and management are complex and unlikely to be successful (Knill and Tosun, 2020). However, Paton (2022) and the findings here indicate that this is the case, at least within the NHS in England. The combination of these policy changes contributes to increasing instability, thus affecting nurses' post-registration development as the change directions coincide.

Democratic societies are caught in a 'responsiveness trap' through which governments repeatedly seek to respond to societal demands by producing more policy outputs (Adam, Steinbeck and Knill, 2018). Subsequently, Adam, Hurka and Knill *et al* (2019) contend that the more governments respond to societal demands through policy accumulation, hollow policy growth (akin to placebo policies), will arise due to stagnating or declining implementation capacities. The increasing misalignment between implementation burden and capacities creates ineffective policy responses and political symbolism, fundamentally undermining democratic societies (Adam *et al*, 2019). As a result, nurses' post-registration development, which is exposed to and encompassed within this policy environment of persistent change, is subjected to placebo policies and the increasing burden and capacity capability of policy implementation, which inhibits progression.

An underpinning mechanism that may evoke greater instability and influence the responsiveness trap is that the 'market' for policy advice is no longer just a closed process within the realm of the civil service and government advisors. There has been a significant increase in an 'open policy making' market for policy advice for health, for example, non-state actors like think tanks, charities, management consultancies, and academics, partly driven by the increasing emphasis on a knowledge economy, knowledge exchange and policy engagement (Exley, 2021). The expansion of non-state actors influencing health policy-making in the UK has been termed 'sofa government' (Paton, 2014a). This shares similarities with the US lobbying system in that special interest groups advocate and influence change. However, there has also been a greater expansion of the 'state' component in that it is not just the DHSC but also a detachment of state actors, for example, NHS Workforce Training and Education and NHS England, who are (in theory) away from but are still part of the Government. Therefore, there

are still aspects of closed cell policy advice. However, there is now a wider net to draw from for advice and evidence. Subsequently, there are more opportunities to identify problems and policy solutions on which the government can act. Conceivably, this can make the policy advice landscape more varied and dynamic, which can be harder to manage and could contribute to more significant fragmentation and instability.

5.2.3 Accountability vacuums and political managers

Coinciding with the repercussions of policy instability, the findings highlighted an intensification of national accountability issues regarding nurses' post-registration development. For example, participants at the meso-level reflected that no national oversight or accountability measures were in place for implementing *Modernising Nursing Careers* (DoH, 2006), which was a reason for its lack of success. Due to frequent policy changes, incentives and organisations are often multiple and poorly coordinated, thus contributing to a lack of national organisational memory due to multiple reforms (Paton, 2013). Participants considered that reforms had impaired communication and caused crisis management, which hindered partnership working throughout the healthcare system. The NHS has a multi-level governance system, which has innate complexity, and an output of that governance type and complex architecture is an 'accountability vacuum' (Cairney and Kippin, 2023), which, when paired with the chronic instability of policy, is made more complex. An accountability vacuum is when many bodies and organisations are theoretically responsible for something without clear accountability measures to ensure progress (Cairney and Kippin, 2023). The knock-on effect of accountability issues at a national level impedes and replicates at an organisational level. The findings here demonstrated that, although organisations may theoretically be responsible for their contribution to nurses' post-registration development, there are unclear accountability measures to ensure progress.

To address challenges around accountability and placebo policies, Paton (2006) presents that 'political managers' at the meso-level must reconcile and sometimes abandon conflicting and empty policies at this level. Political managers at the meso-

level encompass the breadth of individuals responsible for implementing and trying to make a national policy requirement a reality. These managers are a form of state actor, as they are trying to act on behalf of a government agency, in this case, NHS England and the DHSC, to enable policy implementation. As a result, many political managers operate at the meso-level, from ICS leads to Chief Executives and Nurses of a Trust to nursing ward managers. While numerous governance reforms have changed political managers' and, thus, state actors' identities and locations, their accountability around policy implementation and diffusion remains. Therefore, state actors possess a significant level of accountability in attempts to implement and diffuse policy at an organisational level, which, the findings have shown, impacts nurses' post-registration development.

The conjoining of symbolic policies and political managers at an organisational level was highlighted in the findings as a problem for nurses' post-registration development. Throughout the analysis, AfC, despite being a long-standing national policy, was shown to be unable to respond to the persistent wider policy changes. AfC was repeatedly acknowledged as inflexible, undynamic and unable to meet service and professional requirements at an organisational level for post-registration development. Subsequently, despite the AfC policy being touted as a core proponent of a development framework for nurses, the findings demonstrated that it cannot respond to the context and environment in which it sits. Therefore, AfC becomes only symbolic of change and progress. Furthermore, the findings show that the aim of introducing AfC to try and ensure that pay terms and conditions kept pace with the changes in the healthcare systems (DoH, 1999) has not been achieved. Although AfC is a national policy, the findings demonstrated organisational variation in how it was utilised. The findings highlighted that AfC could be used as a tool by managers and organisations to reduce service spend on labour, for example, through down-banding or meeting role expansion requirements within policy. Therefore, AfC can be used by managers at an organisational level to help address other policy directives or achieve organisational finance goals. However, the findings further identified that this is often at the cost of sustainable and long-term planning for nurses' post-registration development.

5.2.4 Theoretical considerations: The Multiple Streams Approach and policy window sequencing

Although changes and shifts in policy are not a new phenomenon, ascribing the chronic instability of health policy directly to problems with nurses' post-registration development is a novel attribution. Attributing a specific theory of public policy and instability to this analysis is a challenge, as although there are many theories of policy change, no one theory can explain the chronic instability highlighted in the findings completely.

Paton (2014b) and Exworthy (2014) show that health policy research is an academic hybrid, encompassing intellectual pluralism, and requires a focus on intersecting axes, such as central-local, competition-collaboration and state-profession. Predominately, the state-profession axis focuses on the medical profession and the state (Exworthy, Mannion and Powell, 2023), excluding nursing and nurses. Despite this omission, the state-profession axis within health policy research is an appropriate framing point to consider health policy instability and nurses' post-registration development. Alongside the intersecting axes, Exworthy (2014) highlights that health policy research needs to include the interplay between axes, ideas, interests, and institutions, blending empirical and theoretical perspectives.

Considering the need for the interplay of various components within a healthcare system, it is possible to utilise an existing public policy theory and augment it to help understand health policy instability. Additionally, encompassing these challenges enables a holistic consideration of potential key fault lines and forges a critical perspective on nurses' post-registration development. As Paton (2006) highlights, political economy acts as a countervailing pressure on policy alongside day-to-day initiatives and agendas, which work at either end of the extremes and are factors which, although separate, need to be viewed together and reconciled.

A way to address these challenges and explore the chronic instability of policy, which has impeded nurses' post-registration development, is through the Multiple Streams Approach (MSA) by Kingdon (1995).[74] The MSA has been used in other research to

[74] The MSA is also sometimes referred to as the multiple streams framework, multiple streams analysis or multiple streams model.

consider health policy, including policy responses to COVID-19 (Amri and Logan, 2021) and public health (Milton, 2015). The MSA is grounded in bounded rationality, which states that policy making is not a rational process, is confined to the limits of gathering and processing policy information, and cannot separate values from facts (Cairney, 2020). The MSA aims to understand the policy process through three streams: problems, policies and politics (Kingdon, 1995). Problems are deemed policy issues that require attention, policies are ideas or solutions available to address the problem, and politics entails policymakers being receptive to ideas or solutions at a particular time (Kingdon, 1995). For change to occur, these three 'streams' must come together simultaneously in a 'window of opportunity' (Kingdon, 1995). The 'window' can be opened by any of these three streams initially (Hill and Varone, 2021). The impetus for policy change can also come from 'policy entrepreneurs', who Kingdon (1984) describes as actors who use their knowledge of the policy process to further their own ends. Entrepreneurs possess connections and knowledge and 'lie in wait' in and around the government with solutions, waiting for a problem to arise on which they can attach their solution (Kippen Cairney, 2021). Kingdon (1984) states that policy entrepreneurs can be elected politicians, civil servants, organisational heads, leaders of interest groups or unofficial spokespeople from interest groups. Consequently, they can be a blend of state members, state actors and non-state actors. In relation to the findings, the creation of, and problems with, *Liberating the NHS* (DoH, 2010c) and the HSCA 2012, were widely discussed. Andrew Lansley, the then Secretary of State for Health at the time of these reforms would be considered a policy entrepreneur. These reforms were widely touted as the 'Lansley reforms', representing his, Andrew Lansley's, power in relation to change.

Kippin and Cairney (2023) utilise the MSA alongside the concept of sequencing to explore the impact of one policy window on another. There is a sequencing of multiple policy windows connected to each other; thus, a window can produce a 'solution', which can create a problem in another area, which opens another policy window (Kippi and Cairney, 2023). Additionally, Cairney and Denny (2020) highlight that a window can open to a vague solution, which can affect another part of the healthcare system and or government, creating sequencing across sectors and 'levels' of administration.

Therefore, in a multi-level and multi-centric system like the NHS in England, a solution at one level can open a window at another level. This presents a sequencing of policy windows not only at a national level but also at the organisational level (Cairney and Denny, 2020). As the findings demonstrate, the instability of policy nationally had a knock-on effect at the organisational level and, subsequently, nurses' post-registration development. The NHS is a complex and mosaic system, and with repeated changes to healthcare governance and policy, different governance mechanisms and policy initiatives will interact in unpredictable ways with unintended consequences.

In terms of chronic instability, the MSA augmented with the concept of sequencing would indicate that multiple windows are happening in sequence, with one causing another to open, and or at the same time, influencing another either at the same 'level' or subsequent levels within a system. Therefore, the opening and closing of windows is not an isolated, complete, linear pathway. Furthermore, Kippin and Cairney (2023) suggest that the sequencing of policy windows potentially limits the choice or solution options available in another window. If limited choices or solutions are available, and policy makers are also working with resource constraints such as time and finance, the 'ideal' policy response to a problem in isolation may not be possible. Thus, the need to do 'something' is made in the context of the intelligibility of options and, combined with sequencing, can tip the balance of choice from one to another. The implications of this are that sequencing can cause policy fiascos, where the problems that are forced into attention are the result of earlier, ineffective or even counter-productive policies (Hill and Varone, 2021). This can result in feedback cycles that contribute to placebo policies, a responsiveness trap and accountability vacuums, ultimately creating a cycle of chronic instability. Therefore, there is a continuous sequence of attempts to resolve health policy problems, creating new problems and evoking the instability that ultimately impedes nurses' post-registration development. Kippin and Cairney (2023) do not specify explicitly where policy entrepreneurs lie in relation to sequencing, and therefore it is more of a challenge to align that with chronic policy instability. However, at a government level, Kippen and Cairney (2023) highlight ministers' political skill and artistry in the narration of problems, which can impact policy creation decisions, triggering change. Therefore, this analysis can explain the

impact of a type of policy entrepreneur; however, a greater understanding of the role and impact of different policy entrepreneurs, including state and non-state actors, in relation to the MSA and policy window sequencing remains a knowledge gap.

5.2.5 Chronic policy change, implementation, relationships and positionality.

While the MSA and sequencing of multiple policy windows can help illuminate a theoretical framework for chronic policy change, exploring the implications of consistent change is also critical. One of the core problems associated with chronic policy change is policy implementation. Policy implementation is not imposed on a blank canvas. As the findings highlighted, there are challenges for varying policies at any one time to compete for resources and attention within a complex system like healthcare. Multiple and overlapping policies and processes make the implementation issue more relevant (Osborne, 2006). A feminist perspective considers that attention needs to consider relationships to help mitigate challenges and problems with policy implementation and, subsequently, chronic policy change impairing nurses' post-registration development. Carey, Dickinson and Olney (2017) propose a feminist stance where more focus should be placed on developing capabilities and processes for navigating challenges with policy implementation in relation to positionality, as implementation problems are not only structural but relational as well. Positionality is particularly important as cross-boundary working, for example, national to organisational, is critical in policy implementation (Carey *et al,* 2017). Additionally, the NHS is a multi-level and multi-centric governance entity with multiple state actors, where cross-boundary working is imperative.

Cross-boundary relationships and challenges can be attributed to clashes in values, priorities, working practices and identities (Head and Alford, 2015). Therefore, problems are' bounded' parameters for how policy solutions are designed and delivered to navigate cross-boundary (Bacchi, 2009). This has a relationship to the MSA framework and the 'problem' window, which this analysis considers, when ill-defined and understood, can act as a catalyst for sequencing. Subsequently, cross-boundary working means working within groups and structures with different positionalities.

Central to this is that ideas and actions are inherently developed in response to others. Thus, there are no objective or 'true' neutral ideas (Carey *et al,* 2017). Furthermore, Maher and Tetreault (1993) consider that changing contextual and relational factors contribute to defining identities and knowledge in a situation, framing positionality, which will contribute to the success (or not) of cross-boundary working. Additionally, cross-boundary working and relationships would contain a variety of policy entrepreneurs. Therefore, as they can instigate change and governed by their own agendas, their presence may impact implementation.

Subsequently, a greater acknowledgement of positionality enables a closer consideration of the knowledge that builds boundaries as being socially constructed. Changing organisational structure, often instigated by national policy reform, generates new boundaries that must be negotiated. Dickenson and Sullivan (2014) reflect that cross-boundary issues are a matter of 'finessing' structural arrangements and addressing collaborative relationships. Subsequently, more policy implementation research needs to track implementation across different administrative layers and organisational contexts, focusing on relationships and positionality (Carey *et al,* 2017).

5.2.6 Change is the only constant: instability and market shelter development.

The impact of a policy change or initiatives on professions is well established, for example, with considerations of various aspects of NPM (Paton, 2022). However, the consideration of the macro context of chronic policy instability has not been explored at the time of writing.

Market shelters are a social and economic niche for professions; thus, they are susceptible to political actions regarding policy changes, which seek to alter social and economic entities such as health and healthcare. Therefore, developing and strengthening a professions market shelter is 'competing' with the political marketplace, through which parties and politicians contend to acquire power by anticipating and responding to societal demands (Downs, 1957; Hill and Varon, 2021). These are not just state projects regarding the professions specifically (De Vries *et al,* 2009) but state projects regarding the wider context of health and healthcare. The

mechanisms through which power acquisition in these state projects can be possible are through policy initiatives and changes.

The MSA with policy window sequencing theorising would indicate that the persistent opening of policy windows to create change results in chronic instability. In terms of market shelter strengthening and development, this would present that nurses' market shelters cannot strengthen through post-registration development and career frameworks, despite post-Fordist reforms, because there is an unstable environment from which to enact development. Fundamentally, the foundations to create and sustain nurse post-registration development are being weakened by chronic instability, so building sustainable progress from that base is limited. The persistent instability of policy indicates a repeated instability of state projects, which impacts the ability of a profession, such as nursing, to strengthen and develop its market shelter. This argument extends the supply aspect of the interactionist perspective beyond that market privilege is only obtained when there is a *"coincidence with a state purpose"* (De Vries *et al*, 2009, p. 557). It is not just the coincidence with purpose but the stability of state projects that is fundamental.

Light (1991) refers to creating axes of change, for example, competition and commissioning, within healthcare, which has characterised the move away from Fordist principles of organising. This shift in organising and focus reflects the analysis that Paton (2014b) and Exworthy (2014) state is required to acknowledge the intersecting axes within health care policy, such as central-local, competition-collaboration and state-profession, which the MSA and sequencing theorising enables. CPs are political processes encompassing persistent policy changes (Light, 1991). Furthermore, Light (1995) argues that the CPs framework can view these interactions of axes as dynamic, not static because it allows a trace of changes over time. Therefore, the countervailing powers framework from Light (1991, 1995, 2010) enables the instability of policy to be linked with the instability of state projects explained through the MSA and sequencing of policy, and thus the development and strengthening of a nurses' market shelter.

5.3 Theme two: Market shelters and data: nursing by (absent) numbers

5.3.1 Findings overview

Workforce planning throughout policy and across various government administrations is a challenge. There is a disconnect in determining workforce supply and demand due to a lack of integration of service, financial and workforce planning. One of the core issues underpinning these challenges is data generation and analysis. Weaknesses in information systems, including separate and inconsistent workforce data sets, such as the ESR, are acknowledged to make policy-making and cost-efficient care delivery more challenging. Furthermore, defining and quantifying nurses' 'work done' is complex and misunderstood by policy makers. This challenge contributes to a dearth of labour economic analysis of the nursing workforce, essential to inform better policy decisions and contribute to nurses' post-registration development.

At the macro level, participants considered that the economic value of nursing was not recognised politically or in policy. The need to demonstrate 'nursing value' and the impact of nursing development was associated with economic challenges which could be exploited by AfC. For example, participants highlighted that AfC could be used to control staff costs in response to funding restraints and austerity measures. Participants felt that there was a national requirement to speak of nursing development in economic language, including the benefit to wider society and the economy, because 'data talks'. Without the economic language and evidence, participants considered that nursing has less bargaining power. Therefore, the state has greater control and influence over the direction and development of the profession. Nurses are often discussed (nationally) in terms of numbers, particularly in manifestos and policy, but without the data, especially on workforce planning and nurses' post-registration development. A lack of political understanding of nursing work and the gendered nature of nursing was highlighted. This influences and underpins views and policy outcomes, which impair nurses' post-registration development.

Meso-level participants considered that due to funding challenges, the AfC system and framework could enable cost reduction, particularly through the process of down-

banding nurses. Underpinning this and reflecting the policy analysis, participants highlighted that ineffective and inappropriate data systems, such as the ESR, contribute to a lack of effective workforce planning. This impaired strategy development for nurses' post-registration development at an organisational level. Participants further highlighted that gaining data outside the ESR on nurses' post-registration development and understanding service demand was incredibly challenging and made it difficult to relate development to service performance. Fundamentally, a lack of data and evidence meant that it was harder to understand workforce demand and, therefore, easier for the NHS to use AfC to save money at the expense of nurses, negatively impacting development opportunities. Participants stated the data and ESR challenges impaired partnership working and data sharing locally and nationally.

At the micro-level, participants reflected on the need to articulate the value of nursing. An example is the difficulty in securing improved salaries for nurses taking on new roles unless they went into management positions. Participants needed the right economic language to navigate organisational politics. Despite this, participants also highlighted that there was often a lack of organisational interest in gaining data on the impact of workforce initiatives on patient safety, service, and staff retention. Challenges with organisational workforce planning were reflected in participants' experiences, with issues regarding staff release for training and their appraisal process being heavily influenced by their organisation's financial position. Participants recognised that AfC could be used as a management tool, as it encourages viewing nurses purely in terms of their band and thus as a number, which was easier to manage financially. As a result, participants felt that AfC contributes to the erosion of the professional identity of a nurse.

5.3.2 Data and systems: The economic lens and data generation

The findings indicate that NHS organisations and nurses need economic and data language to be able to 'talk' nationally and develop organisational and national strategies in relation to nurses' post-registration development. Without this language,

the nursing profession has less bargaining power with the state to influence decisions on nurses' post-registration development.

The NHS operates within a broader social and economic context. While the primary goal of the NHS is to provide healthcare free at the point of use, economic factors play a significant role in shaping policies and operations. The economic significance is made more prominent because the NHS is a nationally-funded system dominated by the Treasury, and subsequently governed by economic thinking. While the NHS also considers medical, social, and ethical factors in its decision-making processes, a number of factors contribute to the dominance of an economic focus in the English NHS. These include, but are not exclusive to, resource allocation due to the NHS operating within limited financial availability, which then influences the drive for cost-effectiveness and efficiency and productivity of services (Appleby, Devlin and Parkin *et al*, 2009). Economic considerations will also shape policy priorities as governments may prioritise healthcare areas or initiatives based on their economic impact, for example, on public health or alignment with broader economic goals like work and employment (Office for Health Improvement and Disparities, 2022). Therefore, economic data is the currency through which nurses and nursing must be framed to operate within the economic dominance of the NHS.

Despite requiring economic data and language to develop the nursing workforce, as the document analysis and interviews highlighted, NHS organisations often do not have the systems that enable appropriate and effective data collection and sharing. The contribution of data and data-driven innovations are crucial to developing long-term funding plans for modelling the future demands for care (The Health Foundation, 2023c) and meeting policy commitments such as in the *NHS Long Term Plan*. Barriers to data-driven innovations include the lack of data and deficits in linked data with detailed clinical outcomes, induced by problems with a fragmented data landscape across sectors (The Health Foundation, 2022) and an underutilised analytical workforce (The Health Foundation, 2019). Additionally, the deficit in data and effective systems, including linking data, could undermine economic decisions and patient outcomes (Leary and Dix, 2018). This inhibits the development of the economic currency for nursing, which would help to strengthen nurses' post-registration

development. Critically, the creation of data and the language of data are interlinked with the finance of AfC, as AfC is the model and policy for nurses' remuneration, the creation of band parameters and requirements, and job profiling. However, despite the data deficit, which impairs an accurate economic lens on the nursing profession, the focus and influence of an economic lens on the nursing workforce is amplified by AfC. Participants within all the levels of interview analysis reflected that AfC was a set of terms and conditions and reduced nurses down to bands, thus viewing them as numbers and eroding their professional identity. The example of AfC in relation to the economic lens of the profession indicates how a system and policy can amplify a way of viewing and acting on a profession, consequently impacting nurses' post-registration development.

5.3.3 Safety vs service: a tension

An underlying problem with the economic focus and modelling challenges for the nursing workforce is that the healthcare system and workforce are modelled as a service industry, such as retail, not as a safety-critical industry, such as aviation (Rafferty and Leary, 2023). In a safety critical service, front-line expertise is recognised and valued, and the more experienced staff stay closer to front-line operations. Thus, they are not pushed into management as the only means of progression (Fig.5 Leary, 2023). One of the reasons for this is that demand and risk are modelled from the outset in safety-critical services and have safety management systems and intelligence informed by data (Fig.5).

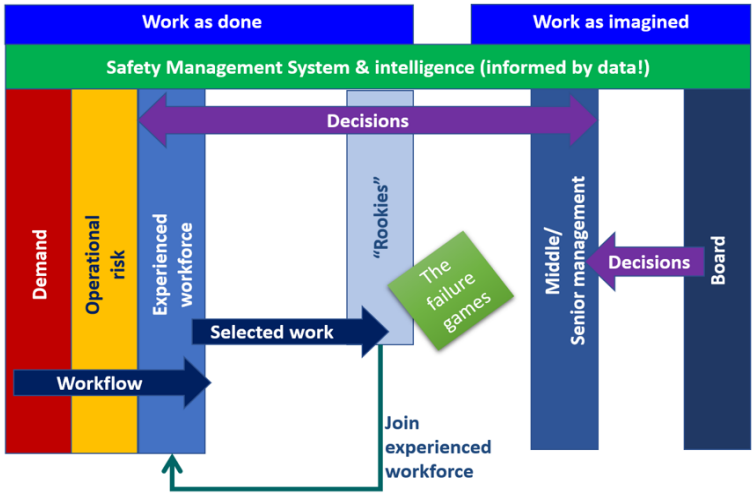

Fig.5 Safety critical systems, Leary (2023)

In healthcare, demand is not fully understood, there is a gap in understanding 'work as done' and 'work as imagined', and there is no overriding safety regulator or management system (Leary, 2023) (Fig.6).

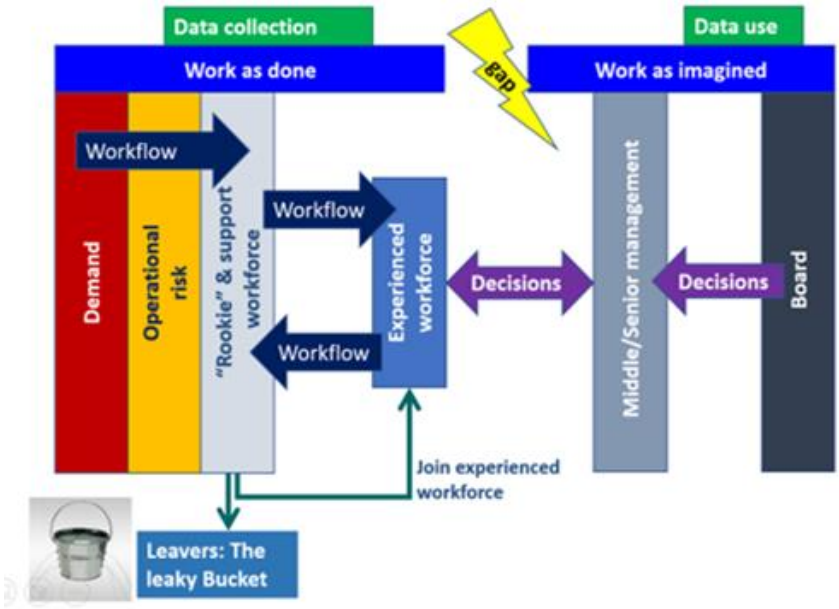

Fig.6 Healthcare system as a service system, Leary (2023)

Healthcare has high operational risk; thus, the work carries high harm potential (Leary, 2023). Yet in healthcare, the consideration of risk and outcomes of care and the workforce is not acted upon until something is proven wrong or harmful, or as is often the case with the regulation of healthcare professionals, like nurses, a patient safety

scandal (Quick, 2017). In safety-critical systems, safety legislation, for example, is precautionary. This means that an understanding and action on the workforce in relation to outcomes is a focus in the planning stage of services (Leary, 2023). Overall, this means that front-line work is more highly valued, and greater emphasis is placed on developing and strengthening the workforce in those positions. In relation to nurses' post-registration development, one of the impacts of modelling healthcare as a service industry is that development is channelled into management roles because front-line patient contact work is not as highly valued (Leary, 2023). Many participants highlighted that AfC only valued management aspects in relation to post-registration development and career opportunities, which means that AfC amplifies the service industry focus and orientation on the nursing workforce. The service industry model then emphasises a tension between the development of the nursing workforce and their deployment, as a service industry focuses on numbers over experience and appropriate risk evaluation of outcomes.

Additionally, Rafferty and Leary (2023) highlight that because the healthcare workforce is not modelled as a safety critical service, the 'burden of proof' requirement is high and falls to the workforce to 'prove' themselves. This proof from the workforce is in place of policy makers gathering the evidence and acting cautiously (Rafferty and Leary 2023). This is even though over 1000 peer-reviewed papers consider the association between nursing and safety (Leary, 2023). An underpinning issue despite this is, as Leary (2023) argues, that quality and safety are not considered in outcomes of healthcare, productivity and activity because, quoting Hollnagel (2022), *"safety in healthcare is not income generating",* which indicates the economic focus and drive placed on healthcare. There is tension in the healthcare system where efficiency, productivity, effectiveness, and quality vie for space and recognition. This tension also affects those setting policy as they must try and reconcile these components (Leary, 2023).

Subsequently, one of the core outputs of a lack of appropriate data generation on the nursing workforce is that this makes evidence-based policy decision-making more difficult and impairs nurses' post-registration development. Associated with, and linking from the first theme analysis, in this discussion on public policy instability, this

lack of data and evidence base can contribute to policy vacuums, with inappropriate and ineffective policies. In relation to the MSA approach and policy sequencing, the lack of inappropriate data would contribute to difficulty in defining the 'problem' and identifying solutions; therefore, developing appropriate policy responses is more challenging. Subsequently, the data challenges can become a catalyst for the sequencing of policy. The lack of appropriate data (and understanding of it) in relation to the nursing workforce will further underpin an insufficiency in political understanding and subsequent action or inaction. The impact of this is a scarcity of appropriate agenda setting, which underpins the bounded rationality of decisions because the decisions cannot be rational when they are based on little to no appropriate or comprehensive data to consolidate them. Fundamentally, this manifests in policy focusing on nursing by (absent) numbers.

5.3.4 Nursing work and 'value': Recognition and understanding

Underpinning the challenge of appropriate data generation, workforce planning, economic analysis, and viewing the healthcare service and nursing workforce as a service industry, is the difficulty of defining and, more crucially quantifying nurses' 'work done'. The challenge with understanding nurses work done was highlighted in the document analysis and is now expanded upon here.

It is necessary to understand what nurses do to collect data and subsequently plan work and job roles for nursing to feed into workforce planning and provide a quantitative base for economic language. Furthermore, the scrutiny of nurses' work done has increased due to changes in healthcare financing and economics. The emphasis on quality of delivery and patient-focused care, alongside staff shortages, has increased focus on exploring how nurses work (Alghamdi, 2016).

There have been attempts previously to create nursing metrics to underpin post-registration development and workforce planning. For example, in 2008, based on the direction of *Modernising Nursing Careers* (DoH, 2006) and the *Next Stage Review Final Report* (DoH, 2008c), the DoH wanted a set of metrics to define clear accountabilities for the quality of nursing from the point of care to the boardroom and develop a set

of measures to identify and quantify the quality of nursing care (DoH, 2008c, 2008d). The then National Nursing Research Unit was commissioned and supported by the DoH as part of a policy research programme to identify national evidence-based metrics to measure nurse-delivered outcomes and patient experiences (Griffiths, Jones, and Maben *et al,* 2008). However, by 2012, this was under review again (Maben, Morrow, and Ball *et al* 2012), and at the time of writing, a defined set of nursing metrics does not exist. Individual employers have produced their own nurse-sensitive indicators on measurable objectives to deliver care (Cannaby, Carter, and Warren et *al*,2023), but these are not standardised nationally. Therefore, comparison and detailed analysis are challenging. The Model Hospital database also contains indicators of performance that can be considered nursing metrics (NHS Improvement, 2019). However, access to this data for workforce analysis was not permitted. Thus, a more in-depth analysis of the components and influence on nurses' post-registration development was not possible from this source.

A challenge that affects defining nurses' work done is the underpinning Taylorist view of healthcare work as discrete and task-based, which fits into a production line with technical competence as the only qualification for work (Rafferty and Leary, 2023). The Taylorist view of work is despite the push for more 'functional flexibility' of the workforce. However, 'flexibility' has been highlighted as a policy rhetoric to persuade people to buy into reforms (Wise, Duffield and Fry *et al,* 2017). Additionally, the flexibility rhetoric is considered only a euphemism for 'change', precluded on the basis that healthcare professionals will concede to changes to their roles (Wise *et al*, 2017). Thus, complex safety critical work like nursing, which is non-linear and involves aspects of labour, such as cognitive, emotional, and organisational, or as Leary (2023) defines as 'vigilance work', is overlooked and undervalued. Leary (2023) describes nurses as the "*air traffic controllers of healthcare"*, safety-critical and essential. In relation to workload, the invisibility of work means that nurses' actual workload and its knowledge-intensive nature are underestimated (Rafferty and Leary, 2023). The invisible work of nurses as highlighted in the document analysis, contributes to the challenge of creating a set of nursing metrics. Currently, an ongoing study is aiming to make invisible work visible; the TRACT study considers the use of a digital tool for

assessing, measuring and planning care trajectory management (Cardiff University, 2024). This research aims to examine the organisational components of nursing work, making them more visible, and thus enhance care trajectory management, which has importance in healthcare quality and safety (Cardiff University, 2024).

The implications of this reductionist and Taylorist view of nursing work is that the nursing workforce will thus be subject to increasing skill dilution, or increasingly, less skilled hands for less money (Rafferty and Leary, 2023). In relation to nurses' post-registration development, this means that it is not viewed as a core part of the nursing role, which causes a lack of focus and resources allocated to it, which participants highlighted throughout the interviews.

5.3.5 Nursing work as womens' work and the economic lens

Another critical aspect in relation to the consideration of 'value' and recognition is that there is a substantial literature base which indicates that nursing work is not valued because it is deemed 'womens' work' (Brennan, 2005. Allen and Hughes, 2002. Davies, 1995. WHO, 2019. Porter, 1992. RCN, 2020). Nursing is often described as 'only natural', requiring neither knowledge nor effort, contributing to the invisibility of nursing work (Adams and Nelson, 2009). As highlighted in the literature review, the gendered nature of the profession has impacted its development, including post-registration. However, the professionalisation process is often viewed as gender-neutral (Witz, 1992). Therefore, the gendered character of nursing is not always acknowledged or addressed. Alongside gender and the quantifying nature of 'work', as highlighted previously, the findings highlighted that a lack of economic language impacted nurses' ability to negotiate with the State and at an organisational level. The document analysis highlighted that a lack of data on the nursing workforce contributes to challenges around labour economic analysis. Therefore, there is not just a political dimension to knowledge production and evaluation in nursing (Kuijper *et al,* 2024) but also an economic dimension as well, creating an epistemic political-economic influence and injustice on nursing development.

Lamberg (2024) highlights that feminist approaches to knowledge must redraw existing barriers of 'credible' knowledge to further knowledge claims to transform economic thinking and policy. Therefore, arguably, one of the challenges nursing has had to articulate its 'value' is because its claims to knowledge are not deemed credible within the bounds of mainstream economic thinking. Feminist economics highlights how gender biases are ingrained within models and methods of economics as a discipline (Lamberg, 2024). Adams and Nelson (2009) state that the Western mainstream classical economics, which is deeply rooted in ideas around appropriate gender roles and gender-differentiated access to power and resources, hides and devalues nursing.

To redraw boundaries of 'credible' knowledge presents a consideration of knowledge boundaries, specifically pragmatic knowledge boundaries. Here, knowledge is localised, embedded and invested in practice, and critically, knowledge is invested in ways of doing things and successes that demonstrate its value in practice (Carlile, 2002). Thus, emphasis and importance of knowledge will be placed on what can be shown to be 'credible' and appropriate. Subsequently, pragmatic knowledge boundaries and navigating them are core parts of cross-boundary work and are associated with the relationality and positionality of people working between them (O'Flynn, 2013). This links to the first theme, chronic policy change and implementation. Knowledge boundaries have been acknowledged as important between professions (O'Flynn, 2013) but are arguably important in defining professions, their work, and subsequent impact.

The challenge is thus not just to try and 'speak' in economic terms regarding nursing and have the appropriate economic data for post-registration development through which to navigate the existing system. But to provide more data to enable and challenge shifts in boundaries of knowledge. Indeed, a recent report by the ICN (2024) focused on 'the economic power of care' to show nurses 'full value' to governments. A feminist perspective enables a consideration that there also needs to be a challenge to mainstream economic thinking to manage and improve the pragmatic knowledge boundaries that are present, which would enhance the 'value' placed on and attributed to nurses' post-registration development.

5.3.6 Nursing by (absent) numbers: Data, economics, and market shelter development

The conceptualisation of the 'market' is fundamental to considering market shelters and nurses' professional development. In general terms, markets are economic entities constructed out of data and economic influence. Economic markets can also be viewed from a sociological perspective as social arenas where the actions of different actors are fundamental to market behaviour (Fligstein and Dauter, 2007).

The definition of a market shelter from Friedson (1970a) is that it is erected within an economic market and indicative of a relationship between the state, professions, and the public. Therefore, considering the economic market, its social construction and utility are crucial to understanding nurses' market shelter development. As discussed in the literature review, Light (1991, 1995, 2010) provides a direct avenue into a PE lens on professional development. Thus, as a result, an enhanced approach to the axes of change in the countervailing powers framework is economic, which acts on the professions alongside political markets. However, how the 'market' is defined in terms of a market shelter is arguably bound to the mainstream economic terms in its foundations. As discussed in the previous section, this impairs nursing. Subsequently, this inhibits nursing and places the profession at a disadvantage when trying to strengthen its market shelter through post-registration development.

Despite their interconnected nature, the economic focus on the development of market shelters for professions, including nurses, has been neglected by the SoP literature (Dingwall, 2016). Although some economic influence is acknowledged (Abbott, 1981. Burris, 1993. Larson, 1977, Weeden, 2002), and a market shelter is considered granted by winning the support of the economic elite (Friedson, 1970b. Johnson, 1972), analysis has not tended to move beyond acknowledgement and looked in more detail on the nature of the economic and data influence on the development of a profession's market shelter (Dingwall, 2016), particularly nursing. As the analysis has shown here, data and economic influence were repeatedly acknowledged to affect nurses' post-registration development. It is advanced here that a profession, in this case nursing, can be used to help control or alter an economic market through post-registration development. Rather than viewing the economic

market as separate and something to try and gain control over or influence, the economic market here is proposed to ***be part of*** a profession's development. Much of the SoP literature has discussed the aim of professions to try to gain a monopoly on knowledge and have greater economic returns for their work. However, at the time of writing, there has not been a consideration of how data and the economic view on a profession have impacted their post-registration development.

As this analysis has shown, AfC is used as a managerial mechanism and a tool in response to the nature of economic markets both at an organisational and national level. While finance is important, underpinning this activity is a problem with economic 'value' and how that is determined and quantified, and, therefore, how that relates to an economic market. Furthermore, enhancing nurses' economic market position is obfuscated due to the view of healthcare and nursing as a service industry, compared to safety-critical. Nurses would have a stronger market shelter if healthcare and workforce planning were conducted in a safety-critical industry because the value of front-line work would have greater prominence. This would be further enhanced by the 'right type' of data provision and language to operate within an economic context.

Fundamentally, a reason for nurses being unable to strengthen their market shelter through post-registration development and career frameworks, despite post-Fordist reforms, is because there is a lack of economic data. Furthermore, nurses' economic value is shallowly interpreted, often only through their remuneration. While important, as highlighted, healthcare is not considered income-generating in the direct sense. As a result, the focus and view on healthcare and the nursing profession are disjointed from safety. Consequently, this impacts how the nursing profession is viewed regarding economic value and development. Critically, viewing the development of market shelters as being affected by economic components is not just about aiming to achieve greater economic capital for nursing, for example, increasing remuneration. It is also about how nursing labour is viewed and valued by the state, and organisations like NHS Trusts. As this analysis has shown, a lack of data and economic language makes nursing more susceptible to 'manipulation' by third parties, which is what a market shelter tries to shield against (Friedson, 1994).

5.4 Theme three: Market shelters and juridification: actions have consequences

5.4.1 Findings overview

The introduction of clinical governance as a policy mandate provided a state direction process for organising, monitoring, measuring, and quantifying care quality in the health service. As a part of this, CPD was associated with clinical governance as an underpinning action and culture in and for organisations. Clinical governance was considered to play a role in the development of careers, and AfC was brought in as the mechanism through which this could be operationalised. As part of the regulatory scrutiny process of NHS organisations, underpinned by statutory legislation, organisations are monitored and assessed against key outcomes, including staff skills, knowledge, development, and appraisals. Associated with the key outcomes is the statutory and mandatory training policy that NHS organisations must follow (and which CQC inspections will consider). NHS organisations face regulatory action if they breach parts of the regulations that consider workforce development, including fines, warning notices, or direct prosecution. However, there are challenges with legislative scrutiny and the subsequent or preceding policy drivers that created the environment for clinical governance, which contribute to fragmentation in instability challenges for nurses' post-registration development.

Participants at the macro-level reflected that AfC did not enable nurses' career development and was fundamentally restrictive and inflexible. The mechanisms within AfC inhibited the creation of hybrid roles within nursing and did not enable the flexibility of work required in policy to be implemented practically. Participants considered that underpinning this were issues around benchmarking of CPD provision between NHS Trusts. Often, the only data available to NHS organisations was on mandatory and statutory training, which participants thought did not consider post-registration training and development but only the safety-critical aspects of service provision. However, because legislative and regulatory mechanisms underpinned them, the statutory and mandatory training had precedence over 'other' types of training. Participants further thought that internal market principles, such as competition, monitoring, and the legislative base for implementing them, including the HSCA 2012, had a negative impact on establishing and developing nurses' post-

registration development. For example, participants reflected that competition impaired partnership working, entrenching silo working between stakeholders, which fragmented nurses' post-registration development.

At the meso-level, participants considered that post-registration development was often viewed as the same thing as statutory and mandatory training. Thus, post-registration development ran the risk of frequently being overlooked because they could be encompassed together (echoing the macro participants). Additionally, participants considered that the education that came through the clinical governance cycle, often out of training needs analysis through staff appraisals, ended up with a baseline patient safety focus such as patient handover. Participants reflected that this resulted in increasing monitoring of mandatory and statutory training. Underpinning this issue are organisational governance mechanisms, such as nursing establishment and uplift,[75] which have a set allowance, which means releasing staff to do training beyond the increasing statutory and mandatory training is challenging. These broader organisational governance factors, alongside the clinical governance requirement, were some of the reasons that impaired AfC's ability to work as a development framework. Fundamentally, participants expressed that national mandates within the clinical governance context were restrictive in enabling nurses' post-registration development.

Finally, at the micro-level, participants felt that true post-registration development was considered a luxury and an addition to their role rather than an integral part. The appraisal process was variable and reduced to a tick-box exercise because it was a process necessitated by their organisation, often impaired by a lack of funding and time release. Additionally, participants felt that statutory and mandatory training used much of their study leave. Their experiences and reflections supported the meso-level findings, highlighting that post-registration development and statutory and mandatory training were conflated. Middle-level managers were considered paramount to the appraisal and post-registration development process and the opportunity for nurses.

[75] As expanded upon in the findings, the nursing establishment is staff planning for a given work context, such as a ward, and uplift is where an establishment must include an allowance in the budget for staff leave, both planned and unplanned. This includes annual leave, sickness, and training and development along with other types of leave.

However, they often did not have the training to support the process or could not facilitate action due to staffing pressures. Participants highlighted that AfC contributed to a lack of focus on proper post-registration development, partly due to the appraisal process, which was underpinned by a clinical governance system seeking to monitor and assess rather than develop.

5.4.2 Clinical governance and juridification

The introduction of clinical governance marked a development in increasing the formal legislative basis that underpins working practices. As a result, nurses experience greater scrutiny, oversight, and monitoring of their work, which is bound and orchestrated in policy and legislation. The increase in formal law can be viewed as a process and product of 'juridification'. Juridification is the growth in scope and scale of legal regulation from the modern state (Veitch, Christodoulidis and Goldoni, 2012), including employment and work relations (Browne, 1994. Dickens and Hall, 2006. Blichner and Molander, 2008). Juridification has numerous conceptualisations, both normative and descriptive (Blichner and Molander, 2008), but broadly, there are horizontal and vertical dimensions (Veitch *et al,* 2012). Horizontal dimensions include the spread of law and regulatory reach across a diverse range of social activities, including work (Veitch, *et al* 2012). The vertical dimension considers how legal norms tighten on new or already regulated areas through increased legislation or judicial activity (Veitch, *et al* 2012). Thus, legal standards become more detailed in the specific and factual circumstances that are legally regulated.

As a concept and process, juridification is broadly recognised within healthcare regarding the system's organisation (Davies, 2013) and working practices, such as end-of-life care (MacCormick, Emmett and Paes *et al,* 2018). Analysis has typically looked at the introduction of the internal market into the NHS, the subsequent aspects of competition, mergers, procurement, and EU laws that have, at various points and levels of intensity, affected service design, delivery, and function (Benbow, 2019. Davies, 2013. Osipovic, Allen, and Sanderson *et al,* 2020. Veitch, 2012). Juridification is also acknowledged within the scope of healthcare inquiries (Walshe and Higgins, 2002.

Goodwin, 2018) and within the employment relationship (Cowman and Keating, 2013). To relate directly to the findings, juridification is the process through which an activity, in this case, clinical practice and associated strands, such as the formal monitoring of appraisals and mandatory and statutory training, becomes subject to legal regulation and more in-depth regulation. The inception and formalising of clinical governance, how it is legislated, and how it is operationalised on 'the ground' at a meso and micro-level, for example, through the framework of AfC and its impact on nurses' post-registration development, can be considered a mode of juridification of work and employment relations. Thus, juridification is how the state seeks to control a professional workforce. At the time of writing, clinical governance as juridification has not been linked to nurses' post-registration development.

5.4.3 Juridification as politics

As juridification can act as a way through which the state can control a profession, juridification is not just considered a legal consideration but is also a political phenomenon, and there can be a 'politicisation of law' (Croce, 2021. Magnussen and Banasiak, 2013 and Veitch et al, 2012). Here, the law is a tool or strategy that the State can utilise to control or manage social relations, including through labour law and industrial relations (IRs) (Veitch *et al,* 2012). Therefore, legislation is as much a political decision as it is a legal one. Croce (2021) argues that juridification can be a novel kind of politics where politics is enacted through law. Davies and Mannion (1999) contend that a focus on the quality of care and the subsequent introduction of clinical governance had as much to do with financial goals as it was a political need of the incoming Government to identify an issue through which to articulate public concern on the NHS and enact healthcare reform. There is a structural coupling between political, legal, and economic systems (Teubner, 1987), and a reciprocal interference exists between these interacting systems (Veitch *et al,* 2012), which supports the consideration of the legal component interacting with the PE of the healthcare system.

As juridification can be considered a politicisation of law, the relationship with legislation alone cannot just be a consideration. As highlighted in the policy document

analysis, there is an interlocking nature of policy and legislation within clinical governance. The introduction and operationalisation of clinical governance was a policy creation but also a political decision of New Labour, in *The new NHS: modern dependable* (DoH, 1997), which was formally supported through the introduction of legislation in The Health Act 1999 and is currently managed through the Health and Care Act 2008 (Regulated Activities) Regulations 2014. AfC was part of this process as a mechanism for training and development components within the clinical governance framework (DoH, 1998b). The politicisation of the law can also, as argued by Magnussen and Banasiak (2013) result in politicians abdicating regard to how objectives are understood and implemented in practice. The overarching governance mechanisms of the internal market in the NHS, including clinical governance operationalisation, are devolved down to individual NHS organisations. However, there is no standardised way of 'doing' clinical governance, and from the findings as an example, AfC is enacted and operationalised in different ways in relation to nurses' post-registration development across different NHS organisations. Furthermore, research has indicated that the understanding of clinical governance at different levels within an NHS organisation is fragmented and can create more confusion, conflict, and disagreement on patient care, which could become a barrier to achieving quality improvement in healthcare (Som, 2009).

The rise of juridification is an example of the shift from a command to a regulatory state, in which the motivation is reflexivity and flexibility, and organisation systems are designed to enable feedback and responsiveness (Moran, 2000). This is reflective of the literature review, which explored the transitions from Fordism, post-Fordism, and neo-Fordism. Nurses have been used to pursue these aims, including through increased labour flexibility, presented to nurses as empowerment (Cooke, 2006). Moran (2000) reflects that the dismantling of the command state has given rise to greater state surveillance and direction, inducing an 'audit explosion'; thus, the regulatory state, with the rise of governance, is an audit state. A characteristic of this audit state includes detailed and explicit performance standards and indicators and a surveillance system to ensure that if standards are not met, there are sanctions (Moran, 2000), which are all components of clinical governance. Pollitt and Bouckaert

(2000) consider that one of the contradictory trends of NPM is that it aims to reduce bureaucracy but increase audit, measurement, and juridification. Considering its presence in employment relations, juridification, therefore, is associated with IRs.

5.4.4 A further frontier in industrial relations: a quiet conflict

IRs are the rules and regulations governing employment and work relations (Abbott, 2007). Managing IRs is a core feature of human resource management (HRM) in healthcare (Cowman and Keating, 2013), and juridification is recognised as part of HRM considerations of the employment relationship (Heery and Noon, 2008). IRs has roots in PE and institutional economics; however, as Spencer (2009) argues, the absorption of IR into HRM has meant that PE has not gained traction in the labour process debate. Therefore, the PE of work has not been granted much attention. The PE of work is, among other aspects, a consideration of how work can be a means of self-development and self-actualisation (Spencer, 2009), which is relevant to consider nurses' post-registration development. Therefore, processes and practices that disrupt the self-development and actualisation of nurses, for example, are grounded in how their post-registration development is enabled and enhanced.

Due to clinical governance acting as a framework for monitoring and governing the professions, including nurses, this acts as a component of IRs. This could be, for example, through the formal laws that monitor appraisal completion or statutory and mandatory training. A core consideration within the IR literature is the explicit notion of conflict in the employment relationship, for example, strike actions and unionisation, and power asymmetry between employer and employee (Lewicki, Weiss and Lewin, 1992). Cowman and Keating (2013) argue that changes have affected the IR landscape and mechanisms of the IR system in healthcare, including the juridification of the employment relationship, which alters how conflict arises. As a result, the nature of conflict has altered and only considering explicit measures of conflict, for example, strike action prevalence, fails to capture the range of IR conflict manifestations, which overlooks and underestimates other dynamic components of the employment relationship (Hebdon and Stern, 1998). Other conceptualisations of

conflict include exit, leaving the workforce, employee voice, and resistance, the refusal to accept or comply with something (Cowan and Keating, 2013).

The findings here have highlighted that a 'quiet conflict' has arisen due to the presence and operationalisation of clinical governance, which inhibits nurses' post-registration development. Throughout the interviews, participants reflected that there were persistent tensions due to or related to clinical governance that disrupted and inhibited post-registration development at both the organisational and individual levels. This could include, for example, that statutory and mandatory training would overshadow proper post-registration development, AfC is restrictive and inflexible in creating hybrid roles, the clinical governance framework imposes regulatory action on organisations which forces their hand about where to focus training and education, the appraisal process within AfC underpinned by a clinical governance system seeks to monitor and assess rather than develop, and critically, nurses feeling that post-registration development is seen as a luxury not a core part of their role. Therefore, the conflict described here is arguably more subtle, compared with the explicit conflict of strike action and exiting the workforce, but still manifests as conflict in the employment relationship due to the clinical governance framework.

Like juridification, IR and clinical governance have not been explored explicitly in relation to nurses' post-registration development at the time of writing. The impact of clinical governance on HRM has been considered (Som, 2011), as well as the influence of clinical governance on health sector employment relations in Australia (Iedema, Braithwaite and Jorm *et al,* 2005). Therefore, the analysis here highlighting the 'quiet conflict' gives a further frontier through which to consider clinical governance, IRs conflict and its relationship to nurses' post-registration development.

5.4.5 Clinical governance, control, and constraint.

Within the quiet conflict arising from juridification, clinical governance and industrial relations, there is an underlying theme of control and constraint of professions, including nursing. In the IR literature, the control of workers in the employment relationship can be referred to as structured antagonism (Edwards and Hodder, 2022).

Structured antagonism has not had direct attention in relation to clinical governance. However, clinical governance has had some attention in the literature with regard to the control and constraint of professions, including nursing. Walshe (2000) highlights that clinical governance presents a shift in power from individual clinicians to managers. In presenting the theories and approaches below, this is not advocating for a particular theoretical stance. Instead, this highlights that the consideration of control and constraint of professions has been related to clinical governance.

Davies and Mannion (1999) consider the principal-agent theory, where principals are the service managers (non-clinical or clinical), and the agents are health care professionals, to explore the implications of clinical governance. Here, tension is highlighted between checking and trusting professions, where hierarchical control, allied to incentives and measuring and monitoring, are intended to impact agent (professions) performance (Davies and Mannion, 1999). Furthermore, Davies and Mannion (1999) consider that data is a core component of checking and controlling, which is an essential tool for reducing asymmetries between principles and agents. Yet, a fundamental challenge exists with interpreting data on professional performance, and causal attribution is often "*weak at best and nonsensical at worst"* (Davies and Mannion, 1999, p.9). In relation to the second theme and a deficit of appropriate data on the nursing workforce and development, the concern of a lack of data influencing checking and control mechanisms in clinical governance reflected on by Davies and Mannion (1999) would further support data as a key component within nurses' post-registration development. Additionally, as Moran (2000) reflects on the explosion of the audit state, a data deficit thus makes the audit state ill-informed, which impairs decision-making at a national level.

Additionally, Stanilard (2009) explores the application of new institutionalism theory and clinical governance with nursing. The analysis highlighted that 'coercive ceremonial' management of clinical governance was apparent, driven towards external organisational legitimacy with the State, over the quality of effectiveness of care (Stanilard, 2009). Nurses interviewed by Stanilard (2009) concluded that clinical governance had not raised the quality of bedside care and that they (nurses) had a higher burden in their workload with documentation and risk assessments and, as a

result, were more time-constrained in their practice yet more accountable (Stanilard, 2009). In the findings, participants reflected that the statutory and mandatory training within the clinical governance framework consumed time available for training and restricted proper post-registration development. Stanilard (2009) and the findings here correlate to the Audit Commission's (2002) findings that front-line staff were overwhelmed by bureaucracy, paperwork and targets, and the content of their work was driven by what could be measured, not by what mattered. Despite the increasing accountability placed on nursing, corporate responsibility for clinical governance was highlighted by Stanilard (2009) as weak, and there was a lack of transparency about who was responsible for implementing and managing clinical governance (Stanilard, 2009. 2010).

While Stanilard (2009) and Davies and Mannion (1999) focus analysis more at an organisational level, Flynn (2010) centres clinical governance in a debate on governmentality and the wider expansion of NPM. Flynn (2010) contends that clinical governance represents a critical shift in the regulatory relationship between the state and the professions, which arguably positions juridification within this relationship. Here, clinical governance is presented as another method of strengthening state control over professionals in a decentralised system due to internal market reforms (Flyn, 2010). Dingwall (2009) reflects that clinical governance is arguably a state-coercive initiative to undermine professional authority in the name of quality and safety without improvement in the quality of care. Additionally, in relation to the account of the explosion of the audit state (Moran, 2000), Flyn (2010) reflects that the culture of audit that has arisen means that professions become co-opted into and are expected or required to subscribe to the implementation of clinical governance, thus 'embrace' accountability. Flynn (2010) considers the co-optation of professionals to be a semblance of delegated autonomy rather than enhanced professional autonomy. In relation to the second theme and the consideration of healthcare as a safety vs service system, some of the challenges in enabling clinical governance to have the change intended could be because healthcare is viewed as a service industry, not safety. Thus, the drivers of quality, safety and high-quality patient care from the clinical governance

legislation and policy are incompatible with how the healthcare system is viewed (as service) and, subsequently, how work and the workforce are constructed within that.

Although clinical governance is represented here as a means to control professions, including nursing, it should be highlighted that this framing is not against improving standards of care or enhancing professional accountability to patients and service users. Instead, it aims to understand clinical governance's practical operationalisation and implications and its relationship to nurses' post-registration development. While none of the approaches and theories detailed above consider the relationship of clinical governance directly to juridification and professional development, the implications of control and constraint are relevant for exploring nurses' market shelter development and strengthening.

5.4.6 Classifications and power

The issues of control and constraint on the nursing profession can be considered through the notion of classifications and power. Classifications can be material or symbolic (Bowker and Star, 1999). Part of clinical governance is AfC, a classification system through which bands with specific demarcation points for movement between them and the job profiles and requirements associated with its operationalisation. Clinical governance overall is also a type of classification system. It measures, applies value, and determines 'good' and 'bad' by classifying clinical practice and targets, seen through statutory and mandatory training, which nurses must undertake. In this analysis, it was persistently highlighted that these classifications, both AfC and clinical governance overall, constrict the nursing profession, hindering their post-registration development.

Within a consideration of challenges around feminist knowledge claims, Ahmend (2017) highlights that feminist efforts through knowledge to transform institutions come up against institutionalised power structures and structural obstacles or 'brick walls' that hinder them from being effective. These brick walls can take the form of boundary objects, which classification systems, like clinical governance and AfC, are and can manifest as institutional power structures. Broadly, boundary objects are

interfaces for knowledge production and can include material objects, organisational forms, conceptual spaces or procedures (Star and Griesemer, 1989), and are synonymous with interpretative flexibility (Star, 2010). Feminist institutionalism can help to explore institutional power structures and political 'rules of the game' at an organisational level, which can construct and maintain gender power dynamics (Thomson, 2018). As previously indicated, new institutionalism has been used to explore clinical governance and control of the nursing profession (Stanilard, 2009). Therefore, there is precedent for this type of lens to be focused on the impact and influence of clinical governance and AfC on the nursing post-registration development.

Critically, boundary objects can be a means through which cross-boundary work can be influenced, and knowledge boundaries can be impacted. Boundary objects can be a means through which classifications are understood and utilised, as setting boundaries of categories can ascribe value to some points of view and silence others (Bowker and Star, 1999). Subsequently, Lamberg (2024) considers that power structures and boundary objects shape the forms that feminist knowledge claims can take and how far they can travel. Thus, this can mean more significant challenges in managing knowledge boundaries and cross-boundary working, which links and complements the previous two themes in this discussion. An underpinning reason for why AfC was introduced was due to the success of an equal pay claim, 'equal pay for equal work' (DoH, 1999b), a feminist claim to knowledge. Ironically, the introduction of AfC has constricted the post-registration development of nursing. A feminist perspective encourages consideration of how feminist knowledge claims can be facilitated by boundary objects and how these can act, as seen in this analysis, constricting and controlling the profession. Subsequently, a broader scope of feminist institutionalism, explored through boundary objects may be poignant to consider the post-registration development of nursing in future research.

5.4.7 Actions have consequences: juridification, proletarianization and market shelter development.

The rise of juridification through clinical governance, considered through the lens of IR and conflict, alongside issues of constraint and control, classifications and power, can be expressed as a form of proletarianization. First proposed by Oppenheimer (1972), proletarianization is where administrative routines, measures and targets control professions, and professional work becomes subordinated to bureaucratic structures. In reference to this analysis, post-registration development for nursing is subordinate to the bureaucratic structure of clinical governance. For instance, participants reflected that post-registration development was a luxury, that it was secondary to statutory and mandatory training and that clinical governance and AfC constrained their ability to progress. There is literature on nursing and proletarianization (Briskin, 2012. Coburn, 1988, 1994. Flynn, 1998. Larson, 1980; Wanger, 1980), including in relation to IR (Briskin, 2012), which supports the association made here, and previous analysis of managerial control over nursing work (Cooke, 2006). Light's (1991, 1995, 2010) CPs framework also considers that tighter regulation of clinical performance by agencies and institutions external to professions has increased, acting as a CP on professional autonomy. Thus, arguably, the process, operationalisation, and impact of juridification via clinical governance act as CPs.

The concept of proletarianization by Oppenheimer (1972) was proposed around the same time as the concept of deprofessionalisation by Haug (1973). Deprofessionalisation is focused on professional autonomy being challenged due to rationalisation, the codification of medical knowledge and expertise into rules and procedures (Haug, 1973). While there are aspects of this analysis that could fit with de-professionalisation, including rationalisation and codification, proletarianization aligns better with the concept of the juridification and clinical governance, the relationship of that to IR, and the conflict, control and constraint of the nursing profession through bureaucratic structures. There have been critiques of proletarianization. However, they have centred on medicine, not nursing (Chamberlain, 2012. Elston, 1991. Friedson, 1994). Nursing does not have the same strength of professional autonomy as medicine, which means that CPs and

proletarianization will manifest in different ways, thus affecting them differently and at different points. There have been developments in the SoP literature beyond proletarianization and de-professionalisation, including restratification (Friedson, 1994. Waring, 2014) and protective and connective professionalism (Noordegraaf, 2020). However, they use medicine and the more dominant professions, including law, as their base for critique to advance their arguments rather than nursing.

Additionally, Coburn (1994) highlights that there is increasing control of nursing by employers despite the increased autonomy of nursing in relation to medicine, which signifies different areas of control – control over a profession and control over the labour process. The analysis here would support increasing employer and State control over nursing by introducing clinical governance and AfC. Thus, pressures may appear from employers and or the State at different stages in the development of professions and affect them differently (Coburn, 1994). Light (1995) reflects that there are ebbs and flows of professional autonomy, which are influenced by external regulatory mechanisms, including the regulation of clinical performance, and thus supports this stance.

Overall, a reason for nursing' being unable to strengthen its market shelter through post-registration development and career frameworks, despite post-Fordist reforms, is because there is increasing control and constraint of the nursing profession through clinical governance due to juridification. The control and constraint of clinical governance and AfC are thus acting as a form of proletarianization, impacting the nursing profession's ability to strengthen its market shelter through post-registration development.

5.5 Summary: House building and market shelter development

In this discussion, three core themes have been positioned as impacting the ability of nurses to strengthen their market shelter despite post-Fordist reforms: instability of policy, lack of appropriate economic data and the juridification of practice. In relation to Light's (1991, 1995, 2010) CPs framework, these three components act as CPs on the nursing profession, inhibiting the growth of post-registration development.

Furthermore, they interact with each other, indicating that CPs do not act in isolation or operate linearly. For example, the lack of appropriate economic data arguably causes more challenges and inappropriate 'problem' identification within the MSA, which subsequently impacts policy sequencing. Fundamentally, these countervailing powers are restricting the ability of nurses to strengthen their market shelter.

As an analogy, the development and strengthening of market shelter can be related to building a house, where the house is the market shelter (Fig.7). The house building analogy is a representation of the CPs from this analysis that have resulted in the current challenges nurses have faced in developing their market shelter through post-registration development. Additionally, as these CPs have impaired nurses' post-registration development, challenging and resolving them will, I argue, improve and strengthen nurses' market shelter in the English NHS. Thus, this analogy is both what has happened and, consequently, what can help. In Fig.7, the CPs are shown within the 'house' or market shelter, to indicate that they are core components of its development. Utilising an open-system methodological approach to PE, aligned with the CP framework has enabled for both market actors and broader system factors to be considered together. Additionally, this had enabled the utilisation of a multidisciplinary literature to explore the findings.

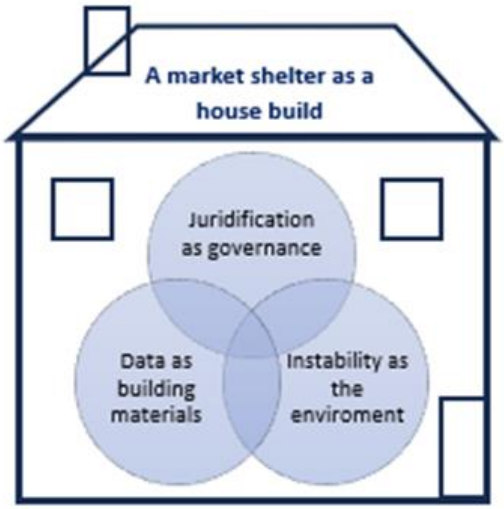

Fig.7 A market shelter as a house build

To have stable foundations on which to build a house, the environment needs stability (stability in policy). Persistent disruption to the environment, for example, through earthquakes, means that foundations are harder to put down, are weaker and then subsequently harder to build on. To build the house, appropriate materials and resources (economic data) need to be used. Without, for example, the right bricks, wiring or cement, the effectiveness and appropriateness of the build may be compromised. Finally, governance systems and procedures must be enabled to support and authorise the build. If the governance systems and procedures are restrictive and constraining (juridification of practice), then the build can be slow or not happen. At any one point, one, two or all three of these components could be at work and interacting with each other, acting as CPs, which would impair the ability to build the house. For example, there could be strong materials available to help withstand turbulent environments; however, if these are not available (lack of appropriate economic data), or their availability is restricted by governance systems (juridification), then building a house to withstand turbulent environments (instability in policy) will be a greater challenge.

Each profession will have a different style of 'house' (market shelter) depending on how these three areas interact and develop. These are not the only areas that could impact the development of a market shelter; however, this thesis has highlighted that the three areas of policy instability, a lack of appropriate economic data, and the juridification of practice impede nurses' post-registration development and, therefore, their market shelter. Thus, addressing and improving these three areas, as stated earlier, will enable a stronger market shelter for nurses to be established in the future. For example, improving the data collection systems and the types of analysis of nurses' work done will improve the decision-making and development of post-registration pathways. Henceforth, the data and pathways will be able to correspond and 'talk to' the wider systems of power that influence decision making.

My contribution is as follows. I used Light's notion of CPs within a wider PE framework, using PE as a methodological approach, rather than an explanatory theory. In the complex open system within which nurses' employment occurs, CPs gives a detailed explanation of why nurses' post-registration development works in the way it does and

how it has changed. This contribution subsequently aids in understanding what impacts the strengthening of nurses' market shelter. This approach could form the basis of future inquiry to enable a comprehensive and in-depth understanding of the influence of PE on professional development with a hybrid focus on systems and a market model of actors.

5.6 Chapter Conclusion

In this discussion, three themes have been explored, drawing together findings from each data chapter and identifying threads that ran through them. These three themes were utilised to consider three 'answers' to the research question exploring why nurses in England do not have a stronger market shelter through post-registration development and career frameworks despite post-Fordist reforms.

First, policy instability was explored, considering placebo policies and the responsiveness trap, accountability vacuums and political managers, the MSA and policy window sequencing, and chronic policy change, implementation, relationships and positionality. Finally, the persistent instability of policy was demonstrated to indicate a repeated instability of state projects, which impacts the ability of the nursing profession to strengthen and develop its market shelter. Overall, in this theme, a reason for nurses' market shelter being unable to strengthen through post-registration development and career frameworks, despite post-Fordist reforms, was related to the unstable environment from which to enact development.

Second, the lack of appropriate economic data was considered, exploring data, the economic lens and data generation, the tension between healthcare as a safety vs service industry, the value of nursing work and its recognition and understanding, and nursing work as women's work and the economic lens. Finally, rather than the economic market being separate and something to try and gain control over or influence on, the economic market here was proposed to be part of a nurse's professional development. Overall, in this theme, a reason for nurses' market shelter being unable to strengthen through post-registration development and career

frameworks despite post-Fordist reforms was related to a lack of economic data and, critically, a shallow interpretation of nurses' economic value.

Finally, the juridification of practice was explored, considering clinical governance and juridification, juridification as politics, a quiet conflict further frontier in industrial relations, clinical governance, control and constraints, and classifications and power. Finally, the concept of proletarianization was explored in relation to nurses' development and how professional work becomes subordinated to bureaucratic structures. Overall, in this theme, a reason nurses' market shelters were unable to strengthen through post-registration development and career frameworks, despite post-Fordist reforms, was related to the issues that the nursing profession was controlled and constrained through clinical governance due to juridification.

As indicated throughout the analysis in this discussion, the three core themes of chronic policy change, a lack of appropriate economic data, and juridification of practice all operate across multiple levels and have multiple interactions. Fundamentally, there are non-linear dynamics between and within all of them. These relationships and interactions in relation to nurses' market shelter development were related to the analogy of building a house. A market shelter was related to a house and how the three core themes here are related to the environment in which a house is built (policy instability), building resources (lack of economic data), and governance of the build process (juridification of practice).

New relationships are developing between the state and the professions, forged by the changing PE landscape. While the three core themes discussed here are not the only components important for nurses' post-registration development, this discussion has centred and emphasised the aspects that present further information to fill knowledge gaps.

Chapter 6: Implications and future research

6.1 Introduction

In this chapter, the implications of this thesis are presented. First, nurses' post-registration development is considered a 'wicked problem'. This includes considerations of possible solutions and mechanisms through which nurses' post-registration development could navigate to become stronger. Consequently, avenues for future research will follow. Finally, a broader consideration of the policy implications of this research will be stated.

6.2 Nurses' post-registration development as a wicked problem

It is argued that the implications of the findings and subsequent discussion present nurses' post-registration development as a 'wicked problem'. While the term wicked problem has a range of meanings (Lonngren and van Poeck, 2021), broadly, they are complex, compromised of multiple overlapping, interconnected subsets of problems that cut across multiple domains and levels of government and, critically, are relentless (Weber and Khadamian, 2008). Healthcare governance, including the NHS has been related and referred to as a wicked problem (Ferlie, Fitzgerald, and Mcgivern *et al,* 2011), as well as components within it, including mental health (Hannigan and Coffey, 2011). While nurses' post-registration development has not had explicit links in the literature to wicked problems, this thesis presents that it is. Additionally, it has subsets of wicked problems: chronic policy change, a lack of appropriate data, and juridification of practice.

Within the discussion, all three themes highlighted that they are complex, have a variety of subsets and overlapping problems, transcend across domains and levels of government and are relentless. For example, within theme one in the discussion on chronic policy change, the changes provoke the remaking of national bodies and regional and local organisational structures, persistently shifting boundaries due to them being redrawn. Subsequently, this alters and obfuscates accountability for nurses' post-registration development, impairing transparency and fuelling fragmentation. The themes in the discussion provide an account of long-term

problems that have grown and developed over many years. While all the themes can stand independently as individual challenges, they are interconnected and must be viewed holistically. This holistic view is crucial for understanding the full extent of the problem and for devising comprehensive solutions. This interconnectedness substantiates the overarching view of nurses' post-registration development as a wicked problem.

Analysis has considered that wicked problem framing needs strengthening through situated relations, routines and rituals (Noordegraaf, Douglas and Geuijen *et al,* 2019). Noordegraaf *et al.* (2019) argue that it is not appropriate to only analyse wicked problems in grand ways and that exploring the social mechanisms and rules can help to frame and focus the complexity of wicked problems better. With this thesis utilising Spencer's (1896) system of professions and considering the channels of interchange alongside Light's (1991, 1995, 2010) CPs framework, the foundation was laid for considering social mechanisms. In utilising Spencer (1896) and Light (1991, 1995, 2010), this thesis placed a greater emphasis on considering interactions between system elements and across levels of analysis. The CPs are acknowledged to be working in the spaces between the state and the profession, helping to consider what Noordegraaf *et al* (2019) consider as 'situated wickedness'. Rather than conceiving nurses' post-registration development as a wicked problem on its own, this thesis highlights the wicked situations, not just the overall problem. Situations can thus have a greater front-line focus for intervention and change.

Criticisms of wicked problem framing and subsequent solutions include the need for more 'street-level' observations of governance practices, people, and places (Noordegraaf *et al.* 2019). This thesis addresses this criticism by illuminating and exploring the experiences of people directly involved in and impacted by the wicked problem of nurses' post-registration development. This thesis highlights the people in organisations and network practices across the macro, meso and micro levels often deemed missing from conceptualising and framing wicked problems (Noordegraaf et al, 2019). Furthermore, Noordegraaf *et al.* (2019) criticise a lack of attention paid to people and their practices in experiencing wicked problems. This thesis has provided insight into this, including highlighting one way Chief Nurses deal with the complexity

and instability of policy and funding, which is to become self-sufficient at an organisational level for development. Other experiences from nurses highlighted their disappointment with their development, not only at an organisational level but also nationally as a profession. Subsequently, this thesis presents the impact of wicked problems from professional perspectives and considers organisational practices to try and mitigate challenges.

Caution is expressed by Grint (2010) in trying to 'solve' wicked problems through a singular institutional framework. In attempting to act decisively and precisely, Grint (2010) argues that this leads to trying to solve a wicked problem as a tame problem. A tame problem is resolvable through unilinear acts and has limited uncertainty (Grint, 2010). In viewing the challenges with nurses' post-registration development as a wicked problem, Grint (2022, p.1523) highlights that a way to address and try and move forward is to look to systems thinking and theory as a means to *"rescue us from wicked problems."*

Within all three themes in the discussion, issues with a lack of, or inappropriate, systems thinking were prevalent throughout, transcending all levels of analysis. For example, within theme one on chronic policy change, a lack of a system-based perspective was apparent on how persistent governance changes impact nurses' development. The lack of appropriate economic data, an absence of adequate data systems and data sharing, and an inappropriate view of healthcare as a service industry were stated in theme two. Finally, within theme three, considering the juridification of practice, this was underpinned by a clinical governance system prioritising monitoring and assessing rather than development. Critically, an underlying challenge is that all these system aspects influence and impact each other. Addressing aspects of these system-type failings could be a way to improve nurses' post-registration development. Furthermore, these individual types of system failures can be considered wicked situations, thus addressing the need from Noordegraff *et al,* (2019) to focus more on the mechanisms that formulate a wicked problem.

Grint (2022) additionally considers leadership in addressing wicked problems to be about mobilising a community into addressing its problems. In this case, the implications of this thesis would be that while there are deficits in system practices

and barriers to progress, nurses need to mobilise and have a stronger professional voice in relation to their post-registration development, both nationally and 'on the ground'. This means that action needs to come from within the profession and not just external agencies. This is not an argument for putting the problem back onto nurses themselves and getting them to solve it. Instead, it is presented that they are part of the solution through enhanced community leadership and action. In relation to theme three in the discussion, considering the juridification of practice and issues with AfC, there are already signs that the nursing profession is mobilising to address grievances. As the Enderby v Frenchay Health Authority and Secretary of State for Health (1993) ruling laid the foundations for introducing AfC, more recent cases are being brought against it. In Southern Health and Social Care Trust in Northern Ireland, 13 nurses working in intensive care recently had their request for a job evaluation upheld and were moved to band 6 from band 5 after a 5-year-long case (RCN, 2024b). Consequently, the nurses who fought the case have now provided resources for other nurses to challenge their job evaluation in their organisations (RCN, 2024b).

6.3 Future research

Considering the need from Grint (2022) to consider systems thinking and theory to address wicked problems, there are possible avenues to consider for future research from this thesis.

Regarding specific themes in the discussion, from theme one on chronic policy change, research should explore the role of policy entrepreneurs in policy window sequencing. This would enable a holistic and system-wide consideration of the impact on the multi-level and multi-centric nature of the NHS. In theme two, on the lack of appropriate data, the inappropriate view of healthcare as a service industry requires research to explicitly consider the impact of viewing healthcare as a safety-critical industry on professional development. Existing disciplines of analysis consider safety-critical perspectives on work systems and safety within the fields of ergonomics and human factors engineering (Grundgiger, Hurtienne and Happel, 2021. Xie and Carayon, 2014). Undertaking a multidisciplinary approach to exploring professional development in

healthcare through this lens may provide compelling insights into enhancing governance and management of nurses' post-registration development. Additionally, more research and analysis needs to consider labour economics within workforce planning to improve the data set available to view the workforce in a safety-critical way in such a system. Furthermore, to explore the situated wickedness in more detail, from theme three, future research should consider clinical governance in relation to nursing establishment and uplift practices and the experience and coping mechanisms undertaken by individuals and organisations. Ethnographic work or the utilisation of case studies may provide a more in-depth analysis to understand this wicked situation, including the rituals and routines used as coping mechanisms.

The process of building a house as a market shelter concept could be expanded further and utilised as a conceptual framework to consider other elements that could influence professional development. This could provide a more in-depth analysis of the mechanisms in the state-profession relationship. Consequently, from a broader systems perspective, this thesis has laid a foundation for considering an advanced understanding and exploring wicked problems in relation to professionals' market shelter development, in the context of the sociology of the professions. Future research could consider Spencer's (1896) system of professions and channels of interchange more focally, alongside Lights (1991, 1995, 2010) countervailing powers framework, by incorporating specific system thinkers who acknowledge the interconnections and relationships between system elements. Meadows (2008) considers that systems are embedded in systems, which are embedded in systems. A system can be adaptive, dynamic, goal-seeking and evolutionary, but critically, the interconnections and the relationships that influence system elements require attention (Meadows, 2008). Applying the approach from Meadows (2008) could be a way to consider system thinking explicitly and the 'flows' of information and practices' successes and failures. This may provide fertile ground to explore social mechanisms in wicked problems further. This aligns with the view of Noordegraff *et al,* (2019) that situated relations, for example, need to be part of wicked problems framing and viewing situated wickedness. Subsequently, this could create better practice-informed theory within the sociology of the professions, with an approach that is dynamic,

holistic, reactive and more sensitive to complexity. Furthermore, in incorporating a systems perspective more explicitly in the sociology of professions, an enhanced, in-depth focus could be given to state and non-state actors' role in determining the state-profession relationship. There is the possibility of crossing transnational boundaries and conducting comparative work between countries, as well as additional space to consider developing countries within this context, as well as developed nations.

6.4 Policy impact

The implications of this thesis on policy are diverse. As presented in the introduction, nurses' post-registration development is central to staff retention, as well as high-quality patient care. Therefore, this thesis will benefit any policy mandates considering staff retention and patient safety. Currently, retention is a core component of the *NHS Long Term Workforce Plan* (NHS England, 2023b), which aims to reduce the leaver rate from 9.1% in 2022 to between 7% and 8%. Therefore, the outcomes of this thesis to understand the challenges with establishing nurses' post-registration development could be incorporated into retention strategies, both at a national and organisational level. For example, an enhanced data gathering and systems approach to the workforce and development within NHS organisations could help identify and enhance long-term development opportunities. Furthermore, the *NHS Patient Safety Strategy* (NHSEI, 2019) seeks to build stronger foundations for safer culture and systems. As this thesis has highlighted, there is great importance in viewing the healthcare service as a safety-critical industry and the central role of the workforce and nurses within this is paramount. Consequently, this thesis could contribute to helping develop a critical programme of work to inform the broader safety initiatives and programs the government seeks to implement.

Currently, due to the recent change in the Government,[76] aligning this work with select committee inquiries is difficult as they are only recently established and are in the process of setting up their priorities and inquiries (HSCC, 2024). Previously, however, inquiries into the workforce have been undertaken, as well as on cancer care and

[76] In July 2024, a new Labour government administration was elected

mental health. The latter two inquiries highlighted the challenges with the workforce, including nurses, as a core component of the failure of the government to meet commitments (HSCC, 2022). Therefore, it is likely that this research will be able to contribute to inquiries, as an understanding of the system-wide impacts on nursing, the largest safety-critical workforce in the NHS underpins many of the current challenges being faced by the NHS. House of Lords select committees also have relevant inquiries this thesis could contribute to, such as the Public Servies Committee, which includes health as a focus.[77]

6.5 Chapter conclusion

This chapter has explored the view of nurses' post-registration development as a wicked problem. The three themes highlighted in the discussion are complex, have overlapping and multiple challenges, transcend across domains and levels of government, and are relentless. Addressing wicked problems requires a deeper understanding of situated wickedness and the utilisation of systems thinking and theory to address problems.

Future research avenues were then explored. These included specific considerations from each theme focus in the discussion chapter. This included more research on the role of policy entrepreneurs on policy window sequencing and exploring 'situated wickedness' within the context of clinical governance practices at an organisational level. Additionally, a broader consideration was placed on integrating systems -thinking within the sociology of the professions. This was presented as enabling an enhanced view of the state-profession relationship and the role of state and non-state actors within this.

Finally, the policy impacts of this research were presented. As the introduction highlighted, post-registration development is central to retention and patient safety considerations. This thesis can subsequently impact current policy mandates, including the *NHS Long Term Workforce Plan* and the NHS Patient Safety Strategy. There is also

[77] A previous inquiry considered the public services workforce and whether it was fit for the future. This inquiry focused on healthcare, including the NHS and nurses (Public Services Committee, 2023).

significant potential for this work to contribute to select committee inquiries in the future.

Chapter 7: Conclusion

7.1 Introduction

This chapter will first restate the research question and provide a summary of the ways this thesis has answered it. Then, the contributions to knowledge will be stated, followed by the strengths and limitations of this thesis. Finally, a reflection on the PhD process is presented, and concluding remarks on the importance of this research and nurses' post-registration development will be presented.

7.2 The research question and answer summary

The research aim was to explore the influence of political economy on nurses' post-registration development in the English NHS. From this, the research question in this thesis was:

'Why has nursing in England not established a stronger market shelter through post-registration development and career frameworks, despite post-Fordist reforms?'

The answer to the research question was presented in three ways. First, it was answered through the instability of policy. This was related to the unstable environment from which nurses could enact post-registration development. Second, it was answered through the lack of appropriate economic data. Critically, a shallow interpretation of nurses' economic value was present, which hindered nurses' post-registration development from being understood and valued. Finally, the research question was answered through the juridification of practice. This related to the nursing profession being controlled and constrained through clinical governance and AfC, which impaired post-registration development.

The three answers to the research question, chronic policy change, a lack of appropriate economic data and jurisdiction of practice operate across multiple levels with multiple and non-linear interactions. The relationships and interactions in relation to nurses' market shelter development can subsequently be viewed through the analogy of building a house. A market shelter is a professions house, and the three answers to the research question are related to the environment in which a house is

built (policy instability), building resources (lack of economic data), and governance of the building process (juridification of practice). These three interrelated answers imply that nurses' post-registration development can be considered a wicked problem. Each answer to the research question can be viewed as an aspect of situated wickedness within the wicked problem. Through systems thinking and research, there are possible avenues to explore in future research that could help address the challenges identified as impairing nurses' post-registration development in the English NHS.

7.3 Contribution to knowledge

This thesis consists of theoretical and conceptual contributions to knowledge. From a theoretical perspective, this thesis has enabled a greater consideration within the sociology of the professions of the state-profession relationship regarding state actors and multi-level and multi-centric governance systems. It has explored the mechanisms of the relationship and the 'spaces in between', which have previously not had sufficient attention and theorisation in the literature. Other aspects within this have been enhanced understanding of a professional market shelter development through the stability in state projects, not just their existence, the presence, influence and focus of the economic within the 'market', and the role of increasing state-mandated legal mechanisms through juridification. The analysis of developing a market shelter as a house build is a new and holistic understanding of professional development. This analogy enables the development of greater practice-theory perspectives on professional development, which is currently neglected in the sociology of the professions literature.

From a conceptual perspective, a greater focus has been placed on the role of workforce planning in relation to workforce development. While the lack of workforce planning has recently attracted more attention regarding wider system problems, this thesis fills a gap in knowledge surrounding its impact on post-registration development. Thus, an enhanced understanding of the system-wide implications of workforce planning has been established. Additionally, the way in which an industry is viewed, as service or safety, has been explicitly linked to workforce development. This

has not currently been done at the time of writing. Critically, this enables a greater systems perspective on understanding healthcare governance and the place and importance of workforce development in relation to that. Adjoining this has been a greater emphasis on the role of data and economics, including how data is used to help a profession negotiate with various levels of power within a system. The data currency that professions need to bargain and negotiate with organisations and the state is not currently explored in depth in the literature.

7.4 Strengths and limitations

This thesis has strengths and limitations. In terms of strengths, the sample size for the document analysis and the semi-structured interviews was considerable. This enabled a comprehensive and in-depth exploration of the research question. Additionally, a variety of organisations, geographical areas and individuals were considered and recruited for this study. Throughout the findings, the data analysis was linked and stratified. This enabled a thorough consideration of the impact of political economy and policy throughout the levels of implementation (or the lack of it). Furthermore, while linking and stratifying the data, individual pressure points identified at each level were still enabled to be emphasised. Finally, this thesis has been properly theorised. The arguments for using countervailing powers framework have been consistently reinforced throughout and have produced novel contributions to the literature, including filling research gaps.

In terms of weakness, while there was a large sample size, it was not possible to interview everyone at a national, organisational and individual level. Therefore, it is not possible to claim that the views and opinions presented here are illustrative of everyone within the English NHS system. Additionally, this research was done at one point in time. Thus, while this thesis did consider historical developments through the policy document analysis, the interviews were only from one time period. For instance, it is possible that if the thesis was completed before the COVID-19 pandemic, the responses given by participants may have been different. This would have implications for the findings and subsequent answering of the research question. Finally, other

theoretical perspectives might have produced different results. While the theoretical position for this thesis has been evidenced, it remains that taking another theoretical perspective would have presented a different lens through which the influence of political economy and the theorising around professional development would have been viewed. Subsequently, the answers to the research question, policy impacts, and contributions to knowledge may have focused on different aspects.

7.5 Reflection on the PhD process

As stated in the introduction, through professional experiences and insight, the problem with a lack of nurses' post-registration development was formed into a PhD. While I now have a set of answers I did not have before, the PhD process has also given me a lot more. An aspect not presented in the introduction was the profound negative effect the lack of post-registration development had on me. My departure from the Army was on medical grounds due to significant deterioration in my mental health, in part because of the lack of appropriate post-registration development. This deterioration was so substantial that I removed myself from the professional register for 12 months. Thus, I became part of the statistics detailed in the introduction chapter concerning the retention of nurses. Before my departure and during the year off the register, I doubted if I would ever want to return to the register. I felt like I had been driven from the profession and had no place within it. However, this PhD has reignited my desire and pride to be a registered nurse. I re-joined the register just before the COVID-19 pandemic arrived. While the first time back on a ward post-mental health breakdown was during a pandemic, which I would typically not advise, it was also a significant turning point. It was during this time, and then while helping with the vaccination roll-out, that the importance of my research was brought back into sharp focus. Personally and professionally, I feel that during this PhD, I have been readmitted to the world and the profession. No words can describe the powerful process and journey the PhD took me on during this time. I am not sure even Adele or Rumi could write something to put it into perspective.

Another critical component underpinning this PhD process has been the long-standing challenges I have with dyslexia. From a young age, my teachers discounted me for any academic pursuit. As a result, I long believed I was incapable, and it took until my mid-late twenties to realise this was not true. During my initial nurse training, this realisation came to light, and the seed was first sown about my ability to do a PhD. While I am still plagued by a lack of awareness of grammar and spelling, I can proudly share that, thanks to completing this PhD, I now know and can write the differences between 'to' and 'too', and that my ability to construct sentences of five lines or less is improving. Unsurprisingly, a strong case of impostor syndrome was present during my PhD; however, through the unrelenting support of my supervisors, I have finally come to believe that I belong in this space. A formal diagnosis of Autism and Attention Deficit Hyperactivity Disorder (why have one neurodiverse challenge when you can have three[78]), came later, just as I completed this PhD. Despite the myriad challenges, I look back on this PhD process with immense pride and fulfilment. Not just because a thesis exists, but in the context of everything that led up to and happened during. I am not sure many people would describe their PhD process as a form of therapy; however, it brought me back to life and helped me realise and act on my potential. The journey continues.

Two roads diverged in a wood, and I,
I took the one less travelled by,
And that has made all the difference.

Robert Frost, The road not taken

7.6 Concluding remarks

In the introduction, nurses' post-registration development was placed alongside the critical importance of retention and patient safety. Retaining registered nurses is imperative, with increasing domestic and international shortages. The extent to which the latter is considered a global emergency. High-quality and effective patient care is essential to patient safety, through which retention and nurses' post-registration

[78] Sarcasm

development play a critical role. Despite the importance of nurses' post-registration development, it is limited, fragmented, and lacks transparency in the UK and England. Healthcare governance and policy have altered service delivery and working practices, and nurses' post-registration development has been profoundly impacted. Through healthcare governance and policy, this thesis has demonstrated how the political economy is critical in influencing the nursing profession.

Subsequently, this thesis has contributed to understanding the role and influence of political economy on nurses' post-registration development. From this, a greater insight has been gained, and a path has been laid for other professions to be viewed through this lens. An enhanced perspective on the mechanisms and system influences that impact the professions within a healthcare system have been explored, which have implications for improving retention and patient safety.

References

Abbott, A. (1981) Status and strain in the professions. *American Journal of Sociology*. 86(4), pp.819-835.

Abbott, A. (1988) *The system of professions: An essay on the division of expert labour*. Chicago: University of Chicago Press.

Abbott, A. (2005) Linked ecologies: states and universities as environments for professions. *Sociological Theory*, 23(3), pp. 245 – 274.

Abbott, K. (2007) Employment relations: integrating industrial relations and human resource management. *Problems and Perspectives in Management*, 5(1), pp. 61-71.

Ackers, L. and Abbott, P. (1996) *Social policy for nurses and the caring professions*. Buckingham: Open University Press.

Adam, C. Hurka, S. Knill, C. and Steinbach, Y. (2019) *Policy accumulation and the democratic responsiveness trap*. Cambridge: Cambridge University Press.

Adam, C. Steinebach, Y. and Knill, C. (2018) Neglected challenges to evidence-based policy making. The problem of policy accumulation. *Policy Sciences*, 51(3), pp. 268-290.

Adams, T. and Saks, M. (2018) Neo-weberianism and changing state-profession relations: the case of Canadian health care, *Sociologia, Problemas e Práticas,* 88, pp. 61-77.

Adams, V. and Nelson, J. (2009) The economics of nursing: articulating care. *Feminist Economics*, 15(4), pp. 3-29.

Audit Commission (2002) *Recruitment and retention: a public service workforce for the twenty-first century*. London: Audit Commission.

Aguinis, H. and Solarino, A. (2019) Transparency and replicability in qualitative research: The case of interviews with elite informants. *Strategic Management Journal,* 40, pp. 1291–315.

Ahmed, S. (2017) *Living a feminist life*. Durham, Duke University Press.

Aiken, L. Cimiotti, J. Sloane, D. Smith, H. Flynn, L. and Neff, D. (2011) Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments. *Medical Care*, 49(2), pp. 1047-1053.

Aiken, L. Sloane, D. Bruyneel, L. Van den Heede, K. Griffiths, P. Busse, R. Diomidous, M. Kinnunen, J. Kozka, M. Lesaffre, E. McHugh, M. Moreno-Casbas, M. Rafferty, AM, Schwendimann, R. Scott, P. Tishhelman, C. van Achterberg, T. and Sermeus, W. (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *Lancet*, 383(9931), pp. 1824-1830.

Aiken, L. Sloane, D. Griffiths, P. Rafferty, A-M. Bruyneel, L. McHugh, M. Maier, C. Moreno-Casbas, T. Ball, J. Ausserhofer, D. Sermeus, W. and RN4CAST Consortium (2017) Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. *BMJ quality & safety,* 26(7), pp. 559–568.

Aiken, J. Hanges, R. and Chan, T. (2019) The means are the end: Complexity science in organizational research. In Humphrey, S. and LeBreton, J. (Eds.) *The handbook of multilevel theory, measurement, and analysis,* Washington: American Psychological Association, pp. 115–140.

Alcoff, L. and Potter, E. (1993) *Feminist Epistemologies*. London: Routledge.

Aldrich, H. and Herker, D. (1977) Boundary spanning roles and organisational structures. The *Academy of Management Review*, 2(2), pp. 217-230.

Alexander, N. (2013) *Policy analysis for educational leaders: A step-by-step approach.* New Jersey: Pearson Education.

Alghamdi, M. (2016) Nursing workload: a concept analysis. *Journal of Nursing Management,* 24, pp. 449-457.

Allen, D. (2001) *The changing shape of nursing practice. The role of nurses in the hospital division of labour.* London: Routledge.

Allen, D. (2015) *The invisible work of nurses. Hospitals, organisations and healthcare*. Didcot: Routledge.

Allen, D. and Hughes, D. (2002*) Nursing and the division of labour in healthcare*. Basingstoke: Palgrave Macmillan.

Allmark, P. Boote, J. Chambers, E. Clarke, A. McDonnell, A. Thompson, A. and Tod, A. (2009) Ethical issues in the use of in-depth interviews: Literature review and discussion. *Research Ethics Review,* 5(2), pp. 48-54.

Almeida, J. and Gabe, J. (2016) CAM within a field force of countervailing powers: The case of Portugal. *Social Science and Medicine*, 155, pp. 73-81.

Amri, M. and Logan, D. (2021) Policy responses to COVID-19 present a window of opportunity for a paradigm shift in global health policy: An application of the Multiple Streams Framework as a heuristic. *Global Public Health*, 16(8-9), pp.1187-1197.

Anguera, M. Blanco-Villasenor, A. Losada, J. Sanchez-Algarra, P. and Onwuegbuzie, A. (2018) Revisiting the difference between mixed methods and multimethods: is it all in the name? *Quality and Quantity,* 52, pp. 2757-2770.

Appleby, J. Devlin, N. Parkin, D. Buxton, M. and Chalkidou, K. (2009) Searching for cost effectiveness thresholds in the NHS. *Health Policy*, 91(3), pp. 239-245.

Arts, W. and Gelissen J. (2002) Three worlds of welfare capitalism or more? A state-of-the-art-report. *Journal of European Social Policy*, 12(2), pp. 137-158.

Atkinson, P. and Coffey, A. (1997) Analysing documentary realities. In: Silverman, D. (Ed) *Qualitative research: Theory, method and practice*. London: Sage, pp. 45–62.

Audet, LA, Bourgault, P. and Rochefort, C. (2018) Associations between nurse education and experience and the risk of mortality and adverse events in acute care hospitals: A systematic review of observational studies*. International Journal of Nursing Studies*. 80, pp. 128-146.

Bacchi, C. (1999) *Women, policy and politics*. London: Sage.

Bacchi, C. (2009) *Analysing policy: What's the problem represented to be?* Melbourne: Pearson.

Ball, J. Bruyneel, L. Aiken, L. Sermeus, W. Sloane, D. Rafferty, A-M. Lindqvist, R. Tishelman, C. Griffiths, P. and RN4Cast Consortium. (2018) Post-operative mortality,

missed care and nurse staffing in nine countries: A cross-sectional study. *International Journal of Nursing Studies*, 78, pp. 10-15.

Ball, J. and Pike, G (2009) *Past imperfect, future tense. Nurses' employment and moral in 2009.* London: Royal College of Nursing.

Bambra, C. (2007) Going beyond the three worlds of welfare capitalism: regime theory and public health research. *Journal of Epidemiology and Community Health*, 61(12), pp. 1098-1102.

Beechan, L. (2000) UK Health Secretary Wants to Liberate Nurses Talents'. *British Medical Journal*, 320(7241), pp. 1025.

Bell, L. and Stevenson, H. (2006) *Education policy: Process, themes and impact*. London: Routledge.

Benbow, D. (2019) Juridifcation, the new constitutionalism, and the market reforms to the English NHS. *Capital and Class,* 43(2), pp. 293-313.

Benton, T. and Craib, I. (2011) *Philosophy of social science. The philosophical foundations of social thoughts. Second edition*. Basingstoke: Palgrave Macmillan.

Blaikie, N. (2018) *Approaches to social enquiry. 2nd edition.* Cambridge: Polity Press.

Blichner, L. and Molander, A. (2008) Mapping juridification. *European Law Journal*, 14(1), pp. 836-54.

Boden, L. and Kelly, D. (1999) Clinical governance: The route to (modern, dependable) nursing research? *Journal of Research in Nursing*, 4(3), pp. 177-187.

Bowen, G. (2009) Document analysis as a qualitative research method. *Qualitative Research Journal,* 9(2) pp. 27-40.

Bowker, G. and Star, S. (1999) *Sorting things out: classification and its consequences.* Cambridge: MIT Press.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2). pp. 77-101.

Braun, V. and Clarke, V. (2013) *Successful qualitative research. A practical guide for beginners*. London: SAGE Publications Ltd.

Braun, V. and Clarke, V. (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health,* 11(4), pp. 589-597.

Braun, V. and Clarke, V. (2022) *Thematic analysis. A practical guide.* London: SAGE Publishing Ltd.

Brook, J. Aitken, L. Webb, R. MacLaren, J. and Salmon, D. (2019) Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies*, 91, pp. 47-59.

Braverman, H. (1974) *Labor and Monopoly Capital*. New York: Monthly Review Press.

Brennan, D. (2005) The social construction of 'women's work': nursing labour and status. *Journal of Nursing Management*, 13, pp. 282-285.

Briskin, L. (2012) Resistance, mobilization and militancy: nurses on strike. *Nursing Inquiry*, 19, pp. 285-296.

Brook, J. Aiken, L. Webb, R. Maclaren, J. and Salmon, D. (2019) Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies*, 91, pp.47-59.

Browne, J. (1994) *The juridification of the employment relationship: A study of the impact of the Unfair Dismissals Act 1997 and the Unfair Dismissals (Amendment) Act 1993.* Aldershot: Avebury.

Broyles, L. Rodriguez, K. Price, P. Bayliss, N. and Sevick, M. (2011) Overcoming barriers to recruitment of nurses as participants in health care research. *Qualitative Health Research*, 21(12), pp. 1705-1718.

Buchan, J. Charlesworth, A. Gershlick, B. and Seccombe, I. (2019) *A critical moment. NHS staffing trends, retention and attrition*. Available at: https://www.health.org.uk/publications/reports/a-critical-moment (Accessed 24 August 2024).

Buchan, J. Ball, J (2010) Evaluating the impact of the new pay system on nurses in the UK. *Journal of Clinical Nursing*, 20, pp. 50-59.

Buchan, J. and Evans D. (2007) *Realising the benefits? Assessing the implementation of Agenda for Change*. London: The King's Fund.

Buchan, J. and Evans, D. (2008) Assessing the impact of a new health sector pay system upon NHS staff in England. *Human Resources for Health*, 6(12), pp. 1-7.

Buchan, J. Hancock, C. and Rafferty, A. (1997) Health sector reform and trends in the United Kingdom hospital workforce*. Medical Care*, 35(10), pp. 143-150.

Burris, B. (1993) *Technocracy at work*. Albany: State University of New York Press.

Burnes, B. and Salauroo, M. (1995) The impact of the NHS internal market on the merger of collages of midwifery and nursing. Not just a case of putting the cart before the horse. *Journal of Management in Medicine*, 9(2), pp. 14-29.

Busher, H. (2006) *Understanding educational leadership: People, power and culture.* New York: Open University Press.

Cabinet Office (2015) *Strathclyde Review: Secondary legislation and the primacy of the House of Commons. Cm 9177.* London: Her Majesty's Stationary Office.

Carayon, P. Wetternect, T. Rivera-Rodriguez, A. Hundt, A. Hoonakker, P. Holden, R. and Gurses, A. (2014) Human factors systems approach to healthcare quality and patient safety. *Applied Ergonomics*, 45(1), pp. 14-25.

Care Quality Commission (CQC) (2015) *Guidance for providers on meeting the regulations*. London: Care Quality Commission.

Care Quality Commission (CQC) (2022a) *Key lines of enquiry for healthcare services* Available at: https://www.cqc.org.uk/guidance-providers/healthcare/key-lines-enquiry-healthcare-services (Accessed 24 May 2023).

Care Quality Commission (CQC) (2022b) *Staff skills and knowledge* (healthcare services) Available at: https://www.cqc.org.uk/guidance-providers/healthcare/staff-skills-knowledge-healthcare-services (Accessed 24 May 2023).

Carroll, A. Collins, C. McKenzie, J. Stokes, D. and Darley, A. (2023) Application of complexity theory in health and social care research: a scoping review. *BMJ Open*, 13, pp.1-12.

Cairney, P. (2020) *Understanding public policy. Theories and issues. 2nd Edition*. London: Red Globe Press.

Cairney, P. and Denny, E. (2020) *Why isn't government policy more preventative?* Oxford: Oxford University Press.

Cairney, P. and Kippin, S. (2023) *Politics and policy making in the UK.* Bristol: Bristol University Press.

Calpin-Davies, P. and Akehurst, R. (1999) Doctor–Nurse Substitution: The workforce equation, *Journal of Nursing Management*, 7, pp. 71–9.

Cannaby, AM. Carter, V. Warrn, K. Gwinnett, J. Bailet, K. Mahmud, S. and Gray, R. (2023) Evaluation of the effect of a Nursing System Framework on Nurse Sensitive Indicators, mortality, and readmission in an NHS Trust. *Nursing Open*, 10(2), pp. 953-966.

Campbell, J. and Bunting, S. (1991) Voices and paradigms: perspectives on critical and feminist theory in nursing. *Advances in Nursing Science,* 13(3), pp. 1-15.

Cardiff University (2024) *TRACT: Making invisible work, visible*. Available at: https://www.cardiff.ac.uk/healthcare-sciences/research/projects/tract-an-evidence-based-intervention-to-assess,-measure,-and-plan-care-trajectory-management (Accessed 08 September 2024)

Cardno, C. (2018) Policy document analysis: a practical educational leadership tool and a qualitative research method. *Educational Administration: Theory and Practice*, 24(4), pp. 623-640.

Carey, G. Dickinson, H. and Olney, S. (2017) What can feminist theory offer policy implementation challenges. *Evidence and Policy*, 15(1), pp. 143-159.

Carlile, P. (2002) A pragmatic view of knowledge and boundaries: boundary objects in new product development. *Organisation Science,* 14(4), pp. 442-455.

Caronna, C. (2010). Why use qualitative methods to study health care organizations? insights from multi-level case studies. In: *The SAGE Handbook of Qualitative Methods in Health Research*. London: SAGE Publications Ltd, pp. 71-87.

Carpenter, M. Geletkanycz, M. and Sanders, W. (2004) Upper echelons research revisited: Antecedents, elements, and consequences of top management team composition. *Journal of Management,* 30, pp. 749–78.

Carter Report (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf (Accessed 13 August 2024).

Castles, F. Leibfried, S. Lewis, J. Obinger, H. and Pierson, C. (2010) *The Oxford Handbook of the welfare state.* Oxford: Oxford University Press.

Catania, G. Zanini, M. Cremona, M. Landa, P. Musio, M. Watson, R. Aleo, G. Aiken, L. Sasso, L. and Bagnasco, A. (2024) Nurses' intention to leave, nurse workload and in-hospital patient mortality in Italy: A descriptive and regression study. *Health Policy*, 143, pp. 1-8.

Chamberlain, J. (2012) *The sociology of medical regulation: an introduction.* London: Springer.

Cheyne, H. McNeil, J. Hunter, B. and Bick, D. (2011) United but divided? The need to consider the potential consequences of devolved UK government on midwifery education and practice. *Midwifery,* 27, pp. 770-774.

Cho, E. Sloane, D. Kim, E-Y, Kim, S. Choi, M. Yoo, I. Lee, H. and Aiken, L. (2015) Effects of nurse staffing, work environments, and education on patient mortality: an observational study. *International Journal of Nursing Studies*, 52(2), pp. 535-542.

Coburn, D. (1988) The development of Canadian nursing: professionalisation and proletarianization. *International Journal of Social Determinants of Health and Health Services*, 18(3), pp. 437-456.

Coburn, D. (1994) Professionalisation and proletarianization: Medicine, nursing, and chiropractic in historical perspective. *Labour/Le Travailleur,* 34, pp. 139-162.

Conservative and Unionist Party (2019) *Get Brexit done. Unleash Britain's potential. Manifesto 2019*. Available at: https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba_Conservative%202019%20Manifesto.pdf (Accessed 06 July 2022)

Cooke, H. (2006) Seagull management and the control of nursing work. *Work, Employment and Society*, 20(2), pp. 223-243.

Cooper, D. Lowe, A. Puxty, A. Robson, K. and Willmott, H. (1988) *Regulating the UK accountancy profession: episodes in the relation between the profession and the state. Paper at ESRC Workshop, The State and the Professions in British Industry and Commerce: A Changing Relationship*. London: Policy Studies Institute.

Corlett, S. and Mavin, S. (2018) T*he SAGE handbook of qualitative business and management research methods: history and traditions.* London: Sage Publications Ltd.

Council of Deans of Health (2018) *Nursing, midwifery and allied health clinical academic research careers in the UK.* Available at: https://councilofdeans.org.uk/wp-content/uploads/2018/08/Nursing-midwifery-and-allied-health-clinical-academic-research-careers-in-the-UK.pdf (Accessed 15 October 2024).

Council of Deans of Health (2020a) *Improving clinical academic careers for nurses, midwives and allied health professionals.* Available at: https://www.councilofdeans.org.uk/wp-content/uploads/2020/09/13032020-CoDH-CAC-position-statement-draft-1.pdf (Accessed 15 October 2024).

Council of Deans of Health (2020b) *The academic workforce in health faculties. Analysis of the Council's academic staffing census 2019.* Available at: https://www.councilofdeans.org.uk/wp-content/uploads/2020/01/CODH.ASC.report_v4.pdf (Accessed 15 October 2024).

Council of Deans of Health (2024) *A step change for a sustainable NHS workforce: General Election 2024*. Available at: https://www.councilofdeans.org.uk/wp-

content/uploads/2024/05/GE24-CoDH-Manifesto-Asks.pdf (Accessed 15 October 2024).

Cowman, J. and Keating, M. (2013) Industrial relations conflict in Irish hospitals: a review of labour court cases. *Journal of Health Organisation and Management*, 27(3), pp. 368-389.

Creswell, J. and Poth, C. (2017) *Qualitative inquiry and research design: Choosing among five approaches*. London: Sage publications.

Croce, M. (2021) Juridification as politics: An institutional view. *Philosophy and Social Criticism,* 47(9), pp. 1025-1042.

Crotty, M. (1998) *The foundations of social research. Meaning and Perspective in the Research Process*. London: SAGE Publications Ltd.

Darko, E. Kleib, M. and Olson, J. (2022) Social media use for research participant recruitment: integrated literature review. *Journal of Medical Internet Research*, 24(8), e38015.

Davies, A. (2013) This time it's for real: the Health and Social Care Act 2012. *The Modern Law Review*, 76(3), pp. 564-588.

Davies, C. (1995) *Gender and the professional predicament in nursing.* Buckingham: Open University Press.

Davies, C. (1996) The sociology of the professions and the profession of gender. *Sociology*, 30(4), pp. 661-678.

Davies, H. and Mannion, R. (1999) *Clinical governance: striking a balance between checking and trusting. No 165chedp, Working Papers.* Centre for Health Economics, University of York.

Davis, D. Golicic, S. and Boerstler, C. (2011) Benefits and challenges of conducting multiple methods research in marketing. *Journal of the Academy of Marketing Science*, 39, pp.467-479.

Dent, M. (2003) *Remodelling hospitals and the health professions in Europe. Medicine, nursing and the state.* Basingstoke: Palgrave Macmillan.

Denzin, N. (1970) *The research act: A theoretical introduction to sociological methods.* New York: Aldine.

Denzin, N. and Lincoln, Y. (2011) *The SAGE handbook of qualitative research. Thousand* Oaks: SAGE.

Department of Health (DoH) (1989a) *Working for patients*. London: The Stationary Office.

Department of Health (1989b) *Working for patients. Education and training. Working paper 10.* London: The Stationary Office.

Department of Health (DoH) (1989c) *Working for patients. Funding and contracts for hospital services. Working paper 2*. London: The Stationary Office.

Department of Health (DoH) (1991) *The patient's charter*. London: The Stationary Office.

Department of Health (DoH) (1992) *The health of the nation.* London: The Stationary Office.

Department of Health (DoH) (1996) *The National Health Service. A service with ambitions.* London: The Stationary Office.

Department of Health (DoH) (1997) *The new NHS: modern, dependable*. London: Department of Health.

Department of Health (DoH) (1998a) *A first class service. Quality in the new NHS*. London: Department of Health.

Department of Health (DoH) (1998b) *Working together. Securing a quality workforce for the NHS.* London: Department of Health.

Department of Health (DoH) (1999a*) Making a difference. Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London: Department of Health.

Department of Health (DoH) (1999b) *Agenda for Change*. London: Department of Health.

Department of Health (DoH) (2000) *A Health Service of all the talents: Developing the NHS workforce Consultation Document on the Review of Workforce Planning*. London: Department of Health.

Department of Health (DoH) (2001) *Shifting the Balance of Power within the NHS. Securing Delivery*. London: Department of Health.

Department of Health (DoH) (2004a) *Agenda for Change: final agreement*. London: Department of Health.

Department of Health (DoH) (2004b) *NHS job evaluation handbook*. London: Department of Health.

Department of Health (DoH) (2004c) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process.* London: Department of Health.

Department of Health (DoH) (2004d) *The NHS improvement plan. Putting people at the heart of public service.* London: Department of Health.

Department of Health (DoH) (2006) *Modernising nursing careers: Setting the direction*. London: Department of Health.

Department of Health (DoH) (2007) *Our NHS our future. NHS next stage review*. London: Department of Health.

Department of Health (DoH) (2008a) *Towards a framework for post-registration nursing careers. Consultation response report.* London: Department of Health.

Department of Health (DoH) (2008b) *A high quality workforce. NHS Next stage review*. London: Department of Health.

Department of Health (DoH) (2008c) *High quality care for all: NHS next stage review final report*. London: Department of Health.

Department of Health (DoH) (2008d) *Framing the nursing sand midwifery contribution to driving up the quality of care*. London: Department of Health.

Department of Health (DoH) (2010a) *Vital role of Clinical Nurse Specialists*. London: Department of Health.

Department of Health (DoH) (2010b) *Front line care. Report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010*. London: The Prime Minister's Commission on the Future of Nursing and Midwifery in England.

Department of Health (DoH) (2010c) *Equity and Excellence: Liberating the NHS*. London: Department of Health.

Department of Health (DoH) (2012a) *Liberating the NHS: Developing the healthcare workforce. From Design to Delivery*. London: Department of Health.

Department of Health (DoH) (2012b) *Compassion in practice. Nursing, Midwifery and care staff. Our vision and strategy.* London: Department of Health.

Department of Health (DoH) (2013a) *Independent report. Berwick review into patient safety. A promise to learn – a commitment to act. Improving the safety of patients in England*. London: Department of Health.

Department of Health (DoH) (2013b) *Review into the quality of care and treatment provided by 14 hospital Trusts in England. Keogh Report*. London: Department of Health.

Department of Health (DoH) (2013c) *Workforce Information Architecture in the Reformed NHS Landscape*. London: Department of Health.

Department of Health (DoH) (2014) *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March 2015*. Available at: https://assets.publishing.service.gov.uk/media/5a7da9c6ed915d2ac884ccce/DH_HEE_Mandate.pdf (Accessed 24 September 2024).

Department of Health (DoH) (2015a) *Handbook to the NHS Constitution for England.* Updated October 2023. Available at: https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england (Accessed 24 September 2024).

Department of Health (DoH) 2015b) *Culture change in the NHS. Applying the lessons of the Francis inquires.* London: Department of Health.

Department of Health and Social Care (DHSC) (2022) *Policy paper. 50,000 Nurses Programme: delivery update.* Available at: https://www.gov.uk/government/publications/50000-nurses-programme-delivery-update/50000-nurses-programme-delivery-update (Accessed 11 November 2024).

Department of Health and Social Care (DHSC) (2023) *Guidance. Secretary of State's Guidance under section 42A of the National Health Service Act 2006.* Available at: https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts/secretary-of-states-guidance-under-section-42a-of-the-national-health-service-act-2006 (Accessed 23 August 2024).

Department of Health and Social Care (DHSC) (2024) *Guidance. Code of practice for the international recruitment of health and social care personnel in England*. Available at: https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england (Accessed 17 October 2024).

De Vries, R. Dingwall, R. and Kristina, O. (2009) The moral organisation of the professions: bioethics in the United States and France. *Current Sociology*, 57, pp. 555-579.

Dickens, L. and Hall, M. (2006) Fairness - up to a point. Assessing the impact of New Labour's employment legislation. *Human Resource Management Journal*, 16(4), pp. 338-356.

Dickinson, H. and Sullivan, H. (2014) Towards a general theory of collaborative performance. *Public Administration*, 92(1), pp. 161-177.

Dingwall, R. (1999) Professions and the social order in a global society. *International Review of Sociology*, 9(1), pp. 131-140.

Dingwall, R. (2008) *Essays on professions*. Aldershot: Ashgate Publishing Limited.

Dingwall, R. (2009) The inevitability of professions? IN: Currie, G. Ford, J. Harding, N. and Learmonth, M. (Eds) *Making Public Services Management Critical.* London: Routledge, pp. 71–85.

Dingwall, R. (2016) *Essays on professions.* Abingdon: Taylor Francis.

Dingwall, R. and Allen, D. (2001) The implications of healthcare reforms for the profession of nursing. *Nursing Inquiry,* 8(2), pp. 64-74.

Dingwall, R. and Fern, P. (1987) A respectable profession? Sociological and economic perspectives on the regulation of professional services. *International Review of Law and Economics*, 7, pp. 51-64.

Dingwall, R. and King, M. (1995) Herbert Spencer and the professions: Occupational ecology reconsidered. *Sociological Theory*, 13(1), pp. 14-24.

Dingwall, R. Rafferty, A. and Webster, C. (1988) *An introduction to the social history of nursing*. London: Routledge.

Doering, L. (1992) Power and knowledge in nursing: A feminist post-structuralist view. *Advances in Nursing Science,* 14(4): pp.24-33.

Dover, N. Lee, G. Raleigh, M. and Baker, E. (2019) A rapid review of educational preparedness of advanced clinical practitioners. *Journal of Advanced Nursing*, 75(12), pp. 3210-3218.

Dow, S. (2023) Political economy as a methodological approach. *Review of Political Economy*, 35(1), pp. 98-110.

Downs, A. (1957) An economic theory of political action in democracy. *Journal of Political Economy*, 65(2), pp. 135-150.

Dunleavy, P. and Hood, C. (1994) From old public administration to new public management. Public Money and Management, 14(3), pp. 9-16.

Durkheim, E. (1957) Professional ethics and civic morals. Translated by Cornelia Brookfield. London: Routledge and Kegan Paul.

Dye, T. (2014) *Understanding Public Policy. Fourteenth Edition.* Harlow: Pearson Education Limited.

East Anglian Regional Health Authority (EARHA) (1990) *The Rubber Windmill. Contracting for health outcomes. A report of a workshop to explore the workings of an internal market in the health service, held in Est Anglia – April 1990.* Cambridge: Eapatonst Anglian Regional Health Authority.

Edwards, R. (1979) *Contested Terrain: The Transformation of the Workplace in the Twentieth Century*. New York: Basic Books.

Edwards, P. and Hodder, A. (2022) Conflict and control in the contemporary workforce: structured antagonism revisited. *Industrial Relations*, 53, pp. 220-240.

Eisner, E. (1991) *The enlightened eye: Qualitative inquiry and the enhancement of educational practice. Toronto*: Collier Macmillan Canada.

Elliott, R. and Timulak, L. (2005) Descriptive and interpretive approaches to qualitative research. In: J. Miles, J. and Gilbert, P. (Eds) *A handbook of research methods for clinical and health psychology*. Oxford: Oxford University Press, pp. 147–159.

Elston, M. (1991) The politics of professional power: medicine in a changing medical service IN: Gabe, J. Calman, M. and Bury, M (Eds) *The sociology of the health service.* London: Routledge, pp. 188-203.

Enderby v Frenchay Health Authority and Secretary of State for Health (1993) Court of Appeal (England) - United Kingdom. Case C-127/92. *EUR-Lex*. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A61992CJ0127 (Accessed 14 April 2022).

Engell, S. (2012) *The sociology of work. Continuity and change in paid and unpaid work, 2nd Edition*. London: Sage Publications Ltd.

England, K. (1994) Getting personal: reflexivity, positionality and feminist research. *The Professional Geographer,* 46(1), pp. 80-89.

Esland, G. (1980) Professions and professionalism. In: Esland, G. and Salaman, G. (Eds), *The politics of work and occupations*. Milton Keynes: Open University Press, pp. 213-50.

Esping-Anderson, G. (1990) *The three worlds of welfare capitalism.* Princeton: Princeton University Press.

Etzioni, A. (1969) *The semi-professions and their organizations*. New York: Free Press.

Evetts, J. (2009) New professionalism and new public management: changes, continuities and consequences. *Comparative Sociology*, 8(2), pp. 247-266.

Exley, S. (2021) Open Policy Making in the UK – to Whom Might Policy Formulation be 'Opening Up'? *Journal of Social Policy*, 50(3), pp. 451-469.

Exworthy, M. (2014) The paradox of health policy: revealing the true colours of this 'chameleon concept'. *International Journal of Health policy Management*, 3(1), pp.41-43.

Exworthy, M. Mannion, R. and Powell, M. (2023) *The NHS at 75. The state of UK health policy*. Bristol: Bristol University Press.

Felder, M. Schuurmans, J. van Pijkeren, N. Bal, R. and Wallenburg, I. (2024) Bedside politics and precarious care. New directions of inquiry in critical nursing studies. *Advances in Nursing Science,* 47(4), pp. 22-37.

Ferlie, E. Ashburner, L. Fitzgerald, L. and Pettigrew, A. (1996) *The new public management in action.* Oxford: Oxford University Press.

Ferlie, E. Fitzgerald, L. Mcgivern, G. Dopson, S. and Bennett, C. (2011) Public policy networks and 'wicked problems': A nascent solution? *Public Administration,* 89(2), pp. 307-324.

Ferlie, E. and Pettigrew, A. (1996) Managing Through Networks: Some Issues and Implications for the NHS*. British Journal of Management*, 7(1), pp. 81-99.

Flick, U. (2018) *The SAGE handbook of qualitative data collection*. London: Sage.

Field-Richards, S. (2017) *The lived reality and meaning of Lean Thinking for nurses and nursing at an NHS Hospitals Trust.* PhD thesis, University of Nottingham.

Fisher, N. Bramley, L. Cooper, J. Field-Richards, S. Lymn, J. and Timmons, S. (2022) A qualitative study exploring the influence of a talent management initiative on registered nurses' retention intentions. *Journal of Nursing Management*, 30(8), pp. 4472-4479.

Fligstein, N. and Dauter, L. (2007) The sociology of markets. *Annual Review of Sociology*, 33(6), pp. 1-24.

Flynn, K. (1998) Proletarianization, professionalization, and Caribbean immigrant nurses. *Canadian Woman Studies*, 18(12), pp. 57-60.

Flynn, R. (2010) Clinical governance and governmentality. *Health, Rish & Society*, 4(2), pp. 155-173.

Folbre, N. (2012) The political economy of human capital. *Review of Radical Political Economics*, 44(3), pp. 281-292.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. Executive Summary*. London: The Stationery Office.

Friedson, E. (1970a) *Professional dominance*. New York: Atherton Press.

Friedson, E. (1970b) *Profession of Medicine: a study in the Sociology of Applied Knowledge*. New York: Harper and Row.

Friedson, E, (1986) *Professional powers: a study of the institutionalization of formal knowledge.* Chicago: Chicago University Press.

Friedson, E. (1994) *Professionalism reborn: theory, prophecy and policy.* Cambridge: Polity Press.

Friedson, E. (2001) *Professionalism: The Third Logic*. Chicago: Chicago University Press.

Galletta, A. and Cross, W. (2013) *Research Design to Analysis and Publication*. New York: New York University Press.

General Medical Council (GMC) (2023) *The state of medical education and practice in the UK. Workforce report 2023.* Available at: https://www.gmc-uk.org/-/media/documents/workforce-report-2023-full-report_pdf-103569478.pdf (Accessed 24 September 2024).

General Medical Council (GMC) (2024) *GMC approved postgraduate curricula*. Available at: https://www.gmc-uk.org/education/standards-guidance-and-curricula/curricula (Accessed 24 September 2024).

Given, L. (2008) *The SAGE encyclopaedia of Qualitative Research Methods.* London: Sage Publications.

Goode, W. (1957) Community within a community: The professions. *American Sociological Review*, 22, 194-200.

Goode, W. (1960) Encroachment, charlatanism and the emerging professions: psychiatry, sociology and medicine. *American Sociological Review*, 25, pp. 902-914.

Goodwin, D. (2018) Cultures of caring: healthcare 'scandals', inquires, and the remaking of accountabilities. *Social Studies of Science,* 48(1), pp. 101-124.

Gough, P. (1992) Nurse education in the post-Fordist era. *Nurse Education Today*, 12, pp. 88-93.

Gould, D. Berridge E-J. and Kelly, D. (2007) The National Health Service Knowledge and Skills framework and its implications for continuing professional development in nursing. *Nurse Education Today*, 27(1), pp. 26-34.

GOV.UK (2024) *Departments, agencies and public bodies*. Available at: https://www.gov.uk/government/organisations (Accessed 23 August 2024).

Grasswick, H. (2006) Stanford Encyclopaedia of Philosophy: Feminist social epistemology. Available at: https://plato.stanford.edu/entries/feminist-social-epistemology/ (Accessed 12 July 2022).

Greco, J. and Sosa, E. (1999) *The Blackwell guide to epistemology*. Oxford: Blackwell Publishing Ltd.

Greener, I. (2004) Health service organisation in the UK: a political economy approach. *Public Administration*, 82(3), pp. 657-67.

Greve, B. (2012) *The Routledge handbook of the welfare state*. London: Routledge.

Griffiths, L. and Hughes, D. (2000) Talking contracts and taking care: managers and professionals in the British National Health Service internal market. *Social Science and Medicine*, 51, pp. 209-222.

Griffiths, P. Jones, S. Maben, J. and Murrells, T. (2008) *State of the art metrics for nursing: a rapid appraisal.* London: National Nursing Research Unit.

Grint, K. (2010) Wicked problems and clumsy solutions: The role of leadership. In: Brookes, S. and Grint, K. (Eds) *The New Public Leadership Challenge*. Palgrave Macmillan, London, pp. 169-186.

Grint, K. (2022) Critical essay: wicked problems in the Age of Uncertainty. *Human Relations*, 75(8), pp. 1518-1532.

Grix, J. (2010). *The foundations of research. 2nd Edition.* Hampshire: Palgrave Macmillan.

Gross, E. (1986) What is feminist theory? In: Pateman, C. and Gross, E (Eds) *Feminist challenges: social and political theory*. Sydney: Allen and Unwin, pp. 190-204.

Grundgeiger, T. Hurtienne, J. and Happel, O. (2021) Why and How to Approach User Experience in Safety-Critical Domains: The Example of Health Care. *Human Factors*, 63(5), pp. 821-832.

Guba, E. and Lincon, Y. (1994) Competing paradigms in qualitative research. In: Denzin, N. and Lincoln, Y. (Eds) *Handbook of qualitative research.* London: Sage Publications, pp. 105–117.

Gunn, V. Muntaner, C. Villeneuve, M. Chung, H. and Gea-Sanchez, M. (2019) Nursing professionalization and welfare state polices: a critical review of structural factors influencing the development of nursing and the nursing workforce. *Nursing Inquiry*, 26(1), pp. 1-12.

Hafferty, F. and Light, D. (1995) Professional dynamics and the changing nature of medical work. *Journal of Health and Social Behaviour,* Extra issue, pp. 132-153.

Haines, S. (2016) *Talent management in nursing. An exploratory case study of a large acute NHS Trust*. Thesis. Nottingham: University of Nottingham.

Halford, S. Savage, M. and Witz, A. (1997) *Gender, careers and organisations. Current developments in banking, nursing and local government.* London: Red Globe Press.

Hannigan, B. and Coffey, M. (2011) Where the wicked problems are: the case of mental health. *Health policy*, 101(3), pp. 220-227.

Hansard Society (2014) *The devil is in the detail: Parliament and delegated legislation*. London: Hansard Society.

Hansard Society (2021a) *Delegated legislation: the problems with the process. Introducing the Hansard Society's delegated legislation review.* London: Hansard Society.

Hansard Society (2021b) *The Health and Care Bill: Delegated powers*. London: Hansard Society.

Ham, C. Baird, B. Gregory, S. Jabbal, J. and Alderwick, H. (2015*) The NHS under the coalition government. Part one: NHS reform*. London: The King's Fund.

Haraway, D. (1988) Situated knowledge: the science question in feminism and the privilege of partial perspective. *Feminist studies,* 14(3), pp. 575-599.

Harding, S. (1986) The instability of the analytical categories of feminist theory. *Signs,* 11(4), pp. 645-664.

Harding, S. (1987) Introduction: Is there a feminist method? In: Harding, S. *Feminism and methodology* (Ed), Bloomington: Indiana University Press, pp. 1-14.

Harding, S. (1991) *Whose science? Whose knowledge? Thinking from women's lives*. Cornell University Press: New York.

Harris, P. (2016) *An introduction to law. 8th Edition*. Cambridge: Cambridge University Press.

Harris, C. Cortvriend, P. and Hyde, P. (2007) Human resource management and performance in healthcare organisations. *Journal of Health Organisation and Management*, 21(4-5), pp. 448-459.

Hart, C. (2004) *Nurses and politics: The impact of power and practice.* Basingstoke: Palgrave Macmillan.

Hartley, H. (2002) The system of alignments challenging physician professional dominance: an elaborated theory of countervailing powers. *Sociology of Health and Illness,* 24(2), pp. 178 – 207.

Harvey, S. Liddell A. and McMahon. L. (2007) *Windmill 2007. The future of health care reforms in England.* Available at: https://assets.kingsfund.org.uk/f/256914/x/65c4357767/windmill_2007.pdf (Accessed 04 November 2024).

Harvey, S. Liddell A. and McMahon. L. (2009) *Windmill 2009. NHS response to the financial storm.* Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/windmill-2009 (Accessed 04 November 2024).

Haug, M. (1973) Deprofessionalization: an alternative hypothesis for the future. *Sociological Review Monograph,* 20, pp. 195-211.

Head, B. and Alford, J. (2015) Wicked problems implications for public policy and management. *Administration and Society*, 47(6), pp. 711-739.

Health and Care Professions Council (2024) *Registrant snapshot - 4 October 2024*. Available at: https://www.hcpc-uk.org/resources/data/2024/registrant-snapshot-october-2024/ (Accessed 30 October 2024).

Health and Social Care Committee (HSCC) (2022) *Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England. Third Special Report of Session 2022–23.* Available at: https://committees.parliament.uk/publications/23245/documents/169976/default/ (Accessed 23 September 2023).

Health and Social Care Committee (HSCC) (2023) *Integrated Care Systems: autonomy and accountability. Seventh Report of Session 2022-23. HC 587.* Available at: https://committees.parliament.uk/publications/34611/documents/190541/default/ (Accessed 23 August 2024).

Health and Social Care Committee (HSCC) (2024) *Health and Social Care Committee membership appointed.* Available at: https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/203502/health-and-social-care-committee-membership-appointed/ (Accessed 01 November 2024).

Health Education England (HEE) (2015) *Raising the bar. Shape of caring: A review of the future education and training of registered nurses and care assistants*. London: Health Education England.

Health Education England (HEE) (2017a) *Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027.* London: Health Education England.

Health Education England (HEE) (2017b) (*Multi-professional framework for advanced practice in England*. Available at: https://advanced-practice.hee.nhs.uk/multi-professional-framework-for-advanced-practice/ (Accessed 26 August 2024).

Health Education England (HEE) (2019) *Update on phase 1 of the cancer workforce plan*. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Cancer%20Workforce%20Plan%20phase%201%20progress%20update%20FINAL.pdf (Accessed 15 August 2024).

Healthcare Commission (2007) *National NHS staff survey 2007.* Available at: https://www.nhsstaffsurveys.com/results/results-archive/ (Accessed 04 March 2024).

Healthcare Commission (2008) *National NHS staff survey 2008.* Available at: https://www.nhsstaffsurveys.com/results/results-archive/ (Accessed 04 March 2024)

Hebdon, R. and Stern, R. (1998) Tradeoffs among expressions of industrial conflict: public sector strike bans and grievance arbitrations. *Industrial and Labour Relations Review*, 51(2), pp. 204-221.

Heery, E. and Noon, M. (2008) *A dictionary of human resource management*. Oxford: Oxford University Press.

Herrnstein Smith, B. (1997) *Belief and Resistance: Dynamics of Contemporary Intellectual Controversy*. Cambridge, MA: Harvard University Press.

Hesse-Biber, S. and Johnson, R. (2015) *The Oxford Handbook of Multimethod and Mixed Methods Research Inquiry.* Oxford: Oxford University Press.

Hickson, D. and Thomas, M. (1969) Professionalization in Britain: A preliminary measure. *Sociology,* 3(1), pp. 37-53.

Hill, M. and Varone, F. (2021) *The public policy process. Eighth Edition*. Abingdon: Routledge.

HM Treasury (2024) *HM Treasury – Areas of research interest*. Available at: https://assets.publishing.service.gov.uk/media/673207095364e7efcec4194b/HMT_Areas_of_Research_Interest_-_November_2024.pdf (Accessed 13 November 2024).

Hoffman, J. (2001) Blind alley: defining feminism. *Politics.* 21(3), pp. 193-199.

Hollnagel, E. (2022) *The unification of productivity, quality, safety and reliability*. London: Taylor Francis.

Holloway, S. (1991) *Royal Pharmaceutical Society of Great Britain, 1841–1991: A political and social history.* London: Pharmaceutical Press.

Holloway, K. Baker, J. and Lumby, J. (2009) Specialist Nursing Framework for New Zealand: A Missing Link in Workforce Planning. *Policy, Politics, & Nursing Practice*, 10(4), pp. 269-275.

Holloway, I. and Galvin, K. (2017) *Qualitative research in nursing and healthcare. 4th ed.* Chichester: John Wiley and Sons Ltd.

House of Commons Health Committee (2007*) Workforce planning. Fourth Report of Session 2006-07. HC 171-1.* Available at: https://publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/171i.pdf (Accessed 12 August 2022).

House of Commons Health Committee (2018) *The nursing workforce. Second report of session 2017–19. HC 353.* Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf (Accessed 14 April 2023).

House of Commons Library (2023) *The structure of the NHS in England*. Available at: https://researchbriefings.files.parliament.uk/documents/CBP-7206/CBP-7206.pdf (Accessed 21 August 2024).

Hyde, P. Harris, C. and Boaden, R. (2013) Pro-social organisational behaviour of health care workers. *International Journal of Human Resource Management*, 24(16), pp. 3115-3130.

Iedema, R. Braithwaite, J. Jorm, C. Nugus, P. ad Whelan, A. (2005) Clinical governance: complexities and promises IN: Stanton, P. Willis, E. and Young, S. (Eds) *Workplace reform in the healthcare industry. The Australian experience.* pp. London: Palgrave Macmillan, pp. 253-278.

Institute of Employment Studies (2010) *NHS Staff Council. Review of the NHS Knowledge and Skills Framework*. London: Institute of Employment Studies.

Institute of Fiscal Studies (2022) *Factors associated with staff retention in the NHS acute sector*. London: The Institute of Fiscal Studies.

Institute for Fiscal Studies (2023) *Progression of parents in NHS medical and nursing careers.* London: The Institute of Fiscal Studies.

Institute of Health Equity (2020) Health equity in England: The Marmot review 10 years on. London: Institute of Health Equity.

International Council of Nurses (ICN) (2023) *Recover to rebuild. Investing in the nursing workforce for health system effectiveness.* Available at: https://www.icn.ch/sites/default/files/2023-07/ICN_Recover-to-Rebuild_report_EN.pdf (Accessed 26 August 2024).

International Council of Nurses (ICN) (2024) *International nurses day 2024: The economic power of care.* Available at: https://www.icn.ch/sites/default/files/2024-05/ICN_IND2024_report_EN_A4_6.1.pdf (Accessed 05 June 2024).

Jackson, J. Anderson, J. and Maben, J. (2021) What is nursing work? A meta-narrative review and integrated framework. *International Journal of Nursing Studies*, 122, pp. 1-11.

Jessop, B. (1991) The welfare State in transition from Fordism to post-Fordism In: Kessop, B. Kastendiek, H. Nielsen, K. and Pederson, O. (Eds) *The politics of flexibility.* Aldershot: Edward Elgar, pp. 82-105.

Jessop, B. (1994) The transition to post-Fordism and the Schumpeterian workfare state. In: Burrows, R. and Loader, B (Eds) *Towards a post-Fordist welfare State.* London: Routledge, pp. 13-37.

Joffe, H. (2011) Thematic analysis. In: Harper, D. and Thompson, A. (Eds.) *Qualitative methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester: Wiley, pp. 209-223.

Johnson, T. (1972) *Professions and Power*. London: Macmillan.

Johnson, T. (1993) Expertise and the state. In: Gane, M. and Johnson, T. (Eds), *Foucault's new domains*. London: Routledge, pp. 139-152.

Johnson, T. (1995) Governmentality and the institutionalization of expertise. In: Johnson, T. Larkin, G. and Saks, M. (Eds), *Health professions and the state in Europe.* London: Routledge, pp. 7-24.

Johnson, T. Larkin, G. and Saks, M. (1995) *Health professions and the state in Europe.* London: Routledge.

John, P. (2011) *Making policy work.* London: Routledge.

Jones, K. Baggott, R. and Allsop, J. (2004) Influencing the national policy process: the role of health consumer groups. *Health Expectations*, 7(1), pp. 18-28.

Jones, O. (2014) *The establishment*. London: Allen Lane.

Kahya, E. (2006) A revision of a job evaluation system. *Journal of Advanced Nursing*, 56(3), pp. 314-324.

Kayha, E. and Oral, N. (2007) Job evaluation for clinical nursing jobs by implementing the NHS JE system. *Journal of Nursing Management*, 15, pp. 740-748.

Karas, M. Sheen, N. North, R. Ryan, B. and Bullock, A. (2020) Continuing professional development requirements for UK health professionals: a scoping review. *BMJ Open*, 10(3), pp. e032781-e032781.

Kent, B. Plugaru, E. Page, G. and Coad, J. (2022) *Issues impacting on the mobility of nurses and midwives wishing to traverse between the NHS and Higher Education sectors in pursuit of a clinical academic career: a scoping exercise.* Plymouth: University of Plymouth.

Kiguwa, P. (2019) Feminist approaches: An exploration of women's gendered experiences. In: Laher, S. Fynn, A. and Kramer, S. (Eds) *Transforming Research Methods in the Social Sciences: Case Studies from South Africa.* Johannesburg*:* Wits University Press, pp. 220–235.

Kingdon, J. (1984) *Agendas, alternatives and public policies.* Boston: Little Brown.

Kingdon, J. (1995) *Agendas, alternatives, and public policies*. New York: Addison, Wesley, Longman.

King's College London (2024) *Acute Oncology (Work-based learning) Level 7 - 7KANAOWB*. Available at: https://www.kcl.ac.uk/short-courses/acute-oncology-work-based-learning-level-7-7kanaowb (Accessed 15 October 2024)

Kippin, S. and Cairney, P. (2023) COVID-19 and the second exams fiasco across the UK: four nations trying to avoid immediate policy failure. *British politics*, 18, pp.151-172.

Kirkpatrick, I. Ackroyd, S. and Walker, R. (2005) *The new managerialism and public service professions. Change in health, social services and housing.* Basingstoke: Palgrave Macmillan.

Klein, R. (1983) *The politics of the National Health Service*. London: Longman.

Knill, C. Schulze, K. and Tosun, J. (2012) Regulatory policy outputs and impacts: exploring a complex relationship. *Regulation and Governance*, 6(4), pp.427-444.

Knill, C. and Tosun, J. (2020) *Public policy. A new Introduction, 2nd Edition*. Red Globe Press: London.

Krupp, A. Lasater, K. and McHugh, M. (2021) Intensive Care Unit Utilization Following Major Surgery and the Nurse Work Environment. *Advanced Critical Care*. 32(4), pp. 381-390.

Kuijper, S. Felder, M. Clegg, S. Bal, R. and Wallenburg, I. (2024). "We don't experiment with our patients!" An ethnographic account of the epistemic politics of (re)designing nursing work. *Social Science and Medicine*, 340, 116482.

Kus, B. (2006) Neoliberalism, institutional change and the welfare state: The case of Britian and France. International Journal of Comparative Sociology, 47(6), pp. 488-525

Lamberg, E. (2024) Shifting boundaries, dismantling brick walls: feminist knowledge in the struggles to transform economic thinking and policy. *Gender, Work and Organisation*, pp. 1-16.

Latimer, J. (2014) Nursing, the politics of organisation and the meaning of care. *Journal of Nursing Research*, 19(7-8), pp. 537-545.

Larson, M. (1977) *The rise of professionalism. A sociological analysis*. Berkley: University of California Press.

Larson, M. (1980) Proletarianization and educated labour. *Theory and Society*, 9(1), pp. 131-175.

Leary, A. (2023) *Thinking differently about nursing workforce challenges. Willaim Rathbone X Lecture*, 9th June, 2023. London. Available at: https://qni.org.uk/thinking-differently-about-nursing-workforce-challenges/ Accessed 20 March 2024).

Leary, A. and Dix, A. (2018) Using data to show the impact of nursing work on patient outcomes. *Nursing Times*, 114(10), pp. 23-25.

Leary, A. Maclaine, K. Trevatt, P. Radford, M. and Punshon, G. (2017) Variation in job titles within the nursing workforce. *Journal of Clinical Nursing*, 26(23-24), pp. 4945-4950.

Leatherman, S. and Sutherland, K. (2008) *The quest for quality: refining the NHS reforms. A policy analysis and chartbook*. London: The Nuffield Trust.

Le Grand, J. and Bartlett, W. (1993) *Quasi-markets and social policy*. London: Red Globe Press.

Le Grand, J. Mays, N. and Mulligan, J. (1998) *Leaning from the NHS internal Market. A review of the evidence*. London: The King's Fund.

Lewicki, R. Weiss, S. And Lewin, D. (1992) Models of conflict, negotiation and third-party intervention: a review and synthesis. *Journal of Organisational Behaviour*, 13(3), pp. 209-252.

Light, D. (1991) Professionalism as a countervailing power. *Journal of Health Politics, Policy and Law.* (16(3), pp. 499-506.

Light, D. (1993) Countervailing power: The changing character of the medical profession in the United States. In F, Hafferty. and J. McKinlay. (Eds) *The changing medical profession: An international perspective*. New York: Oxford University Press, pp. 69-80.

Light, D. (1995) Countervailing powers: A framework for professions in transition. In: Johnson, T. Larkin, G. and Saks, M (Eds) *Health Professions and the State in Europe.* London: Routledge, pp. 25-41.

Light, D. (2010) Health-care professions, markets, and countervailing powers In: Bird, C. Conrad, P. Fremont, A. and Timmermans, S. (Eds) *Handbook of Medical Sociology, 6th edition*. Nashville: Vanderbilt University Press, pp. 270-289.

Lipietz, A. (1994) Post-Fordism and Democracy. In: Amin, A. (Ed) *Post-Fordism: A reader*. London: Blackwell Publishers Ltd, pp, 338-357.

Lloyd, C. and Seifert, R. (1995) Restructuring in the NHS: the impact of the 1990 reforms on the management of labour. *Work, Employment and Society*, 9(2), pp. 359-378.

Liu, X. (2018) Interviewing elites: methodological issues confronting a novice. *International Journal of Qualitative Methods*, 17, pp. 1-9.

Locher, B. and Prugl, E. (2001) Feminism and constructivism: worlds apart or sharing middle ground? *International Studies Quarterly*, 45(1), pp. 111-129.

Lönngren, J. and van Poeck, K. (2021) Wicked problems: a mapping review of the literature. *International Journal of Sustainable Development and World Ecology*, 28(6), pp. 481–502.

Lowi, T. (1972) Four systems of policy, politics and choice. *Public Administration Review*, 32(4), pp. 298-310.

Lynn. K. (1963) Introduction to the issue 'the professions'. *Daedalus,* 92(4), pp. 649-654.

Maben, J. Morrow, E. Ball, J. Robert, G. and Griffiths, P. (2012) *High quality care metrics for nursing.* London: National Nursing Research Unit.

MacCormick, F. Emmett, C. Paes, P. and Hughes, J. (2018) Resuscitation decisions at the end of life. *Journal of Medical Ethics*, 44(6), pp. 376-383.

Macdonald, K. (1995) *The sociology of the professions*. London: Sage Publications.

Macmillan (2014) *Impact Brief: Cancer Clinical Nurse Specialists.* London: Macmillan Cancer Support.

Magnussen, A-M. and Banasiak, A. (2013) Juridification: Disrupting the relationship between law and politics. *European Law Journal,* 19(3), pp. 325-339.

Maher, F. and Tetreault, M. (1993) Frames of positionality: constructing meaningful dialogue about gender and race. *Anthropology Quarterly*, 66(3), pp. 118-126.

Marufu, T. Collins, A. Vargas, L. Gillespie, L. and Almghairbi, D. (2021) Factors influencing retention among hospital nurses: systematic review. *British Journal of Nursing*, 30(5), pp. 302-308.

Maybin, J. Addicott, R. Dissonant, A. and Storey, J. (2011) *Accountability in the NHS.* London: Kings Fund.

McHugh, M. Aiken, L. Sloane, D. Windsor, C. Douglas, C. and Yates, P. (2021) Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. *Lancet,* 22(397), pp. 1905-1913.

McNulty, T. and Ferlie, E. (2002) *Reengineering healthcare: the complexities of organisational transformation.* Oxford: Oxford University Press.

Meadows, D. (2008) *Thinking in systems: a primer*. New York: Chealsea Green Publishing.

Meyer, S. (1981) *The five dollar day: Labor management and social control in the Ford Motor Company, 1908-1921*. Albany: State University of New York Press.

McConnell, A. (2010) *Understanding policy success: rethinking public policy*. New York: Palgrave Macmillan.

McConnell, A. (2020) The use of placebo polices to escape form policy traps. *Journal of European Public Policy*, 27(7), pp. 957-976.

McLean, C. Monger, E. and Lally, I. (2005) Assessment of practice using the National Health Service Knowledge and Skills Framework. *Nursing in Critical Care*, 10(3), pp. 136–142.

Mik-Meyer, M. (2020) Multimethod qualitative research. In: Silverman, D. (Ed) *Qualitative research,* London: SAGE, pp. 357-374.

Milton, K. and Grit, J. (2015) Public health policy and walking in England – analysis of the 2008 'policy window'. *BMC Public Health*, 15, pp. 1-9.

Mills, J. Chamberlin-Salaun, J. Harrison, H. Yates, K. and O'Shea, A. (2016). Retaining early career registered nurses: A case study. *BMC Nursing*, 15(57), pp. 1-6.

Mohan, J. (1995) Post-Fordism and welfare: An analysis of change in the British health sector. *Environment and Planning A*, 27(10), pp.1555-1576.

Moran, M. (1992) The healthcare state in Europe: Convergence or divergence? *Environment and Planning C: Government and Policy*, 10(1), pp. 77-90.

Moran, M. (1999) *Governing the health care state, A comparative study of the United Kingdom, the United States and Germany*. Manchester: Manchester University Press.

Moran, M. (2000) From command state to regulatory state? *Public Policy and Administration*, 15(4), pp. 1-13.

Moran, V. Allen, P. and McDermott, I. (2018) *Investigating recent developments in the commissioning system*. Manchester: Policy Research Unit in Commissioning and the Healthcare System.

Morgan, B. and Yeung, K. (2007*) An introduction to law and regulation*. Cambridge: Cambridge University Press.

Mold, A. (2010) Patient groups and the construction of the patient-consumer in Britain: A historical overview. *Journal of Social Policy,* 39(4), pp. 505-521.

Murphy, E. and Dingwall, R. (2003) *Qualitative methods and health policy research.* London: Routledge.

National Audit Office (2009) *Department of Health. NHS Pay Modernisation in England: Agenda for Change.* London: The Stationary Office.

National Audit Office (2018) *A review of the role and costs of clinical commissioning groups*. London: National Audit Office.

National Audit Office (2022) *Introducing Integrated Care Systems: joining up local services to improve health outcomes.* Available at: https://www.nao.org.uk/wp-content/uploads/2022/10/Integrated-Care-Systems-Funding-and-accountability-for-local-health-and-care.pdf (Accessed 23 August 2024).

National Institute for Health and Care Excellence (2023) *What are the risk factors for stroke and TIA?* Available at: https://cks.nice.org.uk/topics/stroke-tia/background-information/risk-factors/ (Accessed 13 August 2024).

National Quality Board (2018) *Safe, sustainable and productive staffing. An improvement resource for adult inpatient wards in acute hospitals*. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/05/safe-staffing-adult-in-patient.pdf (Accessed 13 August 2024).

Navarro, V. (1986) *Crisis, health and medicine: A social critique*. London: Tavistock.

Needleman, R. and Nelson, A. (1988) Policy implications: the worth of women's work. In: Stratham, A. Miller, E. and Mauksch, H. (Eds) *The worth of women's work: a qualitative synthesis*. New York: State University New York, pp. 293-308.

Nelson, L. (1999) Bodies (and spaces) do matter: The limits of performativity. Gender, Place and Culture: *A Journal of Feminist Geography,* 6, pp.331–353.

Neuman, L. (2002) *Social research methods: Qualitative and quantitative approaches.* Boston: Allyn and Bacon.

NHS Business Services Authority (2024) *Future NHS Workforce Solution*. Available at: https://media.nhsbsa.nhs.uk/resources/nhsbsa-future-nhs-workforce-solution-nhs-england-programme-handout-july-2024 (Accessed 15 August 2024).

NHS England (2014a) *Winterbourne view – time for change. Transforming the commissioning of services for people with learning disabilities and/or autism. A report by the Transforming Care and Commissioning Steering Group, chair Sir Stephen Bubb.* London: NHS England.

NHS England (2014b) *The five year forward view.* London: NHS England.

NHS England (2016) *Leading change, adding value. A framework for nursing, midwifery and care staff.* London: NHS England.

NHS England (2019a) *The NHS Long term plan.* London: NHS England.

NHS England (2019b) *Interim NHS People Plan.* London: NHS England.

NHS England (2020) *We are the NHS: people plan for 2020/21 – action for us all*. London: NHS England.

NHS England (2023a) *Continuing Professional Development (CPD) Funding Guidance for Nursing Associates, Nurses, Midwives and AHPs in NHS Organisations / Primary Care Training Hubs 2023/24 Funding Process and Frequently Asked Questions.* Available at: https://www.ncltraininghub.org/assets/nursing/nhs-england---national-cpd-guidance-2023-24.pdf (Accessed 04 March 2024).

NHS England (2023b) *NHS Long term workforce plan.* London: NHS England.

NHS England (2024a) *NHS Workforce statistics interactive report, professionally qualified clinical staff by staff groups, NHS England region and organisation, full time equivalent, June 2024*. Available at: https://app.powerbi.com/view?r=eyJrIjoiMDU0ODdlZWMtYWE3My00NDMwLTk5ODktZTM3N2VjZDQ0NjViIiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9 (Accessed 15 October 2024).

NHS England (2024b) *NHS Vacancy Statistics England, April 2015 - March 2024, Experimental Statistics.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2024-experimental-statistics (Accessed 15 October 2024).

NHS England (2024c) *Professional nurse advocate A-EQUIP model: a model of clinical supervision for nurses.* Available at: https://www.england.nhs.uk/long-read/pna-equip-model-a-model-of-clinical-supervision-for-nurses/ (Accessed 13 August 2024).

NHS England and NHS Improvement (NHSEI) (2019) *The NHS Patient Safety Strategy Safer culture, safer systems, safer patients.* Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf (Accessed 24 September 2024).

NHS Employers (2021) *National job profiles. Combined nursing profiles.* Available at: https://www.nhsemployers.org/system/files/2024-09/Combined%20nursing%20profiles%20-%20JUL%202021.pdf (Accessed 14 October 2023).

NHS Employers (2023) *Nursing and midwifery national job profile review - Evidence report. May 2023*. Available at: https://www.nhsemployers.org/system/files/2023-05/Nursing%20and%20midwifery%20profile%20review%20evidence%20report_May%202023.pdf (Accessed 14 October 2023).

NHS Improvement (2019) *Model Hospital. Efficiency plan development support pack 2019/20.* Available at: https://model.nhs.uk/downloads/20190219_CIPSUPPORT_FINAL%20FULL.pdf (Accessed 21 May 2024).

NHS Staff Council (2010) *Appraisals and KSF made simple – a practical guide*. Available at: https://www.nhsemployers.org/system/files/2021-07/Appraisals-and-KSF-made-simple.pdf (Accessed 14 March 2022).

NHS Staff Council (2018) *Framework agreement on the reform of Agenda for Change.* Available at: https://www.nhsemployers.org/system/files/2021-06/2018-framework-agreement_0.pdf (Accessed 14 March 2022).

NHS Staff Survey (2024) *NHS Staff Survey 2023. National results briefing*. Available at: (https://www.nhsstaffsurveys.com/static/8fce170a75e46bc5b531253d2966c04b/National-Results-Briefing-2023-V3.pdf (Accessed 16 August 2024).

Noordegraaf, M. (2020) Protective or connective professionalism? How connected professionals can (still) act as autonomous and authoritative experts. *Journal of Professions and Organization*, 7, pp.205-223.

Noordegraaf, M. Douglas, S. Geuijen, K. and Van Der Steen, M. (2019) Weakness of wickedness: a critical perspective on wickedness theory. *Policy and Society*, 38(2), pp. 278-297.

Nuffield Trust (2022) *Health and Brexit: six years on*. London: Nuffield Trust.

Nursing and Midwifery Council (NMC) (2013) *NMC response to the Franics report. The response of the Nursing and Midwifery Council to the Mid Staffordshire NHS Foundation Trust Public Inquiry Report*. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/francis-report/nmc-response-to-the-francis-report-18-july.pdf (Accessed 15 October 2024).

Nursing and Midwifery Council (NMC) (2021) *Revalidation: Continuing professional development.* Available at: https://www.nmc.org.uk/revalidation/requirements/cpd/ (Accessed 15 October 2024).

Nursing and Midwifery Council (NMC) (2022a) *Leavers' survey 2022. Why do people leave the NMC register?* Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2022/leavers-survey-2022.pdf (Accessed 15 October 2024).

Nursing and Midwifery Council (NMC) (2022b) *Standards for post-registration*. Available at: https://www.nmc.org.uk/standards/standards-for-post-registration/ (Accessed 24 September 2024).

Nursing and Midwifery Council (NMC) (2024a) *The NMC Register. 1 April 2023-31 March 2024*. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/july-2024/annual-data-report-march-2024.pdf (Accessed 21 July 2024).

Nursing and Midwifery Council (NMC) (2024b) *The NMC Register England. 1 April 2023-31 March* 2024. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/july-2024/england-data-report-march-2024.pdf (Accessed 26 August 2024).

Nursing and Midwifery Council (NMC) (2024c) *NMC register leavers survey summary 2024.* Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/july-2024/annual-data-report-leavers-survey-2024.pdf (Accessed 15 October 2024).

Nursing and Midwifery Council (NMC) (2024d) *Standards for specialist education and practice Specialist education and practice.* Available at: https://www.nmc.org.uk/standards/standards-for-post-registration/pre-2022-post-registration-standards/standards-for-specialist-education-and-practice/ (Accessed 16 November 2024).

Oaten, R. and Plotkin, L. (2024) *Policy briefing: Strengthening the clinical educator workforce to meet future demand*. Available at: https://florence-nightingale-

foundation.org.uk/wp-content/uploads/2024/09/Clinical-Education-Workforce-Policy-Briefing-FINAL.pdf (Accessed 11 November 2024).

Office for Health Improvement and Disparities (2022) *Health disparities and health inequalities: applying All Our Health.* Available at: https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health (Accessed 08 April 2024).

Office for National Statistics (2022*) Deaths due to COIVD-19, registered in England and Wales: 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsregisteredduetocovid19/2021 (Accessed 17 August 2024).

O'Flynn, J. (2013) Crossing boundaries. The fundamental questions in public management and policy. In: O'Flynn, J. Blackman, D. and Halligan, J. (Eds) *Crossing boundaries in public management and policy. The international experience*. Oxford: Taylor and Francis Group, pp. 11-44.

Osipovic, S. Allen, P. Sanderson, M. Moran, V. Checkland, K. (2020) The regulation of competition and procurement in the National Health Service 2015-2018: enduring hierarchical control and the limits of juridification. *Health Economics, Policy and Law*, 15, pp.308-324.

Olgiati, V. (2003). Geo-political constructionism: The challenge of Europe to the comparative sociology of the professions. In: Svensson, L. and Evetts, J. (Eds) *Conceptual and comparative studies of Continental and Anglo-American professions.* Göteborg: Göteborg University.

Osborne, S. (2006) The new public governance? *Public Management Review,* 8(3), pp. 377-387.

Oppenhimer, M. (1972) The proletarianization of the professional. *The Sociological Review*, 20(1), pp. 213-227.

Palaganas, E. Sanchez, M. Molintas, M. and Caricativo, R. (2017) Reflexivity in qualitative research: a journey of learning. *The Qualitative Report,* 22(2), pp.426-438.

Parker, C. Scott, S. and Geddes, A. (2019) Snowball sampling. In: Atkinson, P. (Ed) *Sage Research Methods Foundations.* London: SAGE, pp. 1-9.

Parish, C. (2007) Relaunch of NHS Knowledge and Skills Framework to boost trust co-operation. *Nursing Standard,* 21(41), p.6.

Parishani, N. Mehraban, MA. and Naesh, L. (2021) Nurses' views: organizational resource consumption models in hospitals. *Journal of Advanced Pharmacy Education Resources*, 11(2), pp. 156-162.

Parkin, F. (1982) *Max Weber.* New York: Routledge.

Paton, C. (2006) *New Labour's State of Health. Political economy, public policy, and the NHS*. Ashgate Publishing Limited: Aldershot.

Paton, C. (2013) Never say never again: reforming and deforming the NHS. *Health Economics, Policy, and Law,* 8, pp.243-249.

Paton, C. (2014a) Garbage-can policy making meets neo-liberal ideology: Twenty-five years of redundant reform of the English National Health Service. *Social Policy and Administration*, 48(3), pp. 319-342.

Paton, C. (2014b) The politics and analytics of health policy. *International Journal of Health Policy Management,* 2(3), pp.105-107.

Paton, C. (2016) *The politics of health policy reform in the UK. England's permanent revolution.* London: Palgrave Macmillan.

Paton, C. (2022) *NHS reform and health politics in the UK. Revolution, counter-revolution and covid crisis*. London: Palgrave Macmillan.

Pawson, R. Greenhalgh, J. and Brennan, C. (2016) *Demand management for planned care: a realist synthesis*. Southampton: NIHR Journals Library.

Pavolini, E. and Kuhlmann, E. (2016) Health workforce development in the European Union: A matrix for comparing trajectories of change in the professions. *Health Policy*, 120(6), pp. 654-664.

Pinch, S. (1994) Labour flexibility and the changing welfare state: is there a post-Fordist model? In: Burrows, R. and Loader, B. (Eds) Towards a post-Fordist welfare State. London: Routledge, pp. 2013-222.

Pollitt, C. and Bouckaert, G. (2000) *Public Management Reform: A Comparative Analysis*. Oxford: Oxford University Press.

Porter, S. (1992) Women in a women's job: the gendered experience of nurses. *Sociology of Health and Illness*, 14(4), pp. 510-527.

Powell, M. (2016) Reforming a health care system in a big way? The case of change on the British NHS. *Social Policy and Administration*, 50(2), pp. 183-200.

Powell, W. (1990) Neither market nor hierarchy: Network forms of organization. *Research in Organizational Behaviour*, 12, pp. 295-336.

Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010) *Front line care*. London: Prime Minister's Commission on the Future of Nursing and Midwifery in England.

Propper, C. (1995) Agency and incentives in the NHS internal market. *Social Science and Medicine,* 40(12), pp. 1683-1690.

Punshon, G. Maclaine, G. Trevatt, P. Radford, M. Shanley, O. and Leary, A. (2019) Nursing pay by gender distribution in the UK - does the glass escalator still exist? *International Journal of Nursing Studies*, 93, pp. 21-29.

Quick, O. (2017) *Regulating patient safety. The end of professional dominance?* Cambridge: Cambridge University Press.

Radford, M. (2012). *Power dynamics and professional expertise in the communication between specialist nurses and doctors in a cute hospital settings.* Thesis. Birmingham: Birmingham City University.

Rafferty, A-M. (1996) *The politics of nursing knowledge.* London: Routledge.

Rafferty, A-M, Clarke, S. Coles, J. Ball, J. James, P. McKee, M. and Aiken, L. (2007) Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional

analysis of survey data and discharge records. *International Journal of Nursing Studies*, 44(2), pp. 175-82.

Rafferty, A-M. and Leary, A. (2023) Nursing notes on a scandal. *Future Healthcare Journal*, 10(1), pp. 3-6.

Rafferty, A-M. and Robinson, J. (1996) *Nursing history and the politics of welfare*. London: Routledge.

Rafferty, A-M, Xyrichis, A. and Caldwell, C. (2015) *Post-graduate education and career pathways in nursing: a policy brief: Report to Lord Willis, Independent Chair of the Shape of Caring Review*. King's College London: National Nursing Research Unit.

Reich, M. (2019) Political Economy of Non-Communicable Diseases: From Unconventional to Essential. *Health Systems and Reform*, 5(3), pp. 250-256.

Rhodes, R. (1997) *Understanding governance.* Buckingham: Open University Press.

Richards, D. and Smith, M. (2004) The hybrid state. In: Ludlam, S. and Smith, M. (Eds) *Governing as New Labour*. London: Red Globe Press.

Riska, E. (2010) Health professions and occupations In: Cockerham, W. (Ed) *The New Blackwell Companion to Medical Sociology*. Oxford: Blackwell Publishing Ltd, pp. 335-354

Ritter-Teitel, J. (2002) The impact of restructuring on professional nursing practice. *Journal of Nursing Administration*, 32(1), pp. 31-41.

Royal College of Nursing (RCN) (2019) *Continuing professional development in England*. London: Royal College of Nursing.

Royal College of Nursing (RCN) (2020) *Gender and nursing as a profession*. London: Royal College of Nursing.

Royal College of Nursing (RCN) (2024a) *State of the profession report. RCN employment survey 2023.* Available at: https://www.rcn.org.uk/Professional-Development/publications/rcn-employment-survey-2023-uk-pub-011-484 (Accessed 16 August 2024).

Royal College of Nursing (RCN) (2024b) *RCN helps secure thousands of pounds for wrongly paid nurses.* Available at: https://www.rcn.org.uk/news-and-events/news/uk-rcn-helps-secure-thousands-of-pounds-for-wrongly-paid-nurses-150524#:~:text=Nurses%20in%20Northern%20Ireland%20are,band%205%20to%20band%206. (Accessed 08 October 2024).

Royal College of Radiologists (RCR) (2021) *Clinical oncology speciality training curriculum*. Available at: https://www.gmc-uk.org/-/media/documents/clinical-oncology-curriculum-update-310523-admin-change.pdf (Accessed 24 September 2024).

Royal College of Surgeons of England (RCSE) (2016) *A question of balance: the extended surgical team*. London: Royal College of Surgeons.

Royal College of Surgeons of England (RCSE) (2024) *Advanced Trauma Nursing Course ATNC Provider.* Available at: https://www.rcseng.ac.uk/education-and-exams/courses/search/advanced-trauma-nursing-course-atnc-provider/ (Accessed 15 October 24).

Saks, M. (2010) Analyzing the professions: The case for a neo-Weberian approach. *Comparative Sociology*, 9(6), pp. 887-915.

Saks, M. (2016) A review of theories of professions, organizations and society: The case for neo-Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organisation*, 3(2), pp. 170-187.

Saks, M. (2020) *RE: Enhanced neo-Weberian perspective question.* Email to Nicola Fisher, 22 May 20.

Saks, M. and Adams, T. (2019) Neo-Weberianism, professional formation and the state: inside the black box. *Professions and Professionalism*, 9(2), pp. 1-14.

Saunders, P. (2007) *Urban politics: A sociological interpretation.* Abingdon: Routledge.

Scott, A. Harvey, C. Felzmann, H. Riitta, S. Habermann, M. Halvorsen, K. Christiansen, K. Toffoli, L. Papastavrou, E. (2019) Resource allocation and rationing in nursing care: A discussion paper. *Nursing Ethics*, 26(5), pp. 1528-1539.

Senier, L. Lee, R. and Nicoll, L. (2017) The strategic defence of physician autonomy: state public health agencies as countervailing powers. *Social Science and Medicine*, 186, pp. 113 – 121.

Silverman, D. (2016) *Qualitative Research. 4th Edition*. London: Sage Publications Ltd.

Sin, H. (2003) Interviewing in 'place': the socio-spatial construction of interview data. *Area,* 35, pp.305–312.

Simonet, D. (2015) The New Public Management Theory in the British healthcare system: a critical review. *Administration and Society*, 47(7), pp. 802-826.

Skills for Health (2021) *UK Core Skills Training Framework. Statutory/Mandatory Subject Guide. Version 1.6.2*. London: Skills for Health.

Smelser, N. and Smedberg, R. (2005) *The handbook of economic sociology. 2nd Edition*. Princeton: Princeton University Press.

Smith, K. (2002) Typologies, taxonomies and the benefits of policy classification. *Policy Studies Journal*, 30(3), pp. 379-395.

Smith, K. and Larimer, C. (2009) *The public policy theory primer.* Boulder: Westview Press.

Sofaer, S. (1999) Qualitative methods: what are they and why use them? *Health Services Research*, 34(5 pt2), pp. 1101-1118.

Solarion, A. and Aguinis, H. (2021) Challenges and best-practice recommendations for designing and conducting interviews with elite informants. *Journal of Management Studies,* 58(3), pp. 649-672.

Som, C. (2009) Sense making of clinical governance at different levels on NHS hospital trusts. *Clinical Governance: An international Journal*, 14(2), pp. 98-112.

Som, C. (2011) Clinical governance and attention to human resources. *British Journal of Healthcare Management.* 17(11), pp. 531-540).

Spencer, D. (2009) *The political economy of work*. Abington: Routledge.

Spencer, H. (1896) *The principles of sociology: Vol II.* London: Williams and Norgate.

Stanilard, K. (2009) A sociological ethnographic study of clinical governance implementation in an NHS Hospital Trust. *Clinical Governance: An International Journal*, 14(4), pp. 271-280.

Stanilard, K. (2010) Studying organisations: the revival of institutionalism In: Bourgeault, I. Dingwall, R. and de Vries, R. (Eds) *The SAGE Handbook of qualitative methods in health research*. London: SAGE Publications Ltd.

Stanley, L. and Wise, S. (1993) *Breaking out again: feminist ontology and epistemology,* 2nd ed. London: Routledge.

Star, S. (2010) This is not a boundary object: reflections on the origin of a concept. *Science, Technology and Human Values,* 35(5), pp. 601-617.

Star, S. and Griesemer, J. (1989) Institutional ecology, "translations" and boundary objects: amateurs and professionals in Berkely's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science*, 19(3), pp. 387-420.

Staines, R. (2007) KSF being sidelined by NHS reform. *Nursing Times,* 103(7), p 3.

Stewart, L. and Rae, A (2012) Critical Care nurses' understanding of the NHS knowledge and skills framework. An interpretative phenomenological analysis. *Nursing in Critical Care,* 18(1), pp. 23-31.

Stone, P. and Hernandez, L. (2013) The all or nothing workplace: flexibility stigma and "opting out" among professional-managerial women*. Journal of Social Issues*, 69(2), pp. 235-256.

Storey, J. (2014) *New perspectives on human resource management*. London: Routledge.

Syrett, K. (2007) *Law, legitimacy and the rationing in healthcare*. Cambridge: Cambridge University Press.

Taylor, S. Rizvi, F. Lingard, B. and Henry, M. (1997) *Education policy and the politics of change*. London: Routledge.

Teubner, G. (1987) *Juridifcation of social spheres: a comparative analysis in the areas of labor, corporate, antitrust and social welfare law*. Berlin, Boston: De Gruyter.

Thaler, R. and Sunstein, C. (2008) *Nudge: Improving decisions about health, wealth and happiness*. Yale: Yale University Press.

Thompson, P. (2003) Disconnected capitalism: Or why employers can't keep their side of the bargain. *Work, Employment and Society,* 17(2), pp. 359–78.

The Gold Guide (2022) *A Reference Guide for Postgraduate Foundation and Specialty Training in the UK*. 9th Edition. Available at: https://www.copmed.org.uk/images/docs/gold-guide-9th-edition/Gold-Guide-9th-Edition-August-2022.pdf (Accessed 24 September 2024).

The Health Foundation (2019) *Untapped potential: Investing in health and care data analytics*. London: The Health Foundation.

The Health Foundation (2021) *Nurse supply model: a review of economic factors affecting nurse supply.* London: Health Foundation.

The Health Foundation (2022) *How better use if data can help address key challenges facing the NHS*. Available at: https://www.health.org.uk/publications/long-reads/how-better-use-of-data-can-help-address-key-challenges-facing-the-nhs (Accessed 12 March 2024).

The Health Foundation (2023a) *Nine major challenges facing health and care in England*. Available at: https://www.health.org.uk/publications/long-reads/nine-major-challenges-facing-health-and-care-in-england (Accessed 12 November 2024).

The Health Foundation (2023b) *Health in 2040: projected patterns of illness in England*. Available at: https://www.health.org.uk/publications/health-in-2040 (Accessed 12 November 2024).

The Health Foundation (2023c) *The REAL Centre's role in assessing NHS England's projections modelling*. Available at: https://www.health.org.uk/funding-and-partnerships/projects/nhs-england-s-long-term-workforce-plan (Accessed 12 March 2024).

The King's Fund (2016) *Sustainability and transformation plans in the NHS*. Available at:

https://assets.kingsfund.org.uk/f/256914/x/9e43ad07f4/sustainability_transformation_plans_nhs_2016.pdf (Accessed 10 October 2024).

The King's Fund (2023) *The NHS Long Term Workforce Plan explained*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/nhs-long-term-workforce-plan-explained (Accessed 16 August 2024).

Timmermans, S. (2008) Professions and their work. Do market shelters protect professional interests? *Work and Occupations*, 35(2), pp. 164-188.

Timmermans, S. and Kolker, E. (2004) Evidence based medicine and the reconfiguration of medical knowledge. *Journal of Health and Social Behaviour*, 45, pp.177-193.

Timmins, N. (1995) *The five giants: a biography of the welfare state*. London: Haper Collins.

Timmins, N. (2012) *Never again? The story of the Health and Social Care Act 2012. A study in coalition government and policy making.* London: The King's Fund.

Timmins, N. (2013) *The four UK health systems. Learning from each other.* London: The King's Fund.

Timmins, N (2018) *The world's biggest quango. The first five years of NHS England.* London: The Institute for Government and The King's Fund.

Traynor, M. (1999) *Managerialism and nursing. Beyond oppression and profession*. London: Routledge.

Traynor, M. (2013) *Nursing in context: Policy, politics profession*. London: Palgrave.

Thomson, J. (2018) Resisting gendered change: feminist institutionalism and critical actors. *International Political Science Review*, 39(2), pp. 178-191.

Tosun, J. and Schnepf, J. (2020) Measuring change in comparative policy analysis: concepts and empirical approaches. In: Peter, G. and Fontained, E. (Eds) *Handbook of Research methods and Applications in Comparative Policy*. Cheltenham: Edward Elgar.

Tuana, N. (2001) Introduction. In: Tuana, N. and Morgen, S. (Eds) *Engendering rationalities*. State University of New York Press: Albany, pp. 1-20.

UK Parliament (2024) *What is an Act of Parliament?* Available at: https://www.parliament.uk/about/how/laws/acts/ (Accessed 16 August 2024).

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *The scope of professional practice*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

University Hospitals Association (2024) *Who we are*. Available at: https://www.universityhospitals.org.uk/who-we-are/ (Accessed 13 August 2024).

Usher, P. (1997) Challenging the power of rationality. In: McKenzie, G. Powell, J. and Usher, R. (Eds) *Understanding social research: perspectives on methodology.* London: Falmer Press, pp. 42-55.

van Schothorst-van Roekel, J. Weggelaar-Jansen, A. Hilders, C. De Bont, A. and Wallenburg, I. (2021) Nurses in the lead: a qualitative study on the development of distinct nursing roles in daily nursing practice. *BMC Nursing*, 20(97), pp. 1-11.

Veitch, S. Christodoulidis, E. and Goldoni, M. (2012) *Jurisprudence: themes and concepts. 2nd Edition*. London: Routledge.

Veitch, K. (2012) Juridification, medicalisation and the impact of EU law: patient mobility and the allocation of scare NHS resources. *Medical Law Review*, 20(3), pp. 362-398.

Vincent-Jones, P. (2006) *The new public contracting. Regulation, responsiveness, relationality*. Oxford: Oxford University Press.

Vinson, A. (2016) 'Constrained collaboration': patient empowerment discourse as resource for countervailing power. *Sociology of Health and Illness*, 38(8), pp. 1364 – 1378.

Waddan, A. (2011) The politics and changing political economy of health care in the US and in the UK. In: Casey, T. (Ed) *The legacy of the crash.* London: Palgrave Macmillan, pp. 201-220.

Walby, S. Greenwell, J, Mackay, L. and Soothill, K. (1994) *Medicine and nursing: professions in a changing health service*. London: Sage.

Wallenburg, I. Friebel, R. Winblad, U. Pujolras, L. and Bal, R. (2023) 'Nurses are seen as general cargo, not the smart TVs you ship carefully': the politics of nurse staffing in England, Spain, Sweeden, and the Netherlands. *Health Economics, Policy and Law,* 18, pp. 411-425.

Walshe, K. (2000) *Clinical governance: a review of the evidence*. Birmingham: Health Services Management Centre, University of Birmingham.

Walshe, K. and Higgins, J. (2002) The use and impact of inquiries in the NHS. *BMJ,* 325, pp. 895–900.

Walshe, K. Smith, J. Lamont, T. and Leary, A. (2024) Workforce research priorities for resilience to future health shocks—and the workforce crisis. *BMJ*, 387, pp. 1-5.

Wanger, D. (1980) The proletarianization of nursing in the United States 1932-1946. *International Journal of Health Services*. 10(2), pp. 271-290.

Waring, J. (2014) Restratification, hybridity and professional elites: questions of power, identity and relational contingency at the points of professional-organisational intersecti9on. *Sociology Compass*, 8(6), pp. 688-704.

Warner, C. Black, V. and Parent, P. (1998) Image of Nursing. In: Deloughery, G. (Ed) *Issues and Trends in Nursing* (3rd Ed) St Louis: Mosby, pp.390-411.

Weber, P. and Khademian, A. (2008) Wicked problems, knowledge challenges, and collaborative capacity builders in network settings. *Public Administration Review*, 68(2), pp. 334–349.

Weeden, K. (2002) Why do some occupations pay more than others? Social closure and earnings inequality. *American Journal of Sociology*, 108(1), pp. 55-101.

Weingast, B. and Wittman, D. (2008) *The Oxford handbook of political economy.* Oxford: Oxford University Press.

Wengraft, T. (2001) *Qualitative Research Interviewing.* London: Sage.

White, R. and Taylor, S. (2002) Nursing practice should be informed by the best available evidence, but should all first-level nurses be competent at research appraisal and utilization? *Nurse Education Today*, 22, pp. 220-224.

Whittock, M. Edwards, C. McLaren, S. and Robinson, O. (2002) 'The tender trap': gender, part-time nursing and the effects of 'family-friendly' polices on career advancement. *Sociology of Health and Illness*, 24(3), pp. 305-326.

Willis, P. (2012) *Quality with compassion: the future of nursing education. Report of the Willis Commission 2012.* London: Royal College of Nursing.

Wise, S. Duffield, C. Fry, M. and Roche, M. (2017) Workforce flexibility – in defence of professional healthcare work. *Journal of Health Organisation and Management*, 31(4), pp. 503-516.

Witz, A. (1992) *Professions and patriarchy*. London, Routledge.

World Health Organization (WHO) (2019) *Delivered by women, led by men: A gender and equity analysis of the global health and social care workforce*. Geneva: World Health Organisation.

World Health Organisation (WHO) (2023) *WHO health workforce support and safeguards list 2023.* Available at: https://iris.who.int/bitstream/handle/10665/366398/9789240069787-eng.pdf?sequence=1 (Accessed 15 October 2024).

Wu, X. Howlett, M. Ramesh, M. and Fritzen, S. (2017) *The public policy primer*, 2nd edition. London: Routledge.

Wuest, J. (1994) Professionalism and the evolution of nursing as a discipline: A feminist perspective. *Journal of Professional Nursing,* 10(6), pp. 357-367.

Xie, A. and Carayon, P. (2014) A systematic review of human factors and ergonomics (HFE)-based healthcare system redesign for quality of care and patient safety. *Ergonomics*, 58(1), pp. 33–49.

Zuckerman, H. (1996) *Scientific Elite.* New Brunswick: Transaction Publishers.

Appendix 1: Interview schedules – macro, meso and micro

Macro

General: What do you think is the current state of nursing post-registration development?

What do you think are the main challenges and barriers?

Where do you think the opportunities lie for change?

Aspects to ask about from document analysis:

Clinical governance, Agenda for Change influence and impact. e.g. do you think they impact/impact?

` Data availability and use, e.g., What is your opinion on data for post-registration development?

Changes in healthcare governance and policy, e.g. how/do changes in policy impact?

Meso

General: What do you think is the current state of nursing post-registration development?

What do you think are the main challenges and barriers?

Where do you think the opportunities lie for change?

Aspects to ask about from document analysis and macro interviews

Clinical governance, Agenda for Change influence and impact (as above)

` Data availability and use (as above)

Changes in healthcare governance and policy (as above)

Translating policy to organisational delivery e.g. what are/are there challenges?

Accountability and leadership e.g. presence, issues, challenges

Micro

General: What does post-registration development mean to you?

What do you think is the current state of nursing post-registration development?

What does having a career in nursing mean to you?

What do you think are the main challenges and barriers?

Where do you think the opportunities lie for change?

Aspects to ask about from document analysis, macro and meso interviews

Clinical governance, Agenda for Change influence and impact (as above)

Data availability and use (as above)

Influence of policy on post-reg development, e.g. how do you think it impacts?

Accountability, transparency and leadership (as above)

Appendix 2: Initial list of documents

Document title	Publication year	Government administration	Author(s)/publisher
Working for Patients	1989	Conservative	Department of Health
Working for patients – paper 2 Funding and contracts for hospital services	1989	Conservative	Department of Health
Working for patients – paper 10 Education and Training	1989	Conservative	Department of Health
The health of the nation	1992	Conservative	Department of Health
The National Health Service. A service with ambitions	1996	Conservative	Department of Health
The new NHS. Modern, dependable	1997	Labour	Department of Health
A first class service: quality for the new NHS	1998	Labour	Department of Health
Working together. Securing a quality workforce for the NHS	1998	Labour	Department of Health
Nurse, midwife and health visitor consultants: Establishing posts and making appointments.	1999	Labour	Department of Health
Making a difference. Strengthening the nursing, midwifery and health visiting contribution to health and healthcare	1999	Labour	Department of Health
Agenda for Change: Modernising the NHS pay system'	1999	Labour	Department of Health

A health service for all talents: developing the NHS workforce.	2000	Labour	Department of Health
The NHS plan. A plan for investment. A plan for reform	2000	Labour	Department of Health
Shifting the balance of power within the NHS. Securing delivery	2001	Labour	Department of Health
Delivering the NHS plan	2002	Labour	Department of Health
Skill-mix and policy change in the health workforce: Nurses in advanced roles	2004	Labour	Buchan, J. and Calman, L.
The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process	2004	Labour	Department of Health
NHS job evaluation handbook	2004	Labour	Department of Health
The NHS improvement plan. Putting people at the heart of public service	2004	Labour	Department of Health
Agenda for Change: Final agreement	2004	Labour	Department of Health
Modernising nursing careers: Setting the direction	2006	Labour	Department of Health
Developing the best research professionals. Qualified graduate nurses: recommendations for preparing and supporting clinical academic nurses of the future. Report of the UKCRN Subcommittee for nurses in clinical research (workforce).	2007	Labour	UK Clinical Research Collaboration
Advanced nursing roles: survival of the fittest? Issue 6. Policy plus	2007	Labour	National Nursing Research Unit

evidence, issues and opinions in healthcare			
Our NHS our future. NHS next stage review	2007	Labour	Department of Health
Towards a framework for post-registration Nursing careers: Consultation document.	2007	Labour	Department of Health
High quality care for all. NHS next stage review final report	2008	Labour	Department of Health
A high quality workforce	2008	Labour	Department of Health
Framing the Nursing and Midwifery contribution driving up the quality of care	2008	Labour	Department of Health
Towards a framework for post-registration Nursing careers: Consultation response report.	2008	Labour	Department of Health
The Code. Standards of conduct, performance and ethics for nurses and midwives	2008	Labour	Nursing and Midwifery Council
Department of Heath NHS Pay modernisation in England: Agenda for Change	2009	Labour	National Audit Office
NHS Health and well-being. Interim report.	2009	Labour	Department of Health
NHS Pay Modernisation in England: Agenda for Change	2009	Labour	House of Commons Public Accounts Committee
NHS Health and well-being. Review on NHS staff	2009	Labour	Department of Health
NHS 2010-2015: from good to great	2009	Labour	Department of Health
Preceptorship framework for newly registered Nurses, Midwives and Allied Health Professionals.	2010	Labour	Department of Health
Front line care. Report by the Prime Minister's	2010	Labour	The Prime Minister's

Commission on the Future of Nursing and Midwifery in England 2010			Commission on the Future of Nursing and Midwifery in England
Equity and Excellence	2010	Conservative& Liberal Democrats coalition	Department of Health
Advanced level practice: A position statement	2010	Conservative& Liberal Democrats coalition	Department of Health
Clinical academic careers for nursing, midwifery and allied health professionals	2012	Conservative& Liberal Democrats coalition	Council of Deans for Health
Quality with compassion: the future of nursing education	2012	Conservative& Liberal Democrats coalition	Willis Commission
Compassion in practice. Nursing midwifery and care staff. Our vision and strategy	2012	Conservative& Liberal Democrats coalition	Department of Health
The NHS workforce: how do we balance cost-effectiveness with safety? Time to think differently	2013	Conservative& Liberal Democrats coalition	Buchan, J. (for the King's Fund)
Five Year Forward View	2014	Conservative& Liberal Democrats coalition	NHS England
Workforce planning guidance for the 2014/15 round for 2015/16 education commissions	2014	Conservative& Liberal Democrats coalition	Health Education England
Compassion in practice: two years on	2014	Conservative& Liberal Democrats coalition	NHS England
Clinical academic careers framework: A framework for optimising clinical academic careers across healthcare professions	2014	Conservative& Liberal Democrats coalition	Health Education England
Raising the bar. Shape of caring: A review of the future education	2015	Conservative& Liberal Democrats coalition	Health Education England

and training of registered nurses and care assistants.			
The Code. Professional standards of practice and behaviour for nurses and midwives.	2015	Conservative& Liberal Democrats coalition	Nursing and Midwifery Council
Post-graduate education and career pathways in nursing: a policy brief. Report to Lord Willis, Independent Chair of the Shape of Caring Review.	2015	Conservative& Liberal Democrats coalition	Rafferty, A. Xyrichis, A. and Cladwell, C. (for the National Nursing Research Unit as part of the Shape of Caring review)
Investing in people for health and healthcare: Workforce plan for England. Proposed education and training commissions for 2016/2017.	2015	Conservative& Liberal Democrats coalition	Health Education England
RCN factsheet: Continuing professional development (CPD) for nurses working in the United Kingdom (UK).	2016	Conservative	Royal College of Nursing
Leading change, Adding Value; A framework for nursing, midwifery and care staff	2016	Conservative	NHS England
Developing people – improving care	2016	Conservative	NHS Improvement
Retaining your clinical staff: a practical improvement resource	2017	Conservative	NHS Improvement
Transforming healthcare through clinical academic roles in nursing, midwifery and allied health professions. A practical resource for healthcare provider organisations	2017	Conservative	Association of UK University Hospitals

Rising Pressure: the NHS workforce challenge.	2017	Conservative	Buchan, J. Charlesworth, A. Gershlick, B. and Seccombe, I (for the Health Foundation)
Multi-professional framework for advanced clinical practice in England	2017	Conservative	Heath Education England
There for us. A better future for the NHS workforce	2017	Conservative	NHS Providers
Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027.	2017	Conservative	Health Education England
Next steps on the NHS Five Year Forward View	2017	Conservative	NHS England
The nursing workforce. Second report of session 2017-2019. HC 353	2018	Conservative	House of Commons Health Committee
Clinical academic careers framework: A framework for optimising clinical academic careers across healthcare professions. Revised edition.	2018	Conservative	Health Education England
Review of research nursing and midwifery across the UK and Ireland in 2017: Structures, strategies and sharing. The Whitehouse Report.	2018	Conservative	Whitehouse, C. and Smith, H. (for the Florence Nightingale Foundation)
Developing a strategy for the health and care workforce in England. Summary of a roundtable discussion.	2018	Conservative	The King's Fund
Nursing, midwifery and allied health clinical academic research careers in the UK.	2018	Conservative	Bultruks, D. and Callaghan, P. (for Council of Deans)

Investing in a safe and effective workforce Continuing professional development for nurses in the UK. Policy report	2018	Conservative	Royal College of Nursing
Advanced level Nursing practice. Royal College of Nursing standards for advanced level Nursing practice.	2018	Conservative	Royal College of Nursing
Developing workforce safeguards. Supporting providers to deliver high quality care through safe and affective staffing	2018	Conservative	NHS Improvement
The health care workforce in England. Make or break?	2018	Conservative	The Health Foundation, The King's Fund and the Nuffield Trust
Report on District Nurse Education in the United Kingdom 2016 – 2017- and Five-Year Review	2018	Conservative	The Queen's Nursing Institute
The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates	2018	Conservative	Nursing and Midwifery Council
The NHS long term plan.	2019	Conservative	NHS England
Interim NHS people plan	2019	Conservative	NHS England
A critical moment: NHS staffing trends, retention and attrition	2019	Conservative	Buchan, J. Charlesworth, A. Gershlick, B. and Secombe, I. (for the Health Foundation)
Revalidation. How to revalidate with the NMC. Requirements for renewing your registration.	2019	Conservative	Nursing and Midwifery Council
Closing the gap. Key areas for action on the health and care workforce.	2019	Conservative	Beech, J. Bottery, S. Charlesworth, A. Ecvans, H. Gershlick, B.

			Hemmings, N. Imison, C. Kahtan, P. McKenna, H. Murry, R. and Palmer, B. (for The Health Foundation, The King's Fund and the Nuffield Trust)
The NHS nursing workforce. HC 109	2020	Conservative	National Audit Office
We are the NHS: People plan for 2020-21 – action for us all	2020	Conservative	NHS England
Our NHS people promise	2020	Conservative	NHS England
Consultation: Education, learning and development strategy 2021-2024. RCN Group ELD strategy consultation	2020	Conservative	Royal College of Nursing
Principles for Preceptorship	2020	Conservative	Nursing and Midwifery Council
NHS nursing workforce. HC 408	2020	Conservative	House of Commons

Appendix 3: Final list of documents

Document title	Publication year	Government administration	Author(s)/publisher
Working for Patients – main document	1989	Conservative	Department of Health
Working for patients – paper 2 Funding and contracts for hospital service	1989	Conservative	Department of Health
Working for patients – paper 10 Education and Training	1989	Conservative	Department of Health
The health of the nation	1992	Conservative	Department of Health
The National Health Service. A service with ambitions	1996	Conservative	Department of Health
The new NHS. Modern, dependable	1997	Labour	Department of Health
A first class service: quality for the new NHS	1998	Labour	Department of Health
Working together. Securing a quality workforce for the NHS	1998	Labour	Department of Health
Making a difference. Strengthening the nursing, midwifery and health visiting contribution to health and healthcare	1999	Labour	Department of Health
Agenda for Change: Modernising the NHS pay system'	1999	Labour	Department of Health
A health service for all talents: developing the NHS workforce.	2000	Labour	Department of Health

The NHS plan. A plan for investment. A plan for reform	2000	Labour	Department of Health
Shifting the balance of power within the NHS. Securing delivery	2001	Labour	Department of Health
Delivering the NHS plan	2002	Labour	Department of Health
The NHS improvement plan. Putting people at the heart of public service	2004	Labour	Department of Health
The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process	2004	Labour	Department of Health
NHS job evaluation handbook	2004	Labour	Department of Health
Agenda for Change: final agreement	2004	Labour	Department of Health
Modernising nursing careers: Setting the direction	2006	Labour	Department of Health
Our NHS our future. NHS next stage review	2007	Labour	Department of Health
Towards a framework for post registration nursing careers.	2007	Labour	Department of Health
High quality care for all. NHS next stage review final report	2008	Labour	Department of Health
A high quality workforce	2008	Labour	Department of Health
Framing the Nursing and Midwifery contribution driving up the quality of care	2008	Labour	Department of Health
Towards a framework for post-registration Nursing careers: Consultation response report.	2008	Labour	Department of Health
Department of Health. NHS Pay Modernisation in England: Agenda for Change	2009	Labour	National Audit Office

NHS Pay Modernisation in England: Agenda for Change	2009	Labour	House of Commons Public Accounts Committee
NHS 2010-2015: from good to great	2009	Labour	Department of Health
Front line care. Report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010	2010	Labour	The Prime Minister's Commission on the Future of Nursing and Midwifery in England
Equity and Excellence: liberating the NHS	2010	Conservative& Liberal Democrats coalition	Department of Health
Quality with compassion: the future of nursing education	2012	Conservative& Liberal Democrats coalition	Willis Commission
Compassion in practice. Nursing midwifery and care staff. Our vision and strategy	2012	Conservative& Liberal Democrats coalition	Department of Health
Workforce planning guidance for the 2014/15 round for 2015/16 education commissions	2014	Conservative& Liberal Democrats coalition	Health Education England
Five Year Forward View	2014	Conservative& Liberal Democrats coalition	NHS England
Compassion in practice: two years on	2014	Conservative& Liberal Democrats coalition	NHS England
Raising the bar. Shape of caring: A review of the future education and training of registered nurses and care assistants.	2015	Conservative& Liberal Democrats coalition	Health Education England
Post-graduate education and career pathways in nursing: a policy brief. Report to Lord Willis, Independent Chair of the Shape of	2015	Conservative& Liberal Democrats coalition	Rafferty, A. Xyrichis, A. and Cladwell, C. (for the National Nursing Research Unit as part of the Shape of Caring review)

Caring Review.			
Investing in people for health and healthcare: Workforce plan for England. Proposed education and training commissions for 2016/2017.	2015	Conservative& Liberal Democrats coalition	Health Education England
Leading change, Adding Value; A framework for nursing, midwifery and care staff	2016	Conservative	NHS England
There for us. A better future for the NHS workforce	2017	Conservative	NHS Providers
Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027.	2017	Conservative	Health Education England
Next steps on the NHS Five Year Forward View	2017	Conservative	NHS England
The NHS long term plan.	2019	Conservative	NHS England
Interim NHS people plan	2019	Conservative	NHS England
The NHS nursing workforce. HC 109	2020	Conservative	National Audit Office
We are the NHS: People plan for 2020-21 – action for us all	2020	Conservative	NHS England
Our NHS people promise	2020	Conservative	NHS England

Appendix 4: Ethics approval letter

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Social Sciences
Nottingham University Business School
University of Nottingham
Jubilee Campus
Nottingham
NG8 1BB

18/09/2020

To whom it may concern,

Ethics Review Application: 201819087 - Nicola Fisher: Nursing by numbers: political economy, nurses' post-registration development and market shelters in the United Kingdom (UK)

I am writing as chair of the Nottingham University Business School Research Ethics Committee (NUBS REC) to confirm a favourable ethical opinion for the above research on the basis of the documentation submitted below. This opinion was given on the above stated date.

The School REC operates according to the University of Nottingham's *Code of Research Conduct and Research Ethics, and the Economic and Social Research Council (ESRC) Framework for Research Ethics.*

The documents reviewed and approved are:

- NUBS REC Ethics Review Checklist
- Research Participant Information Sheet
- Research Participant Privacy Notice
- Research Participant Consent Form
- Research Participant Instructions

The following conditions apply to this favourable opinion:

1. The research must follow the protocol agreed and any changes will require prior NUBS REC approval.
2. The appropriate NUBS REC documentation must be completed at the end of the research project.

For further information about the School's Research Ethics Committee or approval process, please contact the Research Ethics Officer, Davide Pero at davide.pero@nottingham.ac.uk or +44 (0)115 84 67766.

Yours faithfully,

Dr Amanda Crompton
Chair of Nottingham University Business School Research Ethics Committee

Appendix 5: Participant information sheet

Information for Research Participants

Thank you for agreeing to participate in the research project. Your participation in this research is voluntary, and you may change your mind about being involved in the research at any time, and without giving a reason.

This information sheet is designed to give you full details of the research project, its goals, the research team, the research funder, and what you will be asked to do as part of the research. If you have any questions that are not answered by this information sheet, please ask.

This research has been reviewed and given favourable opinion by the Nottingham University Business School Research Ethics Committee.

What is the research project called?

Nursing by numbers: political economy, nurses' post-registration development and market shelters in the United Kingdom (UK)

Who is carrying out the research?

This research is being carried as part of a PhD in Business and Management by PhD candidate Nicola Fisher at the University of Nottingham. It is funded by the Economic and Social Research Council.

Supervisors' details: Professor Stephen Timmons, Nottingham University Business School. Professor Joanne Lymn, School of Health Sciences and Dr Sarah Field-Richards, School of Health Sciences.

What is the research about?

This PhD research aims to understand the challenges and difficulties surrounding nurses' post-registration development in the UK. Through undertaking a series of interviews, a range of individuals will be recruited to provide their accounts, opinions and experiences of nursing post-registration development.

What groups of people have been asked to take part, and why?

Three groups of people are being asked to take part. Those involved with policy development and consultation at a national level, those at an organisational (or local) level who are involved in policy implementation and front-line nursing staff, who directly experience post-registration development. You have been identified as someone in one of these groups.

Those involved in national and organisational policy will be interviewed twice at different times. This is because of the way the research has been designed to capture feedback and present opinions from the top-down, but then also from the bottom up.

For instance, individuals involved with national policy will be interviewed first, then individuals involved with organisational policy, and finally, front line nursing staff. Then, this will be reversed, and the views from front line staff will be brought back to individuals involved in organisational policy, and then their responses will be taken back up to national policy individuals.

These three groups have been selected because they represent the three main identified groups who can give accounts of the various stages that nursing post-registration development is experienced in the UK. It is considered that these three groups will be able to provide a rounded and more complete picture of the challenges and difficulties at various points in the UK.

What will research participants be asked to do?

The interviews will take place online, at a time of your choosing. This therefore means that research will not be conducted on or at any NHS sites and organisations. It is intended that you as the participant, will lead on a time that suits you.

The interviews are expected to last for a maximum of one hour. They will be recorded using a voice recorder, and the researcher will make written notes throughout the interview if needed.

You as a participant will be asked a series of questions depending on what group you have been recruited as part of. You will be asked for their experiences, opinions and views on nurse's post-registration development. Questioning is not aimed at determining the competence of you as an individual in your role.

I cannot promise that this study will directly help you, but I hope that you will find it interesting. There are no monetary benefits for you in undertaking this and I do not foresee any risks in you participating in this study.

Participation is voluntary, and there is no requirement for you to agree to take part. If you decide you want to take part, you are free to withdraw at any time and without giving a reason. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form.

What will happen to the information I provide?

Your interview will be recorded and then transcribed afterwards for analysis. Both the tape recordings and written transcripts will be confidential. Your identity will be kept confidential throughout the process and any responses you give during interview will be anonymised in the final research report.

All information collected during this research will be handled, processed and stored in accordance with the Data Protection Act 1998 and the GDPR. All information which is collected about you during this study will be kept strictly confidential, stored in a secure and locked office, and on a password protected database. Your personal data (e.g. email address) will be kept for up to 12 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other study data will be

kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken to maintain your confidentiality, only the researcher will have access to your personal data. This data will not be used for any other research or any other purpose than that stated on this participant information sheet.

You as a participant will not be named directly, instead, a reference will be given to determine what level you have been recruited for. For example, a nurse recruited for the front-line group may be referred to as a 'Band 5 staff nurse'. An individual within an organisation involved in policy implementation would be referred to as 'workforce development lead' or 'Chief Nurse' (or equivalent). An individual involved with national policy creation and consultation would be referred to as 'individual involved with national policy – NHS' or 'individual involved with national policy – non-NHS'.

The organisation you are associated with and or work for will not be given.

What will be the outputs of the research?

This outputs from this research will be used for completion of a PhD in Business and Management. It is intended that peer-reviewed publications, conference papers and potentially book chapters will come from this thesis.

If participants wish to obtain a copy of the outputs of this research, a summary of the research can be provided at the end of the research process. If you as a participant would like a copy, please let the researcher know this, and it will be put on record. An email address of your choosing will be needed to send the summary once it is completed.

Contact details

Researcher: Nicola Mercedes Fisher, PhD candidate, nicola.fisher@nottingham.ac.uk Nottingham University Business School, Room B26 Business School South, Jubilee Campus, Nottingham, NG8 1BB.

Main supervisor: Professor Stephen Timmons, 0115 8466635, stephen.timmons@nottingham.ac.uk , Room C04 Business School North, Jubilee Campus, Nottingham, NG8 1BB.

Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research, then in the first instance please contact the Professor Stephen Timmons.

Or contact the School's Research Ethics Officer:

Davide Pero
Nottingham University Business School
Jubilee Campus

Nottingham NG8 1BB
Phone: 0115 84 67763
Email: davide.pero@nottingham.ac.uk