

Working well?

Results from the *RCN Working well* survey into the wellbeing and working lives of nurses



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Employment Research

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**A summary of this survey, *Working well: a call to employers*, is also available.
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1 Introduction

1.1 RCN membership surveys

The Royal College of Nursing (RCN) has carried out a survey of a sample of its membership each year for over a decade. Since 1992 the questionnaire has contained many standard elements. The length of this time series, the representative nature of the RCN's membership in relation to the general nursing population, and the high response rate the survey regularly achieves¹, mean that the RCN has at its disposal a unique and reliable data set that allows confident and detailed examination of changes over time in the nursing workforce. This includes detailed coverage of the biographical characteristics, working lives, labour market behaviour, attitudes and preferences of nurses in the NHS and in other sectors throughout the UK.

In 2000, to complement this time series, the RCN conducted two separate surveys of its membership:

- the regular survey of a sample of 6,000 full and recently qualified members, examining a range of demographic data and labour market characteristics and behaviours. A report² describing the results from this was published in November 2000. It provides a stock-take of the nursing profession in the year 2000. The membership survey is complemented by the RCN annual labour market review, *Making up the difference*, which was also published in November 2000.
- a second survey of 6,000 RCN full members (excluding students), looking specifically at wellbeing and working lives. This *Working well survey* is part of a comprehensive programme of research the RCN has commissioned or supported during the two years.

This report describes the results from the second of these two surveys, the *Working well survey*.

¹ Typically 65% or more

² Ball J & Stock J (2000) *All part of the plan?* RCN: London.

1.2 Context

The major developments that can be expected to affect the attitudes of nurses and their labour market behaviour in 2000, include:

- the 1999 and 2000 pay awards that, when taken together, have increased starting salaries for newly qualified nurses, and increased earnings prospects for experienced nurses
- significant increases in the numbers of student nursing places since 1995, reversing the sharp reductions of the early 1990s
- concerted attempts to recruit and retain nurses, including Government-supported initiatives to make nursing a more attractive profession.

Despite these changes, the NHS and other sectors still report considerable staffing constraints that have the potential at least to undermine the Government's *NHS National Plan*³ in England and similar modernisation initiatives in Wales and Scotland. For example, it is estimated that 22,000 whole-time equivalent posts were vacant in the NHS in England in March 2000⁴. The population of working nurses continues to age, employment opportunities in other sectors continue to attract nurses and would-be nurses, and the training deficits of the previous decade continue to impact on the current workforce.

In this context, it seems more important than ever to address working practice issues to ensure the health and wellbeing of what has become a scarce resource – nurses. The RCN launched its *Working well* initiative in October 1998. While many of the individual topics that are covered by the initiative had already received considerable attention in the past, *Working well* has provided a useful umbrella to co-ordinate work in this area. A survey was proposed so that data on the range of themes encompassed by *Working well* could be collected at a single point in time and the results reported alongside one another.

1.3 Working well survey methodology

This report is based on the findings of a postal survey carried out by the Psychological Therapies Research Centre at the University of Leeds in the summer of the year 2000. The survey took a random sample of 6,000 RCN members in the UK, drawn from full members of the RCN: that is, those currently paying the full subscription, which excludes student nurses, newly qualified nurses, retired nurses and those on career breaks. The survey was conducted on a completely anonymous basis, so that no identity numbers of any sort were used. Two reminders were sent to the entire sample. In total, 4,110 questionnaires were received, representing a 68.5% response rate.

³ Department of Health (2000) *The NHS National Plan: A plan for investment. A plan for reform.* HMSO Cm 48418-1.

⁴ Buchan J & Seccombe I (2000) *Making up the difference: The UK Nursing Labour Market in 2000.* London: RCN.

Sample

The sample was structured to include disproportionately large numbers of nurses from Wales, Scotland, and Northern Ireland, to allow more detailed analyses within each of these countries. Among all respondents, 60% are based in England, 14% in Wales, 14% in Scotland and 12% in Northern Ireland. Geographical bias produced by this disproportionate sampling has been controlled throughout the analysis by applying a country-based weighting factor (calculated by dividing the proportion of all RCN members in each country, by the proportion found among respondents). After weighting the response, the full data set rises to 4,481 cases with 81% in England, 6% in Wales, 10% Scotland and 4% in Northern Ireland. These figures are in line with national numbers in each country. It is this base figure against which subsequent sub-samples are drawn.

Questionnaire design

Two discrete sections made up the questionnaire used for the survey. The first half covered a series of issues identified by the RCN that all had a *Working well* connection. The second portion contained the 34 statements that make up the CORE measure of psychological wellbeing⁵. John Mellor-Clark of the Psychological Therapies Research Centre, University of Leeds, was involved in the development of the CORE measure and managed the questionnaire layout, survey administration and data processing.

The first section was designed by Employment Research in close collaboration with staff in the RCN's Employment Relations Department.

The questionnaire aimed to collect data on the work experiences and views of nurses from a broad cross section of settings, focusing in particular on their wellbeing at work. Four main types of data were collected:

- Self-reports from nurses about their experiences, for example in terms of incidence of harassment, needlestick injuries, sickness absence, and patterns of work. The data provides a description of the current experiences of nurses – some is new data and provides a valuable snapshot of issues such as harassment and bullying. Other issues build on previously collected data, so that change can be explored.
- Identification of employer activity in relation to these issues. Essentially these questions try to establish the extent to which nurses feel their employers are meeting their *Working well* needs. For example, how much flexibility is there regarding working hours? Are part-time nurses treated fairly, how are incidents of bullying and harassment dealt with, and so on?
- Background information on respondents; for example place of work, grade, and biographical details.
- Assessments of the psychological wellbeing of individuals, allowing us to explore the extent to which respondents' psychological wellbeing is related to characteristics of their employment situation and experiences at work. (Further details of the CORE Outcome Measure that was used to profile psychological wellbeing can be found in Appendix A.)

⁵ Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., McGrath, G. (2000) Clinical outcomes in routine evaluation: The CORE outcome measure. *Journal of Mental Health*, **9**: 247-255.

1.4 Outline of the report

The following chapters are presented thematically to cover the main issues addressed by the questionnaire. The report structure loosely follows the structure adopted in the questionnaire and covers the following:

- Chapter 2 provides an overview of the respondents in terms of their personal profile (age, sex, ethnicity and number of dependants etc.) and their work situation (employment status, employer, work setting and grade etc).
- Chapter 3 explores nurses' working hours. It is split into two main sections: one on mode of working (full-time vs part-time) and the other explores shift working. We present descriptive data on the patterns of work and how they vary between different groups of nurses, and also look at nurse perceptions of how working time issues are dealt with by their employer.
- Chapter 4 looks at issues around workability and wellbeing.
- Chapter 5 focuses more specifically on nurses' views of the services and support that employers offer for employee-friendly working.
- Chapter 6 explores latex allergy – its prevalence, practice protocols and availability of different types of glove. This is an issue that the RCN has been pursuing for some time and data from previous surveys is presented alongside the current results.
- Chapter 7 looks at staff bullying and harassment. This is the first time this data has been collected from RCN members. We look at the prevalence, nature and action taken in response to bullying/harassment of nurses by staff.
- Chapter 8 describes the reported levels of assault/harassment from patients or the public.
- Chapter 9 looks at the prevalence of needlestick injuries and how they are handled.
- Chapter 10 concludes the report by describing how various aspects of working practice impact on nurses' psychological wellbeing. Variation between nurses is explored and the analysis seeks to determine the importance of different *Working well* variables in nurse outcomes and looks at links to reported quality of care.

2 Working well: respondent profile

This chapter presents background and biographical data covering all respondents to the RCN *Working well survey*. Where relevant we compare nurses responding to this survey with other data about the nursing pool. The data provides contextual information to inform subsequent analyses of sub-populations of nurses.

4,110 completed questionnaires were returned, representing 68.5% of all nurses who had been sent a questionnaire.

However, in order to ensure that sufficient responses are received from Scotland, Wales and Northern Ireland the survey is stratified to over-sample nurses employed in these countries (see 1.3 *Working well survey* methodology, above). The full response set after weighting is 4,481.

Of all respondents, 93% were employed and working at the time of the survey. A further 2% were employed but on maternity leave, 1% were employed but on long-term sick leave. The remainder were not employed (3%) or retired (1%).

1.5% of respondents were employed in non-health sector settings. The remainder of this report looks only at the 4,136 nurses (after weighting) who are in nursing related employment (including management and educational work), and includes those who are on maternity or long-term sick leave.

2.1 Biographical summary

The following subsections provide a brief overview of the biographical characteristics of nurses in health sector employment.

Gender

94% of all respondents providing information on their gender are female (and similarly for those employed and working in health settings). This figure is in line with data on the total nursing pool on the UKCC Register (90.5% female), once account is taken of retired nurses on the register.

Age

We know from analysis of the nursing workforce that the mean age of nurses in the UK has been steadily increasing⁶. For example, in 1990, 49% of RCN members surveyed were under 35, whilst in the 2000 survey, only 29% are under 35 years old.

⁶ For a description of the ageing nursing workforce see Buchan J & Seccombe I (2000) *Making up the difference: The UK Nursing Labour Market in 2000*. London: RCN.

The data from the *Working well survey* shows a slightly older profile because the sample was drawn from full members - thus newly qualified nurses were not included (just 21 nurses responding to the survey had been qualified for less than five years). The mean age of respondents was 43 years.

Table 2.1 below shows the distribution of men and women by age. A larger proportion of men are aged between 35 and 50. Analysis of the data on time since registering as a qualified nurse reveals that this is due to larger proportions of men entering nursing as mature students.

Table 2.1 Age profile of all respondents by gender

	Women (profile)	Men (profile)	All
Under 25	<0.5	0	<0.5
25-29	7	6	7
30-34	17	16	17
35-39	20	24	20
40-44	17	20	17
45-49	14	21	14
50-54	14	9	14
55+	11	5	11
<i>Base N =100%</i>	3859	234	<i>N=4093</i>

Source: RCN Working well survey

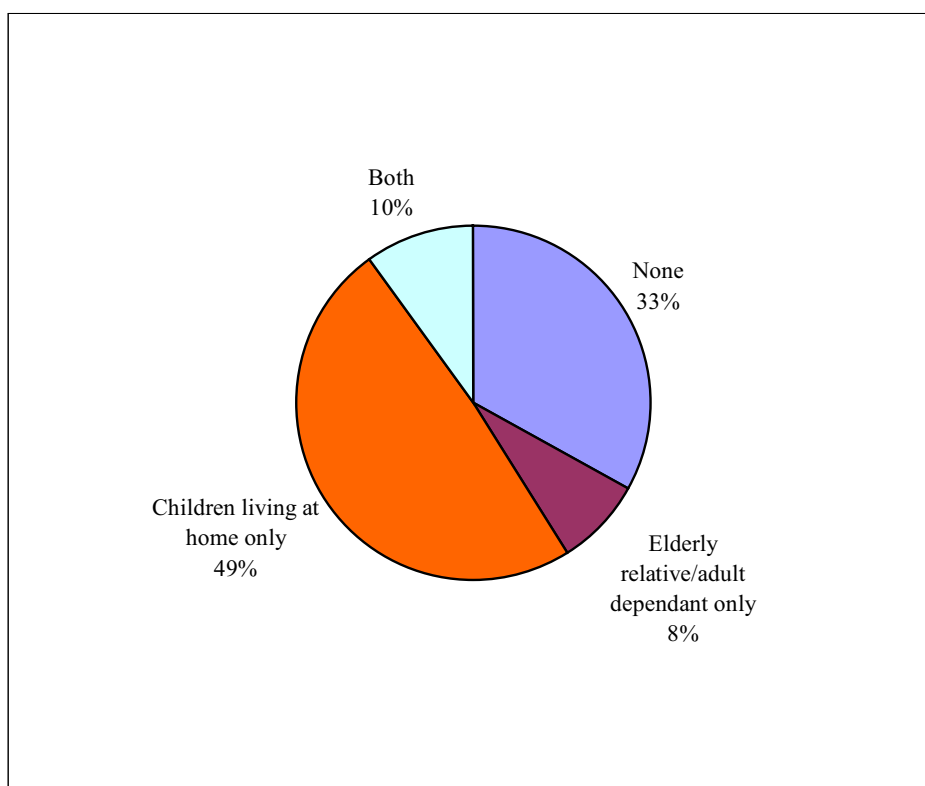
Dependants

Over half (58%) of respondents have children currently living at home. Just under one in five (18%) have pre-school children (aged 0-4) and 36% have children of school age (5-16).

As well as childcare responsibilities, 18% of nurses have regular responsibility for an elderly relative or other adult with care needs. Older nurses are much more likely to have these additional responsibilities (26% of those aged over 40 compared to 8% of nurses aged under 40). One in ten nurses have both children living at home with them and adult caring responsibilities.

Two thirds of nurses employed in health sector work have either children living at home or are responsible for another dependant with care needs. Figure 2.1 depicts the proportion of nurses with caring responsibilities outside of work.

Figure 2.1 Dependants and caring responsibilities of all nurses (percentages)



Source: RCN Working well survey

Ethnicity

Five percent of respondents give their ethnic origin as something other than white – the same as was the case described in the full membership survey⁷. Higher proportions of men and older nurses are from Black/Asian ethnic origins.

Disability

Four percent of nurses completing the questionnaire indicate that they have a physical disability or impairment that affects their ability to work. The longer nurses have worked, the more likely they are to have a physical disability that affects their ability to work – this relationship is in addition to the simple age effect. Of nurses who have worked up to 20 years, 3% have an impairment affecting their ability to work, compared with 7% of nurses who have worked for more than 20 years.

2.2 Working profile

This section presents a profile of the respondents in terms of their working lives. We look briefly at the years worked as a nurse, employment situation and settings covered by nurses in health sector employment (including those nurses on maternity and long term sick leave).

⁷ This figure is likely to be an under-estimate of the proportion of members from ethnic minorities. Analysis of non-response to RCN membership surveys has found that men and members from non-white ethnic groups respond in lower proportions.

Years worked as a registered nurse

The survey asked respondents both when they first registered as a qualified nurse, and the number of years they had worked as a registered nurse. By asking these two separate questions we can look at four things: the year in which they qualified, length of time since qualifying, amount of experience gained in that time and time taken out of their nursing career (for example in career breaks). It should be noted that newly qualified nurses were not included in the survey.

The mean numbers of years that respondents have worked as a registered nurse is 18. Black and Asian nurses have on average worked slightly (but statistically significantly) longer than their white colleagues – 22 years compared to 18 years. This is partly as a result of the older age profile of ethnic minority nurses. However, this is a key variable to consider in subsequent sections of this report; the longer nurses have worked the more likely it is they will have experienced some of the events discussed in other sections of the questionnaire.

It is worth noting here too that despite the age profile being different between men and women, there is little difference between men and women in the years they have worked as a registered nurse. This is due to men qualifying as mature students in higher proportions than women and to the fact that more women have had some time out in their careers.

Employment situation

Of the 4,136 nurses included, eight out of ten respondents (82%) are employed in the NHS (including GP practices). A further 13% are employed in the independent sector, 2% are bank nurses and 1% are agency nurses, and 2% report they are employed elsewhere.

Of respondents employed in the health sectors, 60% are situated in hospital settings, 18% in community settings, 9% in GP practices, 8% in nursing homes and 5% are employed in other settings.

Table 2.2 brings together data on employer and setting to show in greater detail where respondents work. A new composite variable has been constructed which combines both employer type and work setting to provide a ‘workplace’ variable. This allows some more informative analysis in subsequent sections of the report.

Table 2.2 Employer and setting

		Number	%
NHS	- Hospital	2240	55
	- Community	609	15
	- GP practices	355	9
	- Other NHS	96	2
Independent	- Hospital	125	3
	- Nursing home	291	7
	- Other independent sector	92	2
Bank/agency		118	3
School nurses		71	2
Nurse education		64	2
<i>Total</i>		<i>4061</i>	<i>100</i>

Source: RCN Working well survey

Nurses in health care settings are employed across the full range of specialties. Table 2.3 shows nurses' fields of practice by age, gender and employer. Overall, acute adult care (33%) and older people's nursing (12%) are the most often cited. Others include: district nursing (9%), practice nursing (8%), paediatrics and mental health (5% each), management (4%). Between 1-2% are employed in each of the remaining specialties (learning disabilities, occupational health, school nursing health visiting, midwifery and nurse education). 12% specify other specialties.

Contrasting NHS nurses with independent sector nurses, the latter group are much more likely to be employed in older people's nursing (42%) and less likely to be employed in acute adult care (19% compared to 36% for NHS nurses).

Table 2.3: Field of practice/specialty – by gender, age and employer (percentages)

	Men	Women	Over 40	NHS (inc GP)	Non- NHS	All
Acute adult care	27	34	27	36	19	33
Older people's nursing	9	12	15	8	42	12
Mental health	24	4	6	6	1	5
Paediatrics	4	6	4	6	2	6
Midwifery	0	1	1	1	-	1
Learning disabilities	9	2	2	2	3	2
Occupational health	3	2	3	1	9	2
School nursing	0	2	2	2	1	2
Practice nursing	1	9	11	10	1	9
District nursing	1	10	9	11	1	9
Health visiting	2	1	2	2	0	2
Nurse education	8	1	2	1	1	2
Management	8	4	4	3	7	4
Other	6	13	13	12	12	13
<i>Base n=100%</i>	<i>225</i>	<i>3647</i>	<i>2140</i>	<i>3217</i>	<i>486</i>	<i>3906</i>

Source: RCN Working well survey

Field of practice detailed by respondent is correlated by both biographical characteristics and employment status (for example, grade, management responsibility, working patterns). Looking at the make up of different specialties, it is clear from Table 2.3 above that male nurses are more likely than women to be employed in mental health, learning disabilities, nurse education and management, but less likely to be employed in practice nursing and district nursing. Also, a larger proportion of older nurses (aged over 40) are found in practice nursing and older people's nursing, with younger nurses in acute adult care.

Grade

The survey asked respondents to indicate their clinical grade or its equivalent. Despite the fact that many of the respondents work in places where the Whitley Grading system does not apply, the vast majority (95%) gave a grade equivalent. The grade of nurses is significantly correlated with a number of background and employment characteristics. In addition, there is significant correlation by setting, field of practice, gender and length of service. Table 2.4 highlights differences by employment setting.

Table 2.4: Grade by employment setting (percentages)

	Hosp	Comm	GP practice	Nursing home	Other	NHS	Non-NHS	All
C/D	17	13	1	20	7	13	17	15
E	41	23	4	30	15	33	27	32
F	18	12	37	17	10	19	19	18
G	14	35	51	12	21	23	15	21
H	5	12	5	4	9	7	4	6
I	2	2	1	6	8	2	5	2
SMP	2	1	<0.5	1	5	2	0	2
Other	2	1	1	11	26	1	13	3
<i>Base n=100%</i>	<i>2465</i>	<i>724</i>	<i>361</i>	<i>333</i>	<i>214</i>	<i>3386</i>	<i>507</i>	<i>4097</i>

Source: RCN Working well survey

Many of the nurses giving the 'other' category of employment base are employed in universities/colleges as nurse educators on university rather than NHS nursing scales.

- GP practice nurses are most likely to be employed on F or G grades (88%) – compared with only 39% of all nurses
- Staff in older people's nursing, learning disabilities and district nursing are more likely to be on C/D grades than is the case for other specialties.

It is also worth noting here, although this is covered further in the following section, that male nurses are more likely to be employed on higher grades than their female colleagues; 26% on H grades or above compared to 9% of women⁸. Furthermore, nurses with children living at home are more likely to be on C-E grades (51%) than those without children (41%).

Finally, 56% of staff have line management responsibilities, most prevalent among higher graded staff (not surprisingly), full-time staff (66%) and nursing home settings (65%).

⁸ For a fuller examination of gender issues in nursing see:

Finlayson R & Nazroo J (1998) *Gender Inequalities in Nursing Careers*, London: Policy Studies Institute

2.3 Summary

This section has described the nature of the population whose working patterns and experiences we'll now explore. Many of the employment variables (such as setting and grade) are correlated with biographical variables (such as gender, age, ethnicity and domestic responsibilities). The analyses have demonstrated the lack of homogeneity amongst nurses – different settings tend to have different nurse profiles in terms of the age and gender mix and also in terms of the grading – and help set the context of findings in the following chapters.

Key findings are:

- The report is based on nurses who are employed in health care settings.
- 94% of respondents are women.
- Two thirds have caring responsibilities outside work (children living at home and/or caring responsibility for adult dependants).
- 5% of respondents have ethnic origins that are something other than white.
- Just over one in ten of the respondents (12%) work in the independent sector.
- Just over half of all respondents (55%) work in NHS hospitals and a further 15% work in the NHS in the community.
- GP practice nurses make up a tenth of the survey population – they tend to be older nurses with more nursing experience.
- Larger proportions of men work in mental health, learning disabilities, nurse education, and management.
- Nurses with children at home are more likely to be on the lower grades compared to those without.
- A larger proportion of men are found in the higher grades.

3 Working time

The ability to achieve a balance between home and work is an important issue for many respondents, particularly as two-thirds of nurses have children or other dependants to care for. A key feature of employee-friendly working is the flexibility of working practice. Research suggests that choice over working time can alleviate some of the harmful effects of shift working and can promote staff retention (*Shifting Patterns*)⁹. The importance of flexibility and choice over working hours is reflected in the human resource strategies of national health departments. For example, the progress report on *Recruiting and Retaining Nurses, Midwives and Health Visitors in the NHS*¹⁰ states that: ‘The government is committed to increasing further the availability of flexible working practices’ and has published an ‘Improving Working Lives Standard’ setting out what employees can expect of the NHS. In Scotland the issue of more flexible working patterns is tackled by the ‘Staff Governance Standard’.

This chapter explores many of the issues that relate to achieving work/home balance – from shift working and rostering, to part-time working. The next chapter goes on to look at respondents’ perceptions of a range of other things that employers can offer to enhance the quality of their working lives and enable them achieve balance between their working and home lives.

3.1 Working hours

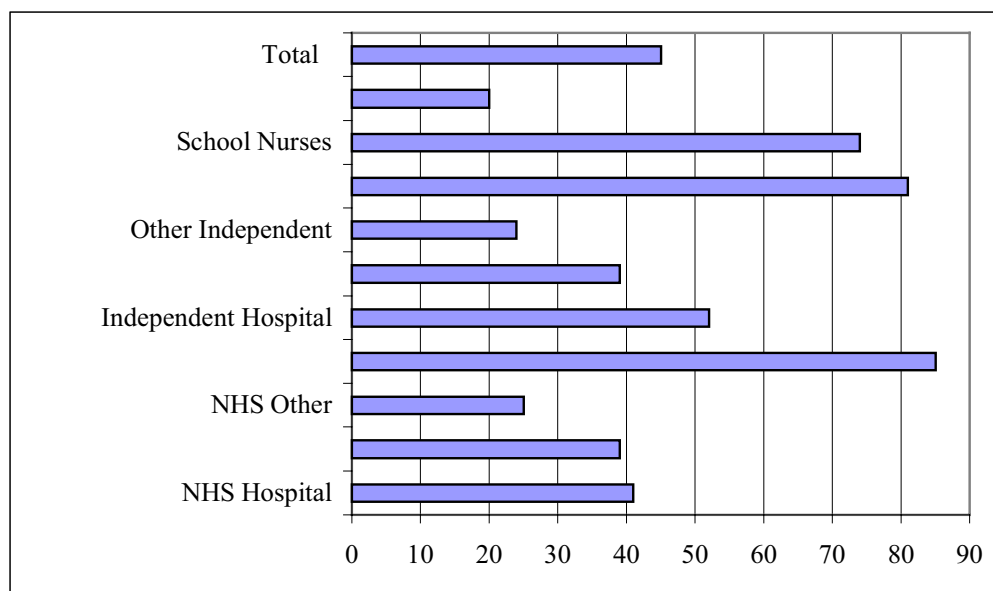
Just over half (55%) of respondents working in the health sectors (including those on maternity and sick leave) are employed on full-time contracts. Nearly all the remainder work part-time, although 2% classified themselves as working ‘occasional/mixed’ hours; these have been recoded for the purposes of subsequent analyses as part-time. Levels of part-time working have increased over the last decade. In a 1992 survey of RCN members 35% worked on a part-time basis whilst the current survey puts the figure at 45%. Figure 3.1 shows the proportion of nurses working part-time by place of work.

The area with highest levels of part-time working is GP practices (85% part-time), whilst nurse education has lowest levels (20%). A larger proportion of staff working in independent hospitals work part-time (52% compared with 41% in NHS hospitals). This may be a reflection of the different range of specialties covered and services provided. The majority of bank and agency nurses work part-time. Within the NHS there is little difference between nurses working in hospital settings and community (41% part-time compared to 39%).

⁹ Royal College of Nursing (2000) *Shifting Patterns*. London: RCN

¹⁰ Department of Health (2000) *Recruiting and Retaining nurses, midwives and health visitors in the NHS – a progress report*. London: Stationery Office

Figure 3.1: Part-time working by place of work (percentages by employer group)



Source: RCN Working well survey

Nurses, just like staff in other jobs, often work part-time to manage domestic responsibilities. So it is not surprising that there is a higher proportion of nurses with children in the part-time group. Fifty seven percent of nurses with children report that they work part-time, compared to 27% of nurses who do not have children. In fact, whether or not nurses have children is the most significant influence on the likelihood of their working part-time.

As one might expect, the picture is different for men and women. For example, men with children living at home are no more or less likely to work part-time than men without children (4-5% of both groups work part-time), but 28% of women without children living at home work part-time compared with 60% of women with children.

Grades by mode of working

Nurses working part-time are less likely to occupy the more senior grades than nurses working full-time, as highlighted in Table 3.1. Indeed, mode of working is one of the most important variables in explaining variation in grade.

Table 3.1: Grade by gender and mode of working (percentages)

	Men	Women	Full-time	Part-time	All
C/D	7	15	9	22	15
E	23	32	26	39	32
F	14	18	18	18	18
G	22	22	26	17	22
H	12	6	10	2	6
I	8	2	4	<0.5	2
SMP	7	1	3	<0.5	2
Other	8	3	4	3	4
Base n=100%	229	3699	2174	1772	3946

Source: RCN Working well survey

A disproportionately high number of part-time nurses are paid on lower grades, and this pattern is found across all the employer groups and in different settings (see Table 3.2). The situation is particularly pronounced in private nursing homes – 79% of part-time staff are paid on an E grade or less compared with 29% of their full-time colleagues.

Table 3.2: Grade by employment setting and mode of working (percentages)

	NHS hospital		NHS community		GP practice		Independent hospital		Nursing home	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
C/D	11	23	5	23		1	5	27	8	36
E	32	56	20	29		6	24	44	21	43
F	21	13	8	10	19	41	28	16	26	7
G	21	6	43	33	68	47	14		19	3
H	8	1	18	4	8	5	7	2	6	
I	3	<1	3	<1	6		7		8	
SMP	3	<1	2	<1					1	
Other	1	1					16	11	12	12
<i>Base n=100%</i>	<i>1317</i>	<i>908</i>	<i>370</i>	<i>234</i>	<i>53</i>	<i>291</i>	<i>58</i>	<i>63</i>	<i>164</i>	<i>113</i>

Source: RCN Working well survey

Nurses with children are also more likely to be on the lower grades (51% are on grade E or lower, compared to 41% of those without children). Among men however, the presence of children makes little difference to the grade distribution, while for women the differences are significant.

Opportunity to work part-time or job share

Respondents were also asked whether their employer offered the opportunity to work part-time, or to job share. Overall, 88% of employed nurses in the health sectors indicate that they could access part-time work if they wanted to. There was no discernible difference between NHS and independent sector employees. A lower proportion report access to part-time working in mental health (78%), nurse education (79%), and occupational health (67%) but otherwise there is little difference in relation to specialty. Nurses in the community are less likely to report access to part-time working.

Interesting differences between respondents in relation to their biographical characteristics emerged here too. Nearly nine out of ten women (88%) and 74% of men think their employer offers access to part-time work. The lower levels of opportunity to work part-time amongst men is likely to be explained by several factors. Firstly, larger proportions of men are found in the specialties (such as mental health, management or nurse education) that have lowest levels of part-time working and least reported access. It is difficult to unravel the cause and effect here – do these areas have more men in because they offer less part-time working or is there less demand in these areas for part-time working? Another factor may be that men feel that they have less opportunity to work part-time than their female counterparts.

Staff who reported that part-time working was available were then asked to say how satisfied they were with their access to it. Satisfaction varies by place of work; nurses working in GP practices are most satisfied with provision (96% satisfied compared to 72% overall). Black and Asian nurses seem less satisfied with provision of part-time working than white nurses (13% dissatisfied compared to 7% of white nurses).

Women are more satisfied with their opportunities to work part-time. Larger proportions of respondents with children and of those already working part-time are also more satisfied. These data would intimate that some male nurses might like to work part-time but may not (perhaps feel they are not) be given equal access to part-time working patterns.

It is also notable that H grade nurses think that their employer is less likely to give access to part-time working. As well as this they are also less likely to feel satisfied with the provision given.

Access to senior grades appears to some extent dependent upon nurses working full-time, perhaps in part explaining the higher proportions of men in senior positions in the nursing profession. There is some evidence here that access to part-time work varies for different staff, and although the issue of career progression and gender goes much deeper than provision and attitudes within the health service, it is worth noting these differences in response.

Across all nurses in employment, 54% report that their employer offered opportunities to job share. Opportunity to job share varies by employer, with a higher proportion of NHS staff reporting access to job shares than those in the independent sector. For example 58% of NHS hospital staff and 63% of NHS community staff report that job shares are available. Only 36% of those working in independent hospitals and 37% of those in nursing homes have access to job shares. The difference may be related in part to differences in organisation size – it could be argued that job shares are more easily accommodated in larger employing organisations.

Despite the fact that more than half of respondents report that job share opportunities are provided where they work, very few nurses actually work in this way. The RCN membership survey conducted in 1999 found that just 1% of all respondents worked as part of a job share, and that there was no difference between the NHS and non-NHS.

Treatment of staff working part-time

Respondents were asked several questions about the approach taken to part-time working in their place of employment (Table 3.3). Apart from some apparent grade inequities, most respondents (72%) feel that part-time staff are treated no differently from full-time staff. However, it is notable that a significant minority (16%) disagreed with the statement that ‘*Staff working part-time are treated as well as full-time staff*’. As might be expected, some staff who actually work part-time have a different perspective compared with their full-time colleagues – one in five (21%) disagree with this statement compared to one in ten (11%) full-time staff.

Table 3.3: Staff working part-time are treated as well as full-time staff –percentages agreeing/disagreeing by mode of working

	Full-time	Part-time	All
Agree strongly	17	12	15
Agree	60	54	57
Neither	12	12	12
Disagree	10	18	14
Strongly disagree	1	3	2
<i>Base n=100%</i>	<i>2111</i>	<i>1713</i>	<i>3824</i>

Source: RCN Working well survey

Nurses with children are less likely still to think that their employer treats part-time staff fairly - 68% agreed with the statement, compared with 80% of respondents with no children living at home. Younger nurses are also less satisfied with their employers' treatment of part-time staff. On the other hand, higher proportions of staff in GP practices and nursing homes feel that their employers treat part-time staff as well as full-time staff.

3.2 Working shifts

Here we look at nurses' working time and schedules, exploring variation in shift patterns between different nurses in different settings. We also examine the discrepancy between shift patterns worked by nurses responding to the survey and the shift pattern they would like to work, given more choice in the matter.

Shift patterns

Table 3.4 presents the findings from a series of questions on shift working for each of the main workplaces. Looking across the main employment settings, 60% of nurses work shifts (the figure is 57% if based on all respondents employed in nursing, regardless of setting). The shift pattern worked is presented for those nurses who report they work shifts.

As one would expect, nurses in community and GP practice settings, occupational health, school nursing, practice nursing, district nursing, nurse education and nursing management are all much less likely to be working shifts. Similarly, shift working is less prevalent among managerial grades. Also, staff in the first ten years of their careers are more likely to work shifts.

Table 3.4: Shift working by place of work (percentages)

	NHS hospital	NHS community	GP practice	Indep. hospital	Nursing home	All (in main settings)
Work shifts <i>Base N =</i>	76 (2121)	13 (583)	18 (337)	76 (122)	82 (281)	60 3444
	Shift patterns of those working shifts (percentages)					
Internal rotation	41	9		5	5	33
Earlies &/or lates	28	27	28	57	41	31
Long days	8	7		12	17	9
Fixed shifts	4	22	64	3	6	7
Permanent nights	15	13		19	26	16
Other	3	22	8	4	5	4
<i>Base N =</i>	(1733)	(103)	(74)	(99)	(242)	2251
Can change shift pattern <i>Base N =</i>	46 (1751)	34 (113)	61 (82)	54 (102)	60 (243)	48 2291
Permanent night duty posts available (excludes not applicable) <i>Base N =</i>	38 (1701)	37 (97)	4 (26)	86 (103)	88 (238)	46 2291

Source: RCN Working well survey

Almost two-thirds (64%) of nurses surveyed work some combination of early, late and night shifts. The type of shift pattern worked varies greatly by employment setting. Internal rotation is most common amongst NHS hospital nurses (41%), whilst in independent hospitals or nursing homes, only 5% of respondents work a combination of early, late and night shifts. GP practice nurses tend to work fixed shifts in higher proportions (64%) and staff in nursing homes are more likely to work permanent nights (26%) compared to 16% overall.

Looking across all employment settings, we find that full-time nurses are much more likely to be working internal rotation systems than those working part-time (40% to 25%). In contrast, a higher proportion of part-time staff work permanent nights (25% compared to 6% of full-time staff). Regression analyses point to working hours as the variable that explains most variation in the type of shift pattern worked by nurses. Length of service is also a factor, and recently qualified nurses are more likely to work internal rotation schemes.

Nurses were asked to say whether or not permanent night shifts were available where they worked. Overall (across all settings, not just those in Table 3.5), 43% say permanent night shifts were available, but this varied significantly by specialty. Nurses working in older people's nursing and management are more likely to say that permanent nights are available. Where managers are concerned, this may be an indication of their greater awareness of employment policy and practice in their organisation. Big differences exist between the NHS and the independent sector in terms of access to night posts. The proportion reporting night duty posts are available in independent hospitals is more than double that in NHS hospitals (86% compared with 38%).

Rest breaks and SDPs

Just over 61% of respondents working shifts say that they can usually take a rest break if they have been working for six hours. One in four say that they can sometimes take a break while one in ten say they can only rarely take a break and 3% say they can never take a break. Of those less likely to take breaks, nearly two thirds rarely or never have the time back. Just 13% say they usually get the time back.

One in four nurses working shifts say that when they take annual leave, their pay includes special duty payments (SDPs); 11% don't know whether or not their pay includes this payment. Of those working rotating or night shifts, 9% have had a health assessment.

3.3 Choice and control over working hours

As well as asking about their current shift patterns, the survey asked respondents what shift pattern they would *like* to work. Table 3.5 shows the distribution of type of shifts worked by nurses, together with their preferred shift pattern (for respondents who are currently working shifts). The most popular ideal shift pattern is a combination of early and late shifts without nights. It is noticeable, though, that the second most popular pattern is fixed shifts, but that currently only 7% of nurses work in this way.

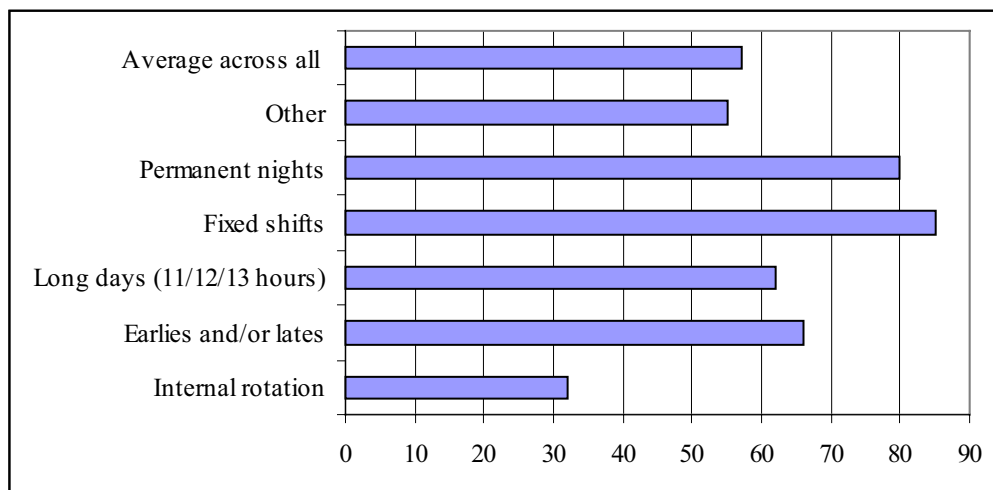
Table 3.5: Actual and preferred shift patterns (percentages)

	Actual shift pattern worked	Preferred shift pattern
Internal rotation	31	12
Earlies and/or lates	31	32
Long days (11/12/13 hours)	9	13
Fixed shifts	7	20
Permanent nights	15	16
Other	6	7
<i>Base n=100%</i>	<i>2457</i>	<i>2343</i>

Source: RCN Working well survey

Figure 3.2 shows the proportion of nurses who are currently working their preferred shift pattern, by their current mode of work. A key finding to emerge from contrasting current and preferred shift patterns, is that 43% of all nurses are not working the shift pattern that they would ideally prefer. The group least happy with their current working pattern is nurses working internal rotation – 68% would rather work some other shift pattern. Given an option to change, nearly a half of those working internal rotation but preferring another pattern would choose 'earlies and/or lates' (46%), 23% would choose fixed shifts, 17% long days and nights and 11% permanent nights.

Figure 3.2 Percentage of nurses working their preferred shift pattern (by type of shift)



Source: RCN Working well survey

Thirty seven percent of nurses working shifts indicated that all nurses in their clinical area have to work internal rotation, rising to 63% for nurses currently working this shift pattern.

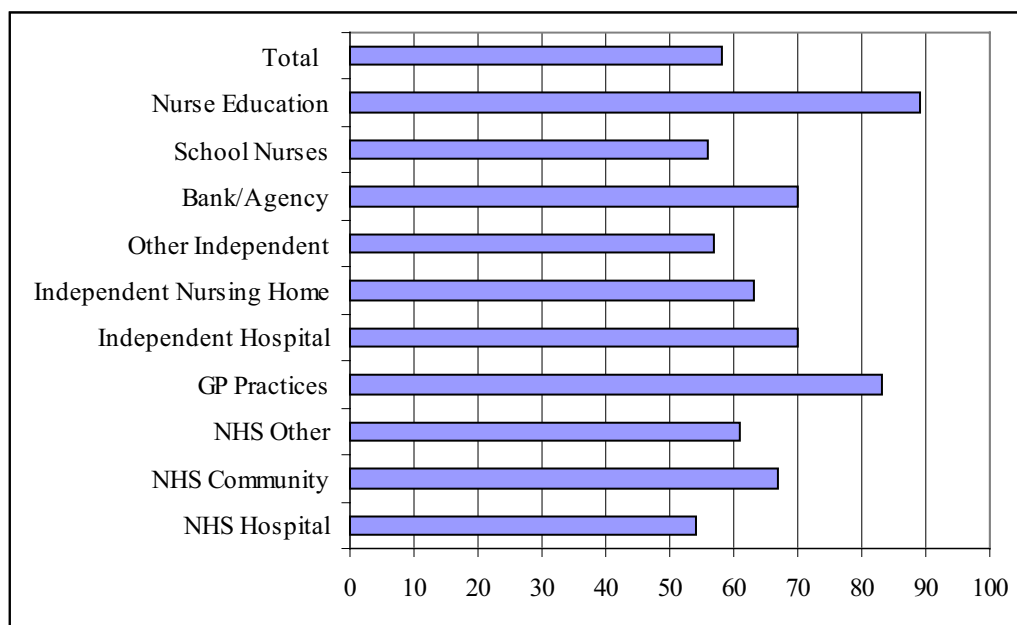
The longer a nurse has worked, the more likely it is she will work the way she wants. For example, of those in service for 1-5 years just 40% are working their preferred shift, but 70% of those who have been registered for 25 years or more work their chosen shift pattern. This is mainly because the least popular pattern of work - internal rotation - is less prevalent among more experienced nurses.

Part-time staff (61%) and nurses in GP practices (81%) are both much more likely to be working their preferred pattern.

Nurses were also asked whether or not they could change their shift pattern if they wanted to. Just under a half (49%) of those working shifts indicate they could change their shift patterns. Nurses who are not working their preferred shift pattern are much less likely to report being able to change (31% compared to 62% of nurses who are working their preferred shift pattern). Predictably, nurses on internal rotation shifts are least likely to say they can change pattern (31%). Lack of control over shift patterns is most reported by nurses aged under 30.

Employment setting influences the likelihood of nurses being able to change shift patterns. For example, taking hospital nurses alone, 46% of NHS nurses can change shift patterns compared with 54% of those in the independent sector. Sixty percent of those in independent nursing homes report that they could change their shift pattern if they wanted to, whilst only 34% of NHS community nursing staff could.

Figure 3.3 Percentage of nurses working their preferred shift pattern (by employer)



Source: RCN Working well survey

Asked about whether they were provided with the opportunity to self-roster, 36% of all nurses report that they have the opportunity, whilst 56% said they did not. The remaining 8% don't know. These across-the-board figures mask considerable variation between nurses in different situations. Three out of every ten (29%) staff working in private nursing homes report access to self-rostering, as do 58% of nurses in GP practices. Higher grades of staff were more likely to report that they can self-roster. This mirrors the pattern of access to flexible working. The proportion indicating they could work flexibly increases steadily with grade: 37% of E grades, 45% of F grades, 52% of G grades, 61% of H grades and 80% of I grades.

Self-rostering is significantly related to shift patterns, with those on internal rotation least likely to have the opportunity to determine their own off-duty (23%). Conversely, 40% of those working fixed shifts reported that their employers provided them with the opportunity to self-roster. The following groups were also more likely to indicate that they are provided with the opportunity to self-roster: older nurses (or those with longer length of service), white nurses, nurses in paediatrics, school nursing, occupational health, practice nursing, district nursing, nurse education and management. It should be noted however, that the key variable explaining most variation is grade.

The survey also asked nurses to give their level of agreement to a number of statements concerning how they feel their employer treats staff in relation to working patterns and hours. These included:

- I am satisfied with the level of choice I have over the length of shifts I work
- My employer respects my wishes about when and how I wish to work
- I am satisfied with the level of input I have in planning my own off-duty/time off
- I am generally able to get the off duty/time off I want
- My manager helps me balance my work and home commitments

- The contribution of permanent night nurses is valued by managers
- My colleagues work well to help each other balance their home and work commitments
- Policies exist where I work to encourage employee-friendly working arrangements.

Table 3.6 highlights the main findings. It shows that in general more nurses are positive about their opportunities to control their working hours than are negative. Eighty percent agree or strongly agree that they can get the off duty they want and two thirds reported that they have a reasonable input into planning off duty/time off. However, nurses express less satisfaction about managerial support offered to help them balance home and work commitments, and about the level of choice over the length of shifts.

Table 3.6: Views of choice and control over working hours (percentages)

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Base N
I am generally able to get the off duty/time off I want	18	62	8	9	3	3889
I am satisfied with the level of input I have in planning my own off duty/time off	14	52	17	14	3	3919
My employer respects my wishes about when and how I want to work	9	40	28	20	3	3907
I am satisfied with the level of choice I have over the length of shifts I work	9	46	24	17	4	3867
My manager helps me balance my work and home commitments	8	31	29	23	8	3761
My colleagues work well to help each other balance their home and work commitments	17	53	17	11	2	3918
Policies exist where I work to encourage employee-friendly working arrangements	7	35	34	20	4	3910

Source: RCN Working well survey

To help explore variation between respondents in their general attitude to employer support on working time and hours, we created a composite variable covering all the statements in the table above.

The scale results vary significantly between groups of nurses. In particular, nurses who are unable to change the pattern of shift they work or who are not working their ideal shift pattern give much more negative responses than others. Other groups which perceive less support for working hour flexibility and control are:

- Nurses employed on internal rotation or permanent night shifts
- Ethnic minority nurses
- D/E grade nurses
- Hospital based nurses (especially in contrast with GP practice nurses)
- Younger nurses (aged under 40)
- Those who have been off sick in the three months before they answered the survey.

It is particularly interesting that there is a correlation between taking sick leave and feeling there is insufficient choice and flexibility over working hours. It supports anecdotal evidence that when staff do not have sufficient choice and control over their working hours, they are more likely to have to resort to taking sick leave as the only way of being able to accommodate their needs. Sick leave and other issues around wellbeing are discussed further in Chapter 5.

3.4 Summary

This chapter looked specifically at the working hours of nurses. The key findings are that:

- The number of nurses working part-time has increased in the last decade, with 41% of NHS hospital nurses currently contracted to work part-time.
- Part-time working is more prevalent outside the NHS.
- Lower proportions of staff who work part-time are on higher grades; similarly nurses with children are likely to be on lower grades.
- Half of all respondents report that their employer offers opportunities to work as part of a job share, although in reality few nurses do so (1% in 1999).
- One in five part-time staff felt they were not treated as well as their full-time colleagues.
- 60% of respondents work shifts.
- Internal rotation was the most common pattern of shift working in NHS hospitals, although this is the least popular pattern.
- Just under a half (43%) of nurses are not working the shift pattern they would like.
- About a quarter of all respondents feel that their employer/manager is not doing all they could to help balance home and work commitments, and that respondents' wishes about when they want to work are not respected. Hospital-based nurses view the support offered most negatively.
- Staff who are dissatisfied with the flexibility and control they are given over their working hours are more likely to have taken sick leave at some time in the three months before the survey.

4 Employee-friendly working

In July 1999 the NHS launched a £1m campaign to 'Improve Working Lives' (England). The 'Improving Working Lives Standard' (October 2000) states that by April 2003 all NHS employees would be entitled to work for organisations that demonstrate commitment to flexible working arrangements. Key elements identified include: childcare support, support for carers, team based self-scheduling, and flexi-time.

In this chapter we explore responses to a series of questions seeking to establish the degree to which a range of employee-friendly working practices are in place, both in the NHS and in the independent sector. We then move on to examine nurses' satisfaction with these facilities and practices.

4.1 Access to employee-friendly working practices

First we present an overview of all the data showing the prevalence of each aspect of employee-friendly working. The results (presented in Table 4.1) are placed in order, from the most frequently available services/practices to the least commonly available. It should be noted that in some areas (for example, access to dependant and parental leave), a relatively high proportion of nurses were unsure about whether their employer provided access or not.

Table 4.1: Employee-friendly working practices (percentages)

	Yes	No	Don't know	Base n=100%
Opportunity for staff development and training	96	3	1	4041
Car parking	90	10	<0.5	4035
Opportunities to work part-time	87	8	4	4001
Breaks/rest times	84	15	1	3942
Catering facilities in the day	78	21	1	3970
Staff rooms for taking breaks	70	29	1	4015
Clinical supervision	70	26	4	3968
Changing facilities	61	35	4	3948
Counselling services	60	27	13	3981
Opportunities to job share	54	29	17	3950
Access to parental leave	48	25	27	3856
Flexible working	46	44	10	3950
Dependant leave	37	32	31	3873
Opportunities to self roster	35	57	8	3929
Catering facilities at night	34	57	9	3970
Workplace nursery or crèche	31	61	8	3922
Careers guidance	29	51	20	3933
Access to term time or school holiday contracts	12	63	25	3904
Staff transport	11	86	3	3929
Holiday play scheme	11	70	19	3916
Out of hours play schemes	3	77	20	3906
Child care vouchers or allowances	2	73	25	3913

Source: RCN Working well survey

In some work settings certain facilities are either not practical or not relevant, and some smaller employers may not be in a position to offer access to these facilities. For example, the viability of workplace nurseries or crèches may depend on a certain number of participants.

Most noticeable is the fact that many of the facilities which are reported least available relate to the provision of childcare or support for childcare. In the majority (about three quarters) of cases, nurses report that their employer does not offer these services to them. Looking across all respondents, less than a third (31%) report that their employer provides a workplace nursery or crèche. There seems to be even less on offer to help those with school age children balance their work and home lives – only 11% report that there are holiday play schemes available, and just 3% indicate that their employer provides an out-of-hours play scheme.

Good working practice is not just about helping employees to balance their work and life commitments; many of the facilities listed refer to more intrinsically work-related issues. For example, half of all respondents report that they are not offered any careers guidance. Not all respondents have access to even more basic facilities such as a staff room for breaks. Clearly the relevance of some of these facilities depends on the specific work context – hospital versus community and so on.

Table 4.2: Availability of working practices by employer – percentages

Practice	NHS hosp.	NHS comm.	GP practice	Indep. hospital	Nursing home
a. Catering facilities in the day	96	36	38	98	85
b. Catering facilities at night	42	10	3	45	50
c. Staff rooms for taking breaks	74	50	72	61	91
d. Breaks/rest times	93	61	64	94	91
e. Staff transport	12	13	1	3	6
f. Car parking	94	82	81	87	97
g. Access to parental leave	53	50	33	38	32
h. Opportunities to work part-time	89	82	91	90	93
i. Opportunities to job share	58	63	38	36	37
j. Opportunities to self roster	30	36	58	38	30
k. Access to term time or school holiday contracts	11	7	9	15	11
l. Child care vouchers or allowances	2	3	0	1	0
m. Out of hours play schemes	5	2	1	0	1
n. Holiday play scheme	16	7	3	3	3
o. Workplace nursery or crèche	46	17	0	2	2
p. Counselling services	68	74	11	47	22
q. Careers guidance	31	28	9	30	23
r. Flexible working	44	37	45	68	49
s. Changing facilities	74	22	36	84	71
t. Dependant leave	41	39	24	28	32
u. Clinical supervision	76	81	45	60	53
v. Opportunity for staff development and training	97	97	98	98	92
Base ¹¹ n=	2211	593	345	123	282

Source: RCN Working well survey

Table 4.2 shows the proportion of nurses who report that their employer offers access to each service/facility by type of work setting. Although these categories split different types of employer, there is no reliable proxy for employer size which might help shed further light on some of these variations in provision.

¹¹ The base here is the maximum, achieved in response to ‘staff development and training’. On the other items the base reduces slightly.

Looking at Table 4.2 further, it is clear that even when community staff are not included, a significant proportion of nurses working in hospitals are not provided with what could be regarded as the most basic of workplace facilities. For example a quarter of NHS hospital nurses are not provided with a staff room for taking breaks and the same proportion do not have changing facilities at their place of work.

In general the independent sector hospitals are about the same or worse in terms of the proportion of staff with access to employee-friendly working practices. For example, only 61% report that they have a staff room for breaks and very few (just 2%) report that a workplace crèche or nursery is available. Fewer independent sector staff report having access to parental leave and dependant leave.

Given the problems of providing appropriate nurseries or crèches for staff working shifts, it may be that childcare vouchers or some form of allowance would prove to be a more appropriate means of support. This would give staff more control and choice in organising childcare to suit their personal needs. However, regardless of employer or setting, virtually nobody (ranging from 0-3%) reports that this form of support is available.

4.2 Satisfaction with access and provision

Table 4.3 below shows the proportion of nurses offered each facility, and of those that use each, the percentage who express satisfaction.

Where access is provided, satisfaction in most cases is relatively high. Highest levels of satisfaction are recorded in relation to ‘opportunities to self roster’, ‘access to staff development and training’, ‘access to part-time working’ and ‘flexible working’. At the other end of the scale, greatest dissatisfaction is expressed about provision of ‘catering facilities at night’ (and to a lesser extent during the day) and ‘changing facilities’. In the case of ‘car parking’, ‘catering facilities during the day’, and ‘staff rooms for taking breaks’, views were much more polarised - high proportions of nurses express dissatisfaction and satisfaction. These cases are looked at in a little more detail to see if the type of employer influences views. In most other cases the numbers responding to the question are too small to make any meaningful comparison.

Satisfaction about car parking facilities varied significantly between groups of nurses, with 56% satisfied and 35% dissatisfied. Nurses in hospital settings were much less likely to be satisfied: 46%, compared to 85% of GP practice nurses and 89% of those working in nursing homes/hospices.

Table 4.3: Services offered and satisfaction with employee-friendly working practices (percentages)

	NHS hosp		NHS comm.		GP practice		Indep. hosp		Indep. n.home	
	Yes	Sat	Yes	Sat	Yes	Sat	Yes	Sat	Yes	Sat
a. Catering facilities in the day	96	64	36	71	38	90	98	87	85	85
b. Catering facilities at night	42	38	10	48	3	78	45	69	50	79
c. Staff rooms for taking breaks	74	64	50	67	72	82	61	67	91	69
d. Breaks/rest times	93	67	61	70	64	84	94	72	91	79
e. Staff transport	12	49	13	70	1	75	3	50	6	80
f. Car parking	94	44	82	60	81	82	87	76	97	92
g. Access to parental leave	53	57	50	63	33	82	38	79	32	85
h. Opportunities to work part-time	89	70	82	70	91	94	90	89	93	87
i. Opportunities to job share	58	60	63	59	38	85	36	94	37	83
j. Opportunities to self roster	30	77	36	88	58	96	38	93	30	91
k. Access to term time or school holiday contracts	11	60	7	59	9	95	15	75	11	77
l. Child care vouchers or allowances	2	62	3	33	0	-	1	-	0	-
m. Out of hours play schemes	5	45	2	60	1	-	0	-	1	-
n. Holiday play scheme	16	34	7	32	3	67	3	50	3	50
o. Workplace nursery or crèche	46	26	17	36	0	50	2	-	2	-
p. Counselling services	68	48	74	50	11	65	47	74	22	79
q. Careers guidance	31	62	28	70	9	86	30	85	23	76
r. Flexible working	44	71	37	83	45	96	68	92	49	91
s. Changing facilities	74	60	22	69	36	87	84	76	71	73
t. Dependant leave	41	63	39	69	24	84	28	86	32	83
u. Clinical supervision	76	62	81	69	45	74	60	67	53	75
v. Opportunity for staff development and training	97	70	97	76	98	87	98	75	92	68
<i>Base¹² n=</i>	<i>2211</i>	<i>1893</i>	<i>593</i>	<i>500</i>	<i>345</i>	<i>288</i>	<i>123</i>	<i>114</i>	<i>282</i>	<i>235</i>

Source: RCN Working well survey

NHS hospital nurses and (to a lesser extent) those working in community settings are less satisfied with car parking, catering facilities during the day and staff rest rooms.

Looking specifically at those who have children aged five or under, we find that only 22% are satisfied with the nursery or crèche that is on offer, and 41% are dissatisfied. Similarly for those nurses who have school age children, just 30% are satisfied with the holiday play scheme provided.

¹² The base here is the maximum, achieved in response to 'staff development and training'. On the other items the base reduces slightly.

4.3 Consultation

Overall, just under 30% of nurses feel that their employer has consulted them about how best they can balance their work and life needs. Results vary by work setting. Staff in GP practices respond most positively (52% agree that they have been consulted by their employer about how best their work and life needs may be met); nurses in NHS hospitals and community settings tend to be least satisfied; and the independent sector results fall between the two. Nurse educators are also more satisfied with the level of consultation they feel they have received. Table 4.4 shows the proportion of nurses indicating that their employer consults staff about the factors listed.

Table 4.4: Consultation with nurses about balancing work and life needs and facilities (percentages)

Consultation ...	Setting					All nurses
	NHS hosp.	NHS comm.	GP practice	Indep. hosp	Nursing home	
About work and life needs	26	22	52	38	39	29
<i>Base n=100%</i>	<i>2075</i>	<i>548</i>	<i>326</i>	<i>114</i>	<i>265</i>	<i>3328</i>
About facilities required	19	16	47	33	34	23
<i>Base n=100%</i>	<i>2065</i>	<i>543</i>	<i>324</i>	<i>114</i>	<i>265</i>	<i>3311</i>

Source: RCN Working well survey

The most significant variation in responses to this question concerns whether or not nurses are working their ideal shift, work part-time or not and if they feel they are able to change their shift pattern. For example, just 16% of nurses not working their preferred shift pattern said ‘yes’, they feel their employer has consulted them about how to balance their work and life needs – compared to 35% of those who are working their ideal shift. Just 20% of nurses who say they cannot change the pattern of shift they work, and 26% of nurses working full-time, say their employer has consulted them. Interestingly, those working part-time are significantly more positive: 35% say their employer has consulted them.

In terms of facilities, a similar pattern emerges, with differences in response between nurses working in NHS hospital and community settings against GP practices and the independent sectors (see Table 4.4).

4.4 Summary

Despite the current nursing shortage and the stated desire to improve working lives in order to retain nurses, about half of all nurses (across different employers) do not have access to a number of employee-friendly working arrangements, such as self-rostering, childcare support, flexible working and dependant leave. Even the most basic facilities are not being offered to employees in a significant number of cases – one in four hospital nurses do not have a staff room to take breaks in or changing facilities.

The findings suggest that in many cases the NHS, along with the other health care employers, has a long way to go before it can be regarded as being employee-friendly. Less than one in five NHS nurses have been consulted by their employer about the facilities they want or need.

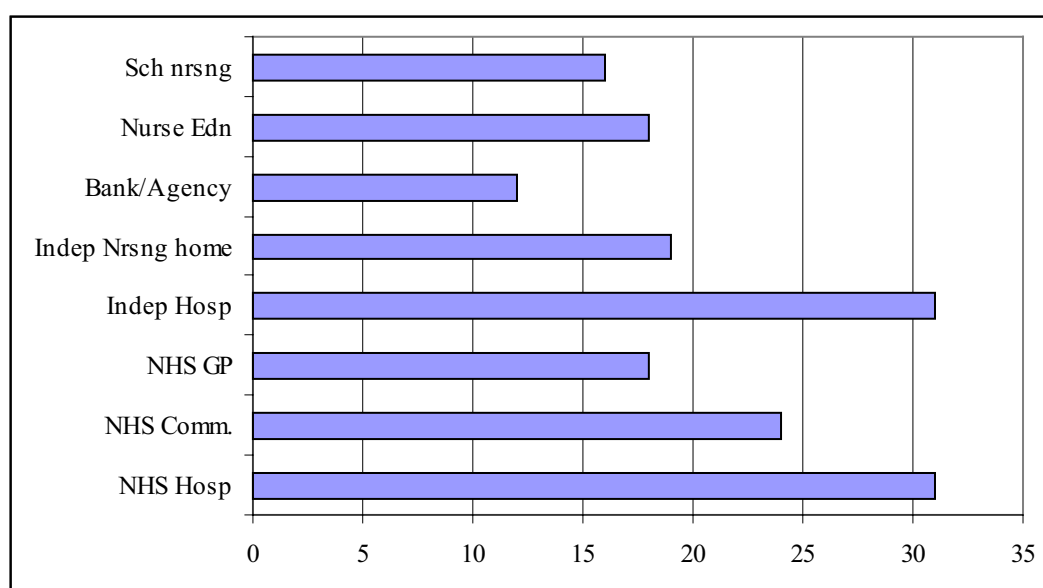
5 Workability and wellbeing

This section is concerned with the nature and frequency of ill health and time off due to ill health. The data set is also interrogated to examine respondents' views of their employer's response to sickness absence and the support offered to nurses suffering ill health.

5.1 Sick leave in the last three months

One in four nurses (employed in the health sectors) took sick leave in the three months before they answered the survey. Figure 5.1 shows the proportion of nurses in each employer setting who took time off sick during that period.

Figure 5.1: Nurses taking sick leave by employer type (percentages)



Source: RCN Working well survey

Nurses in the NHS are more likely to have taken time off due to ill health than are those in the independent sectors (28% compared to 22%). Nurses working in hospital settings (both NHS and independent sector) are most likely to take time off due to ill health (31% in both cases). Nurses in GP practices (18%) are less likely to take time off. In terms of specialty, nurses in mental health (36%), paediatrics (34%), and acute adult care (29%) seem most prone to ill health. Nurses in schools, nurse education and management report lower incidence of time taken off due to ill health.

Perhaps unsurprisingly given the wording of the question, nurses who indicated that they had a physical impairment that affected their ability to work (186 of all nurses or 4%) were more likely to have taken sick leave (50%). However, the numbers are small in this group.

Younger nurses, especially those aged under 30, are more likely to have taken time off sick, as are those on lower grades. Although age and grade (as well as employer) are linked, grade seems to exert an influence independently from age and employer (Table 5.1).

Table 5.1: Nurses taking sick leave by grade (percentages)

Sick leave in last three months	Grade								All nurses
	C/D	E	F	G	H	I	SMP	Other	
Yes	27	31	27	21	26	18	20	17	26
No	73	69	73	79	74	82	80	83	74
<i>Base n=100%</i>	<i>598</i>	<i>1306</i>	<i>730</i>	<i>858</i>	<i>260</i>	<i>96</i>	<i>71</i>	<i>139</i>	<i>4058</i>

Source: RCN Working well survey

Amount of time off and reasons for sick leave

Of those who had taken sick leave in the last three months, the amount of time taken off ranged from one shift (in 31% of cases) to 88, with a mean average of five shifts. The most typical amount of time off (ie. the mode) was one shift. If the amount of sick leave is averaged across all respondents (including those who did not take any time off), the mean sick leave taken is 1.3 shifts.

Among those who took time off in the three month period, a total of nearly 6,400 shifts had been lost, at an average of just over six shifts per individual. Men had taken off significantly more shifts than women (nine compared to six).

Physical ill health was the main reason for nurses to have taken time off the last time they were off sick. This accounted for nearly three-quarters (74%) of all reasons given. A further 10% cited injury as the main reason, 4% cited a sick child or other dependant, 1% gave 'other domestic crisis' as their reason, and 3% cited mental ill-health.

Sixteen percent of respondents said that on the last occasion they took time off in sick leave, their ill-health or injury was work-related. Nurses working in the NHS were more likely to report work-related injury or ill-health than those in the independent sector. This difference holds true even when the settings are matched. For example, 17% of nurses working in NHS hospitals report that on the last occasion they were off sick, the cause was work-related, while only 11% of those working in independent sector hospitals reported work-related sickness absence. Field of practice is also a factor, with a fifth (21%) of those working in mental health reporting work-related sick leave and 23% of those in management. The lowest levels of sick leave were reported by those working in midwifery and school nursing (4% in each case).

Interestingly, work-related ill-health/injury is significantly correlated to job satisfaction. Almost three quarters (72%) of those whose sickness absence was not work-related reported they were satisfied with their jobs, whilst only 57% of those with work related absence did.

5.2 Employer support

Most nurses say that they have access to an occupational health service at their place of work (84%) and in 87% of these cases nurses can access the service directly, without referral. Just under two thirds of respondents said that their employer provides access to a counselling service and in 79% of cases this service can be accessed directly.

Significant variation is apparent between employer groups in access to these services. Nurses in GP practices and the independent sectors are much less likely to have access than nurses in NHS hospitals and community settings. Table 5.2 highlights the key differences.

Table 5.2: Access to occupational health and counselling services by employer type (percentages)

Access to services	Employer category								All nurses
	NHS hosp	NHS comm.	GP	Indep hosp	Indep nrsng home	Bank/ agency	Nurse edn	Sch nrsng	
Occ. health	99	99	20	85	23	59	86	86	84
<i>Base n=100%</i>	2228	601	344	123	285	115	64	71	4011
Counselling	76	78	13	49	18	46	86	69	64
<i>Base n=100%</i>	2107	581	336	127	284	116	65	77	3871

Source: RCN Working well survey

Just 23% of nurses in independent nursing homes and 20% of those in GP practices report that they have access to occupational health services at work compared to nearly everyone in NHS hospitals and community work settings. Although there are large differences between the NHS and independent sectors, there is also significant variation within each sector. A similar picture of perceived access to counselling services emerges.

In 36% of cases, employers help nurses to get the treatment needed to allow them to return to work following illness or injury. Nurses in hospital settings are most likely to report provision of support/treatment to help them get back to work (42%), while staff in nursing homes are least likely to be supported in this way (13%).

The shift pattern deployed, and the degree of choice over shift pattern, are closely related to perceptions of the support provided to help staff back to work. For example, where nurses are working their preferred shift, 40% report that their employer provides access to treatment - but just 28% of nurses not working their preferred shift pattern respond in this way. Nurses working permanent nights appear less likely to get access to treatment following injury or illness (27%). Perhaps this is because these treatments (fast-tracking systems) are operated during the day.

Generally, nurses feel that their employers are supportive of colleagues in helping them get back to work. Twice as many respondents agreed with the statement '*colleagues are given the support they need to help them back to work after injury or illness*' as disagreed (54% compared to 27%). But nurses who report that their employer provides a fast-track back to work are almost twice as likely to agree with the statement as nurses who report that they are not provided with this facility (78% compared to 40%).

Again, whether or not nurses are working their preferred shift pattern has a relationship with perceptions of the employer support offered. Here, 39% of those working their ideal shift agreed that their employer offered support to help bring them back to work, compared to 57% of those not working their preferred shift. This relationship is exaggerated further for those nurses who report that they are unable to change their shift pattern. Other factors which seem to influence nurses' views of employer support include:

- Mode of working – 59% of staff working full-time agree that their employer is supportive in getting colleagues back to work compared to 49% of part-time staff. Is more attention given to full-time staff or is it difficult for part-time staff to access the service?
- Where respondents have had a work-related illness they seem less likely to think that their employer helps them back to work – 40% disagree with the statement compared to 29% of staff that have not had a work-related illness.
- Bank and agency nurses, and nurses working in nursing homes, are less likely to feel supported by their employers in helping colleagues get back to work.

5.3 Summary

Several key points emerge from this chapter:

- One in four nurses have taken some sick leave in the last three months. In a significant number of cases (for example, 17% of NHS hospital nurses) the absence was work related.
- NHS trusts are generally better than GP practices or independent sector employers at providing an occupational health service and counselling.
- About a half of respondents reported that their employer was supportive in terms of helping sick colleagues back to work.
- The level of support offered by employers correlates with the degree of choice offered to nurses over their shift pattern.

The analyses discussed in this section suggest that many of the variables concerning the support offered by employers may be interrelated. For example, those employers who provide nurses with the opportunity to work their preferred shift pattern appear also to be the employers who help nurses get back to work, and that staff working in these environments are more supportive of each other.

The idea of classifying employer types according to the level of support offered is explored further in Chapter 10.

6 Latex allergy

Latex is found in many of the products used by nurses, most commonly in protective gloves. The increases in blood-borne infections has led to a need for greater protection, and the use of latex gloves has greatly increased because they offer the best protection from blood and other bodily fluids.

Whilst latex gloves offer good protection, however, allergy to latex can pose a serious health risk. It can lead to chronic ill health, early retirement or in extreme cases to death. Powdered latex gloves are particularly hazardous, as the powder can sensitise skin, increasing the risk of developing an allergy. There is also evidence that the powder in latex gloves can have an adverse affect on patients, delaying wound healing and causing surgical adhesion. The powder also acts as a dispersal agent, increasing the level of airborne allergens.¹³

The RCN launched a latex allergy campaign in 1998, to draw attention to the health risks associated with latex and to reduce the risk of allergies. The campaign sought to eliminate the use of powdered latex gloves and to raise awareness of the measures required to prevent latex allergy (for example, through appropriate glove choice).

A European Commission working group has been established to review the scientific evidence regarding latex gloves. It is charged with looking at the implications for practice and whether or not powdered latex gloves should be banned.

This chapter explores latex allergy, looking at the percentage of nurses suffering from the allergy, the availability of different products, and knowledge of correct procedure in dealing with latex allergies. We also look at how the results of this survey compare with a similar survey in 1999 – has there been any change in the products supplied or in the prevalence of latex allergy?

6.1 Which gloves are supplied?

Respondents were asked to indicate which types of gloves were available where they worked – powdered latex gloves, non-powdered latex gloves or latex-free gloves (for example, 'nitrile' gloves). Four percent of respondents report that gloves are not supplied or used in their area of work, and in a further 5% of cases nurses do not know what type of gloves are supplied. Of the remainder, 42% report that powdered latex gloves are supplied, 79% say non-powdered latex gloves are supplied and in 49% of cases, latex-free gloves are used.

Considerable differences between work settings are noticeable. Table 6.1 summarises the data.

¹³ For more information about Latex allergy see:

Royal College of Nursing (1999) *Latex Allergy in Health Care Settings* Employment Brief 25/99, London: RCN

Table 6.1: Type of glove supplied by sector (percentages)

	NHS hosp	NHS community	GP practice	Indep hosp.	Nursing home	All nurses
Powdered latex gloves	39	29	50	27	55	39
Non-powdered latex gloves	80	61	67	83	69	75
Latex-free gloves (eg Nitrile)	54	29	26	51	36	46
<i>Base n</i>	2240	610	355	125	291	3621

Source: RCN Working well survey

It's clear that GP practices and nursing homes are much more likely to use powdered latex gloves than hospitals and NHS community settings. Hospital settings, both NHS and independent sectors, place more emphasis on using non-powdered latex gloves and latex-free gloves.

This data was re-configured to make them more comparable with the data collected in the 1999 RCN membership survey. Latex-free gloves had not been presented as a response category in the 1999 survey, so the results for this category have been excluded from the comparison (note that in fact in all the cases where latex-free gloves are supplied, a latex glove is also supplied). The results by sector are shown in Table 6.2 below.

Table 6.2: Types of gloves supplied by sector in 1999 and 2000 (percentages)

	NHS		GP Practice		Non- NHS	
	1999	2000	1999	2000	1999	2000
Powdered latex gloves	9	7	29	23	18	16
Non-powdered latex gloves	34	46	24	41	38	42
Both	48	39	43	34	36	39
Not used	2	3	-	1	2	-
Don't know	2	5	-	2	2	3
<i>Base n=100%</i>	2837	2734	289	348	578	404

Source: RCN Working well survey

comparison with data from 1999 shows that in the NHS and amongst GP Practices there has been a significant shift away from powdered latex gloves to the use of non-powdered gloves. In 1999, 57% of NHS nurses reported that powdered gloves were available (either as the only type or in addition to non-powdered) whilst in 2000, 46% report that they are supplied. While the prevalence of powdered gloves has reduced, there is still a long way to go before their use has been eliminated entirely. There has been less of a change in the non-NHS sector: whilst more nurses have access to non-powdered gloves than in 1999, the number reporting the use of powdered gloves has changed little (54% compared with 55%).

6.2 Latex allergy

Of the 4,010 nurses in health sector employment surveyed, 4% report that they have a diagnosed latex allergy, and 3% have an allergy where the type is not known. In 11 cases nurses indicated a Type I allergy and in six cases a Type IV allergy. To put this in context, in 1999 only 1% of NHS nurses had a diagnosed allergy, compared with 4% in 2000.

The survey asked about respondents' knowledge of the procedures to follow if a colleague has a latex allergy. The responses by type of workplace are given in Table 6.3. The most commonly recognised procedure is that everyone must wash their hands after wearing latex gloves (47% reported) and that the colleague must wear latex-free gloves (50%).

Table 6.3: Knowledge of practice in relation to latex allergy by employment setting (percentages)

	NHS hosp	NHS comm.	GP practice	Indep hosp.	Nursing home	All nurses
Colleague wears powder-free gloves	11	11	9	6	11	11
Colleague wears latex-free gloves	54	39	45	56	46	50
Everyone must wear latex-free gloves	17	16	14	19	8	16
Everyone must wear powder free gloves	12	12	11	10	9	11
All medical devices must be latex-free	22	17	19	26	13	20
Everyone must wear vinyl gloves	4	6	5	3	4	4
Everyone must wash their hands after removing latex gloves	50	40	42	49	46	47
<i>Base n</i>	2240	609	355	125	291	3620

Source: RCN Working well survey

Again there is some variation in response between different workplace settings. Nurses working in hospital settings (NHS and independent sector) appear to be slightly more stringent in their approach to latex and the protection of those with an allergy.

6.3 Summary

- Latex allergy is a serious and potentially fatal problem.
- Four percent of respondents report a diagnosed latex allergy, and the figure has increased since 1999 (when it was 1%).
- Those working in GP practices or nursing homes are most likely to have powdered gloves supplied.
- Although in the NHS there has been a decline in the availability of powdered latex gloves since 1999 (from 57 to 46%), they remain widely available.
- Knowledge of the appropriate action to reduce risk to allergy sufferers is limited particularly concerning the risks of using powdered gloves.
- Those working in nursing homes have least awareness of latex allergy and preventive action.

7 Bullying and harassment by members of staff

Bullying and harassment is recognised as a significant problem in the workplace, although there has been little research documenting the extent to which this problem affects nurses. A 1995 survey conducted by the Policy Studies Institute found that more than a third of ethnic minority nurses reported that they had been racially harassed by colleagues¹⁴. Other research evidence points at the deleterious effect that bullying can have on staff motivation, attendance and productivity¹⁵.

The *Working well survey* presented an excellent opportunity to collect some baseline data on nurses' experience of bullying and harassment in different settings. This chapter looks at bullying and harassment from colleagues, whilst Chapter 8 looks and harassment and assault from other sources (patients, relatives or members of the public).

We look first at the prevalence of bullying and harassment before describing the perceived sources and perceptions of staff about why it took place. Finally, we describe the action nurses took to deal with the situation.

7.1 The extent of bullying and harassment

One in six nurses (17%, which equates to 670 respondents) report that at sometime in 12 months before the survey, a member of staff at their place of work has bullied them. This aggregate figure conceals some significant variation between nurses.

Who is most affected?

Whilst there is no significant difference between NHS nurses and nurses in non-NHS employment, there are some differences in the prevalence of reported bullying when examined by specific employment setting. Those working in GP practices have lowest levels (13%) whilst respondents working in nurse education had highest levels (24% of reported having been bullied or harassed by staff in the last twelve months). NHS staff in the community are as likely as their hospital colleagues to indicate they had experienced bullying or harassment (17% in both cases). In the independent sector, the proportion is fractionally lower - 15% of those in hospital settings have been bullied and 14% of those in nursing homes.

¹⁴ Policy Studies Institute (1995) *Nursing in a multi-ethnic society*, as reported in Royal College of Nursing (2001) *Challenging Bullying and Harassment*, London: RCN.

¹⁵ Hoel, H. & Cooper, C.L. (2000) *Destructive conflict and bullying at work*. Unpublished report, University of Manchester Institute of Science and Technology.

Table 7.1 presents the data by disability and ethnicity, the two background variables that appear to account for most of the variation in the incidence of bullying and harassment among nurses.

Table 7.1: Nurses experiencing bullying and harassment by ethnicity and disability (percentages)

Experienced bullying and harassment in last 12 months	Disability		Ethnicity		All nurses
	With disability	No disability	White	Black/Asian	
Yes	41	16	16	29	17
No	59	84	84	71	83
<i>Base N=100%</i>	<i>170</i>	<i>3814</i>	<i>3799</i>	<i>190</i>	<i>3989</i>

Source: RCN Working well survey

It is of some concern that four out of ten (41%) nurses reporting a disability indicate that sometime in the last year they have experienced bullying and harassment by a member of staff. There is also a higher level of reported harassment amongst nurses from an ethnic minority - three out of ten (29%) nurses from a minority ethnic group report having been bullied or harassed sometime in the last year, compared with 16% of white nurses.

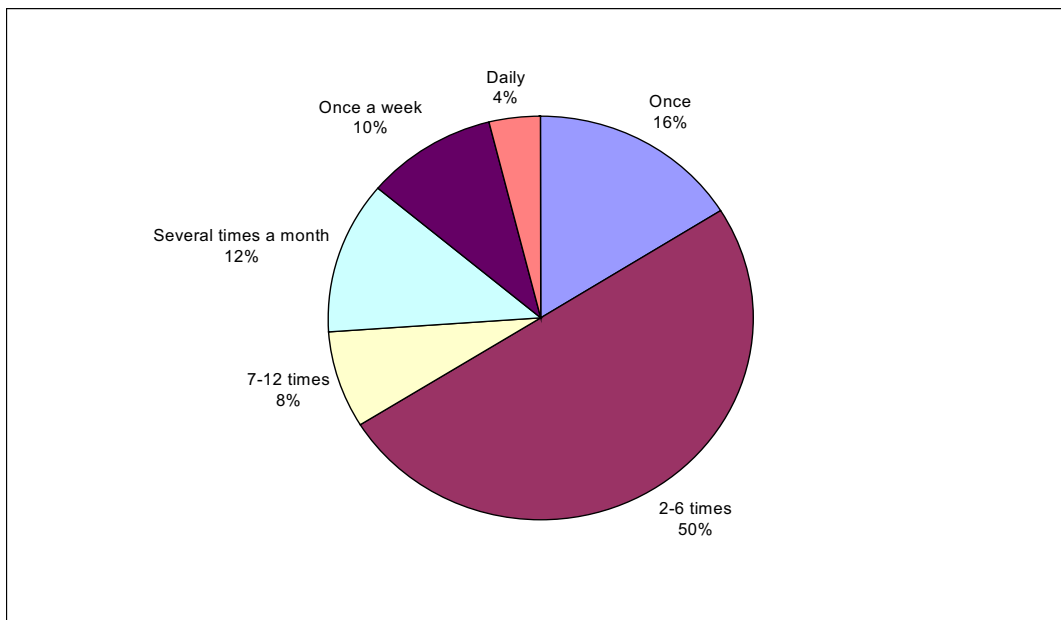
These figures are statistically highly significant and, taking into account other factors, explain most of the variation in nurses' experience of bullying and harassment. Other factors that play a part include:

- **Mode of employment** – full-time staff (21%) are much more likely to have experienced bullying and harassment than part-time staff (12%) – they are at work longer so are more likely to experience any work based event.
- It is worth noting here that ethnic minority nurses are more likely to work full-time and that some of the variation in the incidence of bullying and harassment by ethnicity can be explained by mode of working - but not all. Even when looking only at full-time nurses, it remains the case that black and Asian nurses are significantly more likely to report experiencing bullying and harassment (33%) than is the case among their white colleagues (21%).
- **Type of employer** – nearly 30% of nursing agency staff report having been bullied or harassed by a member of staff in the previous 12 months.
- **Field of practice** – nurses employed in occupational health (28%), learning disabilities (26%), nurse education (24%), health visiting (21%) and midwifery (42%) seem more likely to experience bullying and harassment than nurses employed in other fields of practice.
- **Grade** – SMP (26%) and H grades (25%) also report a higher incidence of bullying and harassment.
- **Working patterns** – staff employed on long day working patterns (11/12/13 hours) report higher levels of bullying and harassment
- There was little difference between nurses by gender, childcare responsibilities or age, although interestingly those nurses with responsibilities in caring for an elderly relative report experiencing bullying and harassment in higher proportions.

7.2 How often does bullying and harassment take place?

Typically, nurses report being bullied or harassed every few months, but some experience problems with other members of staff on a frequent, even daily, basis. Figure 7.1 shows the frequency of incidence (looking only at nurses who report experience of bullying or harassment).

Figure 7.1: The frequency of bullying and harassment (percentages)



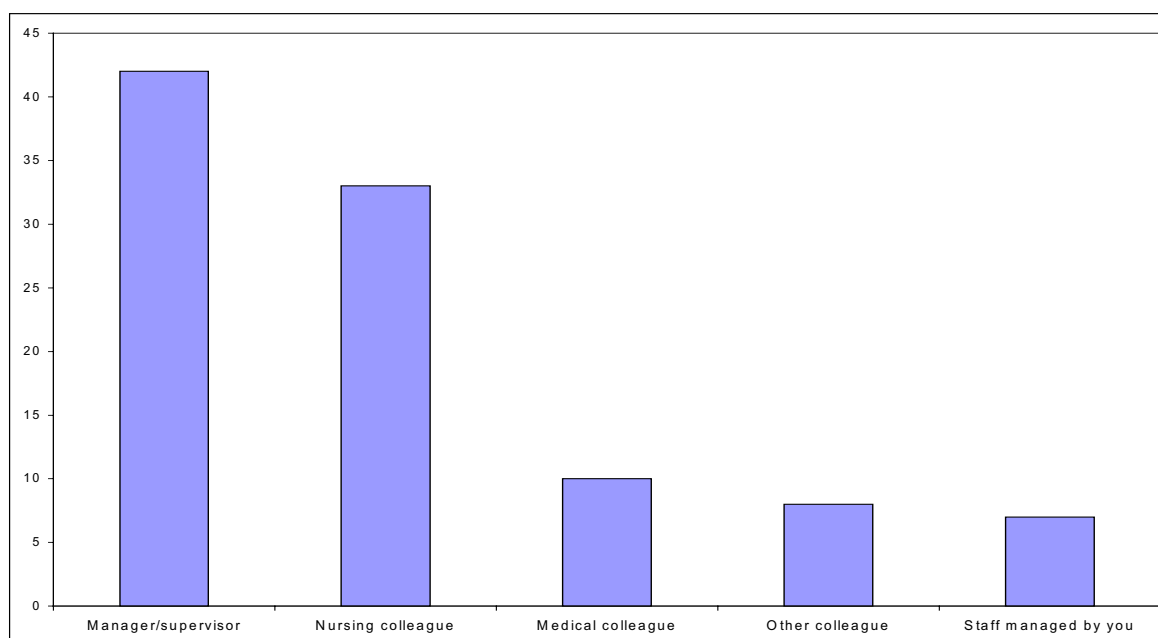
Source: RCN Working well survey

7.3 The source and focus of bullying and harassment

To provide an indication of the underlying causes and focus of the bullying and harassment nurses were asked to state who they perceived to be responsible for their situation.

Most commonly (41%) nurses report that their immediate supervisor or manager is the main person responsible for their bullying and harassment. However, in a further third of cases a nursing colleague is considered the main source of the bullying. Figure 7.2 summarises the data.

Figure 7.2: Source of bullying/harassment (percentages)



Source: RCN Working well survey

Staff working shifts are more likely to report that other nursing colleagues are a source of their problem, compared with those not working shifts who are more likely to mention other (unspecified) colleagues. On further analysis we find that this is likely to be related to grade and seniority, since senior staff are less likely to be working shifts. For example, 23% of G grade nurses who report having been bullied or harassed, identify ‘nursing colleagues’ as the source compared with 44% of E grades, or 52% of D grades.

Other than this there was little to differentiate between nurses in terms of the source of their experience of bullying and harassment.

The questionnaire asked nurses to indicate what they felt was the main focus of the bullying and harassment. The response categories included the following factors: sex/gender, age, race, sexuality, personality clash and other. Overall, personality clashes (38% of those experiencing an incident of bullying and harassment in the previous 12 months) and ‘other’ (64%) were given as the most common reasons for the bullying and harassment. This suggests that for the majority of nurses their situation is not related directly to any of the common forms of discrimination.

However, black and Asian nurses have a different perspective. In more than half of cases, they feel the focus of the bullying and harassment is linked to their colour. It is also interesting to note that ethnic minority nurses are more likely to feel that the bullying and harassment is linked to their age or gender than is the case for white nurses. Table 7.2 highlights these different perceptions.

Table 7.2: Main focus of bullying and harassment by ethnicity (percentages)

	White	Black/Asian	All nurses
Gender	4	11	5
Race	2	56	6
Age	4	16	5
Sexuality	2	2	2
Personality clash	38	40	38
Other factors	67	36	64
<i>Base N=</i>	<i>620</i>	<i>55</i>	<i>675</i>

Source: RCN Working well survey

It is noticeable too that in the predominantly female profession that nursing is, men are more likely to report that bullying and harassment at work is linked to their gender than women. Fifteen percent of men cite their sex as a focus of bullying and harassment compared to 4% of women. Interestingly, older nurses are no more or less likely to feel that bullying and harassment is linked to their age than younger nurses.

Clearly for most nurses (who are white and female) the precise focus of the bullying and harassment they experience is more complicated than simple gender, race, age or sexuality discrimination. The preponderance of ‘other’ reasons may suggest that we need to be looking at these incidents from a different perspective and asking whether harassment is driven more by the nature of the perpetrator rather than being related to personal characteristics of the victim. Further research is required to unravel these issues.

Views on the problem

Nurses were asked to give an indication of how serious a problem they feel bullying and harassment is in their workplace. Table 7.3 below contrasts the responses of those who have experienced bullying and harassment with those that have not. It is clear that of those staff who have not experienced bullying and harassment, the problem appears largely invisible - only 6% agree that it is a serious problem. In contrast, 32% of these who have been bullied or harassed feel there is a serious problem at their work.

Table 7.3: Perceptions of bullying and harassment as a serious problem, by experience (percentages)

Bullying and harassment is a serious problem in my workplace....	Bullied/harassed?		All nurses
	Yes	No	
Strongly agree	6	1	2
Agree	26	5	9
Neither	31	15	18
Disagree	31	52	48
Strongly disagree	6	27	23
<i>Base N=</i>	<i>649</i>	<i>3155</i>	<i>3804</i>

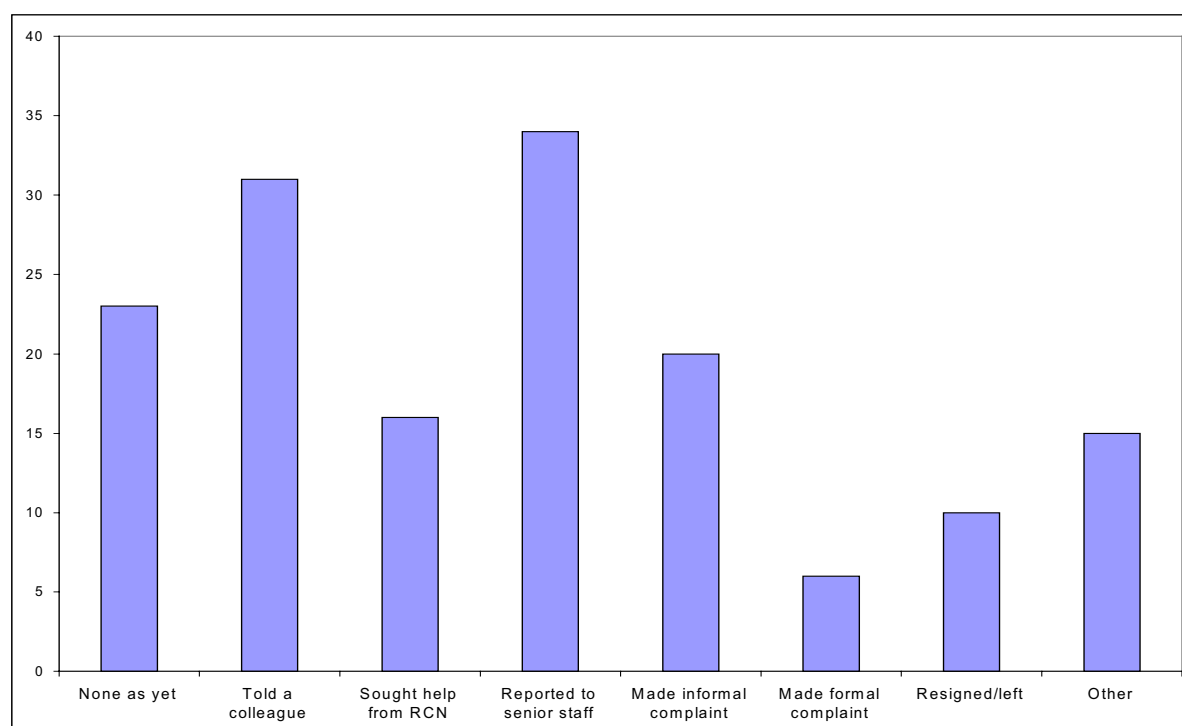
Source: RCN Working well survey

7.4 Actions taken to deal with bullying and harassment

Just under one in four nurses (23%) say they had not taken any action in response to bullying and harassment they experienced. For those who say they took action, three in ten told a colleague (31%). This action is slightly more likely to be taken by younger nurses.

Just over a third (34%) of nurses who were bullied reported the issue to senior staff, while 20% made an informal complaint. Sixteen percent sought help from the RCN - senior grades were more likely to have taken this course of action - 21% of G/H grades sought RCN support, compared to 14% of C, D, E and F grades. Only 6% made a formal complaint, and 10% say they resigned or left because of bullying or harassment. Figure 7.3 presents the data in response to bullying and harassment.

Figure 7.3: Action taken in response to bullying and harassment (percentages)



Source: RCN Working well survey

In total, 45% of those bullied or harassed either reported the problem to a senior colleague or made a complaint (informal or formal). About a quarter of those who were bullied or harassed did not take any action.

Looking only at those nurses who made their employer aware of the incident, we find that in 38% of cases no further action was taken by the employer. The most common action taken was an informal discussion (55% of cases), although 11% report that a formal investigation was conducted, and 4% report that a disciplinary hearing was held. In 5% of cases disciplinary action was taken.

Employer support

Most nurses who have experienced bullying and harassment were not satisfied with their employer's handling of the situation. Just under 30% were satisfied, 57% were not satisfied, while 14% of cases were still in progress at the time of the survey.

Satisfaction with the way employers handled the situation varies by employment setting. A smaller proportion of nurses working in GP practices were satisfied (21%), and only 9% of bank/agency nurses were satisfied with their employer's response.

Respondents who indicate that the main focus of the bullying was age-related were significantly less satisfied than others (80% of this group indicate dissatisfaction). In cases where sexuality was a focus, however, employers' handling seems relatively well received (nearly three quarters say they were satisfied). In both these groups, however, the numbers of cases are small.

Nurses who resigned or left their posts were significantly less satisfied with the role played by their employers than nurses who had not taken this course of action (89% not satisfied compared to 63% of those who had not resigned or left). Senior grades (H and I) were significantly more likely to be satisfied with their employer's response than was the case among lower grades.

Respondents were also asked to give their views about the overall approach and support provided by their employers. Data shows clearly that those staff who have experienced bullying and harassment feel much less confident that their organisation is doing all it can to combat bullying and harassment. Table 7.4 presents the mean scores for each of three questions concerning employer support around bullying and harassment. The scores can range between one and five, the higher the score, the less agreement there is with each statement.

Table 7.4: Views of employer support, by experience of bullying and harassment (mean scores)

	Bullied or harassed by member of staff in last 12 months	
	Yes	No
'I am confident that I would be treated fairly if I reported having been harassed at work by a colleague'	3.2	2.3
'I am confident that the organisation is taking steps to eliminate bullying and harassment in the workplace'	3.2	2.6
'I believe staff who have suffered harassment and bullying are supported'	3.5	2.7

Source: RCN Working well survey

Of nurses who have experienced bullying and harassment, 45% report that they would not be confident that their employer would take the problem seriously if they reported being harassed by a colleague. This compares with 12% in nurses who have not experienced bullying and harassment.

Encouragingly though, those nurses who took some action feel slightly more confident that their employer takes the problem seriously than is the case for nurses who have taken no action as yet (35% compared to 26% agree with the statement). Similarly, where action was taken, a higher level of satisfaction with the employer response is reported – 46% indicate confidence in their employers’ response should they experience bullying and harassment, compared with 22% in nurses who took no action.

Nurses who had reported bullying and harassment were more likely to be negative about the steps taken by their employer to eliminate bullying and harassment than those who had not reported it (38% compared with 9%). Again though, those staff that have taken action themselves or where their employers have done something about the case are more likely to be confident that their employer is moving in the right direction.

7.5 What are the implications of bullying and harassment?

This section presents some initial data on the effects of bullying and harassment on nurses. First we explore the effects on health and wellbeing, and then any influences on nurses’ career and work intentions.

Psychological wellbeing

Using the psychological wellbeing data derived from CORE, we can assess if there is a relationship between bullying/harassment and psychological well being. The results from regression analyses indicate that experience of bullying and harassment is the single most significant variable in explaining variation in psychological wellbeing. Those that experience the problem on a daily basis are most vulnerable with a score double that of the whole sample.

The psychological wellbeing score can be used to divide respondents into two groups, according to whether they match a ‘clinical’ population or not (the use of CORE is described in greater detail in Chapter 10 and Appendix A). Of those who have been bullied or harassed by a member of staff, one in four (24%) nurses are over the cut-off point beyond which an individual is deemed to be in the ‘clinical’ group. Nurses who have experienced bullying and harassment by members of staff are thus three times more likely to be above this CORE cut off point than nurses who have not had these experiences.

The source and focus of bullying, and the action taken, affect levels of distress nurses experience. Psychological wellbeing seems most affected when the bullying is by a lecturer/tutor or supervisor/manager. Nurses who see bullying or harassment as concerning issues of sexuality or gender report higher levels of distress. Importantly, it appears that where no action was taken following bullying, higher levels of distress are recorded. However, in those cases that have led ultimately to a disciplinary hearing, high levels of psychological distress are found. This may be because involvement in formal proceedings can itself be a major cause of stress.

Long term sick leave

Although the numbers are small (44), it is interesting to note that 30% of nurses who are on long-term sick leave indicate that they have experienced bullying and harassment. This compares with 17% of all nurses. Clearly, there is a link between nurses having to take long-term sickness and exposure to bullying and harassment. The exact nature of the link cannot be determined from this survey.

Intentions to leave nursing

Finally, and importantly in terms of the implications for the longer term retention of nurses, a third of nurses who have been exposed to bullying and harassment indicate that they intend to leave within the next 12 months (see Table 7.4). This contrasts with 16% of nurses who have not been exposed to bullying and harassment. This problem is exaggerated for nurses who feel the focus of their problem is their age. In these cases, 56% of nurses are intent on leaving within the next 12 months

Table 7.5: Intentions to leave nursing position, by experience of bullying and harassment (percentages)

Intention to leave present nursing position:	Bullied or harassed in last 12 months		All nurses
	Yes	No	
Within next 6 months	16	7	9
Within next 12 months	17	9	10
No plans to leave nursing within the next year	67	84	81
<i>Base N=</i>	<i>677</i>	<i>3300</i>	<i>3977</i>

Source: RCN Working well survey

7.6 Summary

- One in six nurses (17%) reported that a member of staff had bullied them in the past year.
- A larger proportion of nurses from ethnic minority backgrounds had been bullied or harassed in the last 12 months – 29%.
- More than half of those who are the victims of bullying or harassment report that they are dissatisfied with the way the situation was handled by their employer.
- Being bullied or harassed at work is correlated with lower level of psychological wellbeing and higher sickness absence, particularly if no action is taken to deal with the situation.
- A third of those affected say they intend to leave (compared with 16% of those who had not been bullied or harassed).

8 Harassment and assaults by patients/relatives

This chapter explores the harassment and assault experienced by nurses from patients, their relatives or members of the public. We also present nurses' views on the underlying reasons for the assaults, and the action they took in response to the problem.

8.1 The extent of assaults and harassment by patients

A third (34%) of respondents indicate that they were harassed or assaulted by a patient/client or the patients' relatives in the 12 months before they answered the survey. Most commonly, these assaults/harassments happen to full-time staff (because they are at work longer), those employed in the NHS (primarily in hospital settings), and especially in the fields of learning disabilities (49%), acute adult care (44%), mental health (46%) and old people's homes (45%). Staff in the independent sector, bank and agency settings are less likely to have experienced harassment or an assault in the last 12 months.

Almost one in 3 nurses (30%) report that they had been physically assaulted at work at some stage in their careers. Table 8.1 shows the incidence of harassment and assault in the last 12 months, and of physical assault during a nurse's career, providing a breakdown by employer setting.

Table 8.1: Harassment and assault by employment setting

	NHS hosp	NHS comm.	Setting GP practice	Indep hosp	Nursing home	All nurses
Harassed or assaulted by patient/client or relative in last 12 months (Base N)	43% 2071	23% 582	25% 338	22% 116	36% 272	34% 3801
Physically assaulted at work (Base N)	32% 2081	26% 574	15% 337	24% 118	39% 269	30% 3787

Source: RCN Working well survey

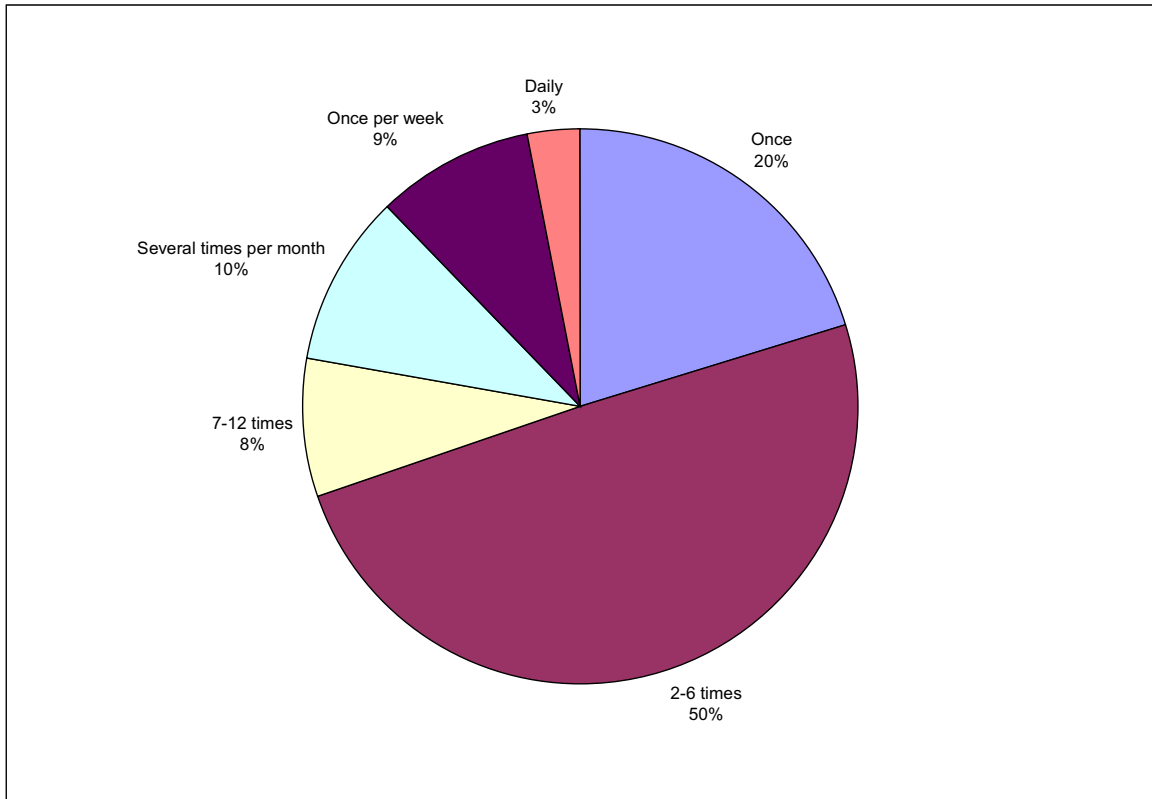
Nurses working on shifts also experience a greater incidence of harassment and assault by patients and their relatives (43% compared to 21% of nurses not working shifts). But of those working shifts, nurses on fixed shifts seem much less likely to experience harassment and assault (24% compared to 42% overall for those working shifts). Nurses on internal rotation (46%) and permanent nights (48%) appear to be most exposed.

It is also worth noting that staff who have experienced bullying and harassment by a member of staff are also more likely to have been assaulted by patients or their relatives (46% compared to 31%).

8.2 Frequency and source of assaults

Looking only at those nurses who have been harassed or assaulted in the last 12 months, in 20% of cases this had only happened once in the last 12 months, whilst 12% of nurses had experienced assault or harassment at least once a week. Just under a half (49%) had experienced an assault 2-6 times in the previous year (Figure 8.1)

Figure 8.1: Frequency of assault and harassment – percentage of those experiencing at least one assault in previous 12 months



Source: RCN Working well survey

Nurses in the following groups all report higher rates of assault than other nurses: E grade staff, those aged under 40, those working in learning disabilities or mental health, and those working late shifts, permanent nights or on internal rotation.

In only a small proportion of cases (4%) are the assaults committed by members of the public; in 61% of cases they are committed by patients themselves and in 35% of cases by relatives.

8.3 Reporting harassment and assault

Of those nurses who had been harassed or assaulted by patients in the previous 12 months, just over a half (51%) did not report the incident by completing an accident form. On the other hand, 10% reported five or more incidents. The mean number was just less than two incidents in the last 12 months.

Table 8.2: Reporting assaults in the previous 12 months, by type of location and nature of harassment/assault (percentages)

	Location					All nurses
	Hospital	Community	GP practice	Nursing home	Other	
Completed report	43	59	74	66	42	49
Did not	57	41	26	34	58	51
Base N=	960	160	85	114	36	1355

Source: RCN Working well survey

Looking at the last occasion respondents were harassed or assaulted, Table 8.3 highlights the reporting of the incident with the nature of the assault. Nurses in nursing homes and other settings are most vulnerable to physical and verbal abuse, but are least likely to report the incident

Table 8.3: Reporting of last occasion of harassment or assault, by type of location and nature of harassment/assault (percentages)

	Location					All nurses
	Hospital	Community	GP practice	Nursing home	Other	
Completed report	43	33	18	13	44	38
Did not	57	67	82	87	56	62
Physical assault	9	4	0	19	14	9
Verbal abuse	17	8	11	24	23	16
Threats	10	6	9	4	6	9
Other	1	1	1	3	3	1
Base N=	960	160	85	114	36	1355

Source: RCN Working well survey

It is clear that the nature of the harassment or assault has a bearing on whether or not nurses report an incident. In cases where there was a physical element, 60% reported the assault, compared to 36% where there was no physical element.

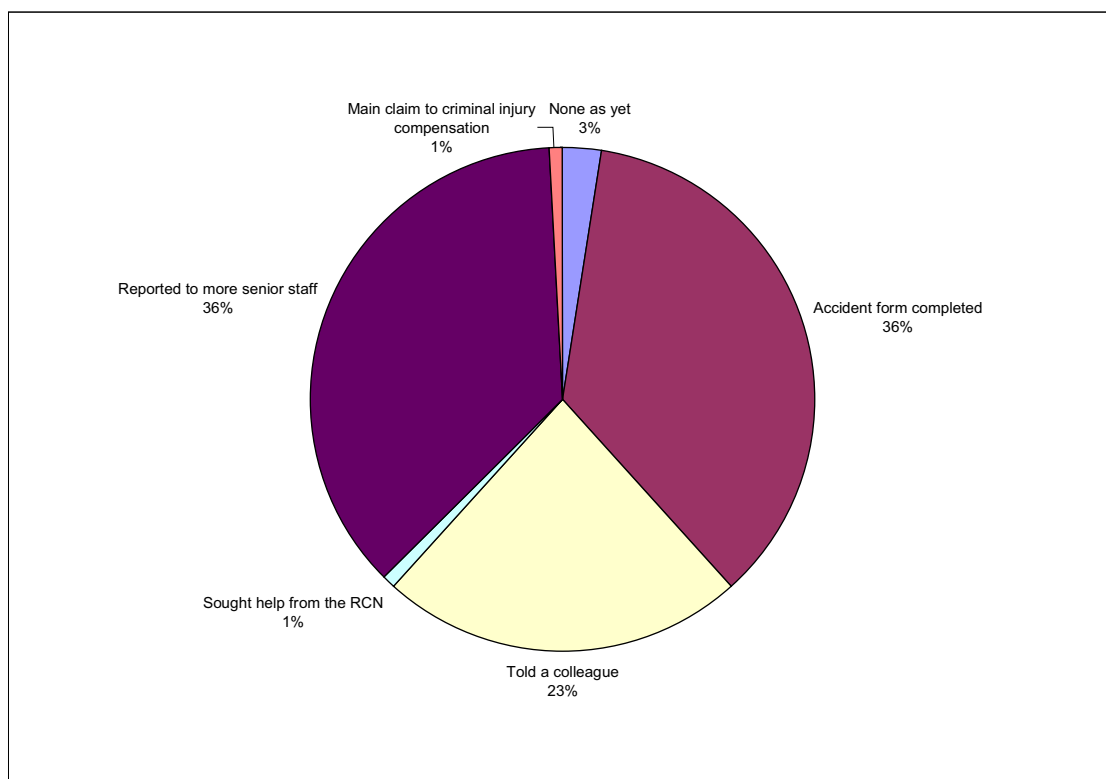
The focus of the harassment/assault is rarely clearly defined within the options given to respondents. Four percent indicated their sex to be the focus of the assault, 2% their race, 2% their age, 1% their sexuality, 3% a personality clash and 5% mentioned other factors.

8.4 Action taken in response to physical assault

Respondents were asked specifically about whether they had been physically assaulted at work: 30% reported they had.

Unlike bullying and harassment by a member of staff, most nurses have taken some action (97%) following physical assault. In the main, this action was to complete an accident report form (41%). Other actions include telling a colleague (27%) and reporting the incident to a more senior member of staff (42%). However, in nearly 80% of cases there was no outcome from the action. In just 8% of cases, a verbal warning was issued, in 5% care was discontinued and in 5% the incident was reported to the police. In just 2% of cases was an offender prosecuted.

Figure 8.2: Action taken in following physical assault



Source: RCN Working well survey

In 14% of cases of assault/harassment by patients and their relatives, nurses were offered counselling/debriefing to cope with the incident. As one might expect, this service was most likely to be offered if the offender was prosecuted (43% of cases), in cases where the incident was reported to the police (29%), where care was discontinued (25%) and where an official warning was issued (29%).

Many staff (60%) were satisfied with the way the incident was handled by their employer, rising to 90% in cases where counselling or debriefing was offered. Offering these services seems to be the key factor in nurse satisfaction with their employers' handling of these types of cases.

When asked the degree to which they agreed with the statement *'I am confident that my manager would support me if I were physically assaulted at work'*, those nurses who have experienced assaults/harassment are less confident of their manager. 64% agreed with the statement, compared to 86% of those who had not been assaulted at work by a patient. However, of those nurses who had experienced an assault or harassment but where counselling/debriefing was offered, 93% agreed with the statement, compared to 64% of nurses who had not been offered counselling.

8.5 Implications of harassment and assault

When nurses are assaulted or harassed by patients or patients' relatives, the effects on work attendance and job intentions are less obvious than is the case for bullying and harassment by members of staff. They are no more or less likely to be on long term sick leave, although they are more likely to consider leaving within 12 months (although the differences are not great - 22% compared to 17% of nurses who have not been harassed or assaulted).

However, in terms of their psychological wellbeing, nurses who have been assaulted or harassed by patients show poor psychological wellbeing. These nurses are twice as likely as those who have not been assaulted/harassed to have psychological wellbeing scores above the CORE cut off point (ie. their scores match those in a clinical population).

The effect of assault on psychological wellbeing is exacerbated by the frequency of assault, and in more serious cases where the offence was reported to police or the offender was prosecuted, nurse wellbeing is further detrimentally affected. For example, in cases where the offender was prosecuted, 30% are in the poorer psychological wellbeing group compared to an average of 17% across all the outcomes considered.

8.6 Summary

- Just over a third (34%) of respondents had been harassed or assaulted by a patient in the last 12 months – more in NHS hospitals (43%).
- Almost one in three nurses have been physically assaulted by patients at some point in their careers.
- In most cases the assault or harassment is from patients themselves (61%) but in more than a third of cases the assault is by a relative of the patient.
- Of those nurses who were harassed or assaulted by patients in the previous 12 months, just over a half (51%) did not report the incident by completing an accident form.
- Nurses who have been bullied or harassed by patients/relatives in the last 12 months have a lower level of psychological wellbeing.

9 Needlestick/sharps injuries

Sharps injuries pose a serious occupational hazard to nurses. Up until recently, most of the research evidence available has been gathered in the USA, and information on occupational exposure to blood and body fluids in the UK has been scant. USA research¹⁶ estimates that between 600,000 and one million health care workers sustain sharps injuries every year, and that 1,000 per year are estimated to contract a blood-borne infection.

In the UK, voluntary surveillance of high risk sharps injury was undertaken between 1997 and 2000¹⁷ and found that there had been 822 reports of work-related, high risk injury, exposing health care workers to blood-borne viruses such as HIV and hepatitis.

This chapter starts by looking at the prevalence of needlestick or sharps injuries among respondents in nursing employment, before describing the nature of the injuries and action taken.

9.1 The extent of needlestick/sharp injuries

Just over one in three nurses (37%) have been stuck by a needle or sharp previously used on a patient, at some point in their career. Although there seems to be little difference between the NHS and independent sectors in general, those undertaking agency work are much more likely to have experienced a needlestick or sharp injury during their careers (49%).

Not surprisingly, nurses with a longer length of service are more likely to have been stuck at some point during the course of their careers. Just under a third (30%) of those who have been in service for between one and five years have been stuck, compared to 38% of the remainder.

The relationship to length of service has a knock-on effect on specialty. A higher proportion of GP practice nurses report having been stuck, but the data reveals that GP practice nurses tend to be older with longer years of service. To get rid of the length of service effect, we need to look at the incidence of needlestick injuries over a given time period.

The last 12 months

Nurses were asked how many times they had been stuck in the last 12 months before the survey. Of all respondents, 7% had been stuck once or more in the previous 12 months. Put another way, of those staff who reported having been stuck by a needle or sharp during their careers, 18% report having been stuck in the last 12 months. The remainder of this section looks at how the incidence of needlestick injury in the last 12 months varies.

¹⁶ National Institute of Occupational Safety and Health alert, (1999) *Preventing Needlestick injuries in health care settings*, publication no. 2000-108 USA: NIOSH.

Cited in Royal College of Nursing (2001) *Be Sharp- Be Safe*, London: RCN

¹⁷ PHLS Communicable Disease Surveillance Centre (2000) Communicable disease report: Surveillance of health care workers exposed to blood-borne viruses at Work, July 1997-June 2000, in *CDR Weekly* Vol 10 No 33 (Aug) p293.

Of all those who had been stuck in the last year, the vast majority (85%) had only been stuck once in this period, 10% had been stuck twice and 5% three or more times.

Variation is most significant between field of practice, shift patterns and by ethnicity. Among the larger sub groups, practice nursing still emerges as the area with highest needlestick injury rates - 11% having been stuck in the last year. Acute adult care and older people's nursing also have higher than average injury rates (9% and 8% respectively). Lower rates are noticeable among management/nurse education (not surprisingly), learning disabilities/mental health and occupational health. Thus the variation according to field of practice remains even when the length of service effect is removed.

Nurses in independent sector hospitals have a higher rate of injury - 10% had been stuck in the last 12 months compared with 7% of those in NHS hospitals. In addition, staff on long days and fixed shifts (11% in each case) show higher rates of this type of injury. It is also the case that ethnic minority nurses seem to have higher rates of injury than is the case for their white colleagues (11% compared to 7%). This can partly be explained by grade differences and variation in fields of practice, but not entirely.

Tables 9.1 and Table 9.2 detail the main differences by setting and field of practice.

Table 9.1: Needlestick or sharp injuries in last 12 months, by location (percentages)

Stuck by needle or sharp in last 12 months	Location					All nurses
	Hospital	Community	GP practice	Nursing home	Other	
Yes	7	5	11	5	5	7
No	93	95	89	95	95	93
Base N=	2414	714	354	339	207	4028

Source: RCN Working well survey

Table 9.2: Needlestick or sharp injuries in last 12 months, by field of practice (percentages)

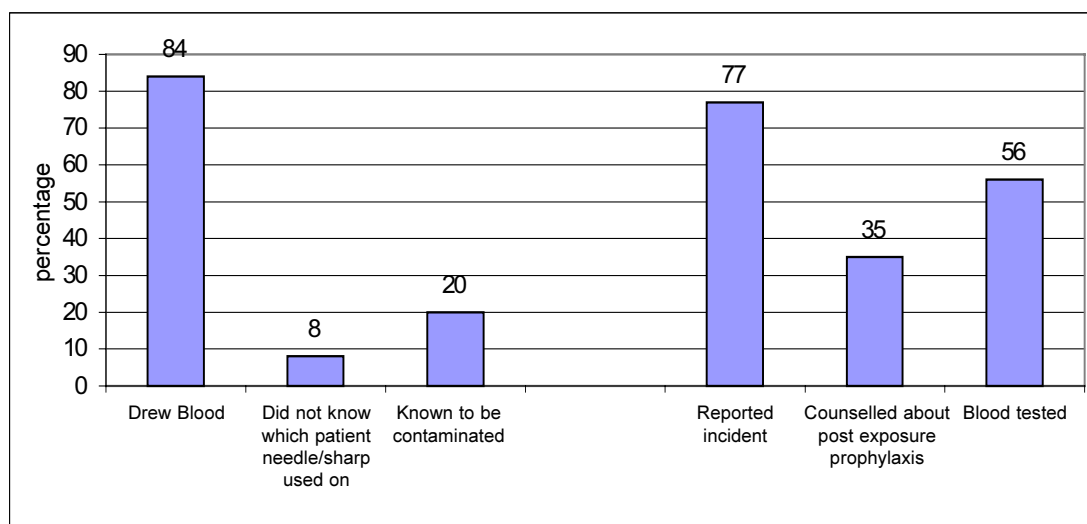
Stuck by needle or sharp in last 12 months	Field of practice						All nurses
	Acute adult care	Older people's nursing	Mental health	Occ. health	Practice nursing	School nursing	
Yes	9	8	3	4	11	7	7
No	91	92	97	96	89	93	93
Base N=	1266	468	189	75	327	70	4042

Source: RCN Working well survey

9.2 The nature of needlestick/sharp injury and outcomes

Here we look only at those nurses who have been stuck in the last 12 months (258 cases). Figure 2.1 shows the proportion of injuries that drew blood (84%), were from an unidentified patient (8%), and where the needle or sharp was known to be contaminated (20%). In 87% of injuries, nurses were exposed to at least one of these situations.

Figure 2.1: Nature of needle injuries and outcomes of incidents (percentages)



Source: RCN Working well survey

In approximately three-quarters of cases (77%) nurses reported the incident (also in Figure 2.1). This went up to 79% where the injury drew blood, was contaminated or from an unidentified patient. In 36% of cases, nurses were counselled about post prophylaxis and in 56% of cases nurses had a blood test. Where the injury drew blood, or was from a contaminated or unidentified source, the proportion of nurses receiving a blood test rose to 59%.

9.3 Summary

- At some time in their careers, 37% of nurses responding to the survey have been stuck by a needlestick or sharp that had previously been used on a patient; 7% of all respondents had been injured in the last 12 months.
- Almost half of all agency nurses (47%) had been stuck at some point in their careers.
- GP practice nurses report a high level of sharps injuries – in the last year more than one in ten (11%) had been stuck by a sharp or needle that had been used on a patient.
- Nurses in independent hospitals have higher injury rates than in NHS hospitals.
- Staff working long shifts are also more likely to have been injured in the last 12 months.
- 84% of injuries drew blood
- One in five cases involved a sharp/needle that was known to be contaminated.
- Nurses reported the incident in 77% of cases, and about half of these were counselled about post exposure prophylaxis.

10 Working practice and nurse outcomes

This chapter explores the relationship between the working wellness of nurses and aspects of working practice over which employers have influence. For the purposes of this analysis, nurses' working wellness is speculatively regarded as an 'outcome' of working practice, and is measured by nurses' psychological wellbeing, levels of sickness, and job satisfaction. The data is also explored to look at another 'outcome' of working practice, nurses' views of the quality of care provided where they work.

To support this analysis, a number of new variables have been produced which are composites of the original variables covered in the survey. The first section of this chapter describes these new 'summary' variables. The use of the CORE Outcome Measure to assess psychological wellbeing is then described in greater detail, before finally exploring the relationships between employer practice and outcomes.

Employer practice variables	Outcome variables
<ul style="list-style-type: none"> Number of employee-friendly services & facilities provided 	<ul style="list-style-type: none"> Psychological wellbeing (CORE-OM)
<ul style="list-style-type: none"> Satisfaction with services provided 	<ul style="list-style-type: none"> Job satisfaction 'Overall I am satisfied with my job', scored on five-point agreement scale
<ul style="list-style-type: none"> Views of employer (overall) <ul style="list-style-type: none"> - Factor 1 'Values' - Factor 2 'Supports & protects' 	<ul style="list-style-type: none"> Sickness absence - amount of sick leave taken in last three months
<ul style="list-style-type: none"> Employer practice typology <p>Composite variable based on following:</p> <ul style="list-style-type: none"> - Shift patterns - Employer consultation - Part-time and flexible working - Choice over when work - Family-friendly working - Professional development and support - Response to bullying 	<ul style="list-style-type: none"> Perceived quality of care delivered 'I am satisfied with the quality of care provided where I work', scored on five-point agreement scale

10.1 Summarising respondents' views of their employers

In order to explore the relationships between the outcome variables and employer practice, the many different aspects of employment practice covered in the survey were collapsed into composite variables that reflect respondents' views of key aspects of their place of work.¹⁸

The new scales act as a summary of the responses to a number of different variables. For example, the questionnaire asked respondents to indicate which of 22 different services and facilities their employer offers. Rather than looking at the responses to each of these items individually in relation to job satisfaction or wellbeing, a composite has been created that indicates the total number of services provided. We can thus look at the overall level of service provision against different outcome measures (this variable is referred to as 'Service provision'). Respondents were also asked to rate their satisfaction with each of the 'employee-friendly' services provided. Again a composite variable was created to provide the average level of satisfaction with services ('Service satisfaction').

Another of the new variables constructed is based on nurses' responses to the 19 questions which relate to their views of their employer. 'Views of employer' encapsulates many aspects of working practice covered by other sections of the questionnaire, and can be regarded as a general measure of nurses' satisfaction with the 'employee-friendliness' of their employer. More importantly, 'Views of employer' relates to nurses' satisfaction with aspects of working practice over which the employer has some control or influence.

Having established the reliability of this scale, factor analysis was used to identify key components. Two main factors emerged that can be regarded as sub-scales of 'Views of employer'. These factors encompass the underlying latent variables or operant mechanisms within the 'Views of employer' scale, and are:

- a) Factor 1, entitled 'Values' (nine items from 'Views of employer'), represents the extent to which respondents feel valued by their employer. This covers issues such as the extent to which employers offer respondents flexibility in their working patterns. More generally, 'Values' concerns nurses' satisfaction with the degree of control they have over their working lives and the extent to which their wishes and needs as employees are valued, which in part is indicated by employers' preparedness to listen and respond to nurses' needs.
- b) Factor 2, entitled 'Protects' (six items from 'Views of employer'), concerns nurses' perceptions of how well employers support and protect nurses, particularly in terms of bullying and harassment, but also in terms of support offered to nurses when they return to work after illness or injury.

The composition of these two factors is shown in Table 10.1.

¹⁸ See Appendix B for further details regarding the analysis undertaken to support the construction of new variables.

Table 10.1: Scales produced from the 'Views of employer'

Factor 1: 'Values' (9 items) Alpha reliability = 0.88

I am generally able to get the off-duty/time-off I want
My manager helps me balance my work and home commitments
The contribution of permanent night nurses is valued by managers
Staff working part-time are treated as well as full-time staff
My employer respects my wishes about when and how I wish to work
I am treated as an individual by my manager
I am satisfied with the level of choice I have over the length of shifts
My colleagues work well to help each other balance their home and work
I am satisfied with the level of input I have in planning my own off-duty time

Factor 2: 'Protects' (6 items) Alpha reliability = 0.85

I am confident that I would be treated fairly if I reported having been harassed
Colleagues are given the support they need to help them get back to work
I am confident that the organisation is taking steps to eliminate harassment in the workplace
I believe that staff who have suffered harassment and bullying are supported
I am confident that my manager would support me if I were physically injured
Policies exist where I work to encourage employee-friendly working practices

Source: RCN Working well survey

Developing an employer practice typology

A series of questions were systemically extracted from different sources in order to generate a number of new composite variables representing working practice (particularly those areas that employers' composite variable incorporates nurses' responses to better questions and cover the following areas of working practice:

- Shift patterns (whether working ideal pattern, ability to change)
- Degree of employer consultation
- Mode of working (opportunity to work part-time and flexibly)
- Choice over when to work
- Family-friendly working
- Professional development and support
- Response to bullying.

Scores for new variables were determined on the basis that if all aspects of working practice incorporated under this composite variable were awarded a '1'. If, however, they said that at least one aspect of the target list was 'good' they were awarded a '0'.

A further composite variable, 'Employer practice', was created incorporating all the above variables. The 'Employer practice' variable divides the respondents into two groups – those who report that ALL aspects of working practice incorporated under this composite variable were 'good', and those who give a 'poor' score on at least one of the constituent aspects of working practice. This single variable thus summarises seven aspects of working practice and is used as an employment practice typology.

10.2 Measuring psychological health and wellbeing

The CORE Outcome Measure [CORE-OM]

For the first time in the RCN's annual membership survey, a psychometric questionnaire was included in the 2000 survey. The RCN decided to include a psychometric questionnaire in order to profile the psychological health of members and to establish whether, as a nursing population, they profiled any differently from the existing CORE non-clinical population. It was also the intention to identify the potential impact of work factors on psychological health and to have a nursing non-clinical population that could be compared to clients of the RCN Counselling Service.

The questionnaire was developed using the CORE Outcome Measure (CORE-OM), a method for assessing psychological health and wellbeing which is widely used in NHS and independent sector psychological therapy. The CORE-OM score is used to assess whether a respondent falls into a 'normative' population, or into a 'clinical' population - ie someone who is experiencing a level of distress similar to people referred to or using psychological therapy services.

4,110 questionnaires were returned to the RCN, and psycho-social profiles were calculated for a total of 4,049 (98.5%). The remaining responses from 61 respondents were invalid because they did not respond to the minimum of 31 items essential for valid and reliable scoring.

Of the valid responses, 448 (11%) of the sample are on or above the clinical cut-off and therefore of a similar profile to people receiving NHS psychological therapies. Only 239 of these nurses (53%) are currently receiving counselling or other treatments for psychological problems.

For the 11% above the clinical cut-off table 10.2 shows differences in CORE-OM scores between those receiving counselling and those receiving any other intervention for their psychological problems compared with those who are not. Anyone with a CORE score of 1.28 or over is categorised as falling within a clinical population. The CORE scores for the group receiving counselling indicate greater levels of psycho-social distress, relative to those

that are not receiving counselling.

composite variable were 'bad', they aspect of working practice from

Table 10.2: CORE-OM scores for those receiving counselling and other treatment and those not receiving treatments for psychological problems

	Yes	CORE	No	CORE	DIFF
Are you currently receiving counselling?	85	1.36	3726	.61	.75
Are you receiving any other treatment, therapy medication or remedy for a psychological problem?	154	1.17	3645	.61	.56

Source: PTRC University of Leeds/RCN Working well survey

Individual CORE item profiles

Here, the mean responses to individual items on the questionnaire are arranged in a hierarchical list. This is shown in Table 10.3, and gives a snapshot of what has troubled the nursing sample in the week before they completed the questionnaire.

Table 10.3: Individual CORE-OM questions hierarchically organised by mean score

Negatively framed items	Mean	Standd. dev.
Scale: 0 (not at all) 1 (only occasionally) 2 (sometimes) 3 (often) 4 (most or all the time)		
I have felt totally lacking in energy and enthusiasm	1.51	1.09
I have been troubled by aches, pains or other physical problems	1.34	1.23
I have felt tense, anxious or nervous	1.17	1.05
I have had difficulty getting to sleep or staying asleep	.95	1.11
I have felt unhappy	.84	.97
I have been irritable when with other people	.82	.87
I have felt criticised by other people	.81	.93
I have felt like crying	.77	.99
My problems have been impossible to put to one side	.71	1.00
I have thought I am to blame for my problems and difficulties	.71	.96
I have felt terribly alone and isolated	.64	.95
Talking to people has felt too much for me	.42	.80
Tension and anxiety have prevented me from doing important things	.41	.79
I have been disturbed by unwanted thoughts and feelings	.36	.76
I have felt overwhelmed by my problems	.36	.75
Unwanted images or memories have been distressing me	.32	.75
I have felt humiliated or shamed by other people	.31	.68
I have felt despairing or hopeless	.29	.70
I have thought I have no friends	.27	.67
I have felt panic or terror	.24	.63
I have threatened or intimidated another person	.12	.45
I have thought it would be better if I were dead	.06	.36
I have thought of hurting myself	.05	.34
I have been physically violent to others	.03	.25
I have hurt myself physically or taken dangerous risks with my life	.03	.24
I made plans to end my life	.02	.22
Positively framed items		
Scale: 4 (not at all) 3 (only occasionally) 2 (sometimes) 1 (often) 0 (most or all the time)		
I have felt I have someone to turn to for support when needed	1.44	1.30
I have felt optimistic about my future	1.28	1.20
I have achieved the things I wanted to	1.20	1.12
I have felt OK about myself	.96	1.11
I have felt warmth or affection for someone	.77	1.02
I have been happy with the things I have done	.77	1.01
I have felt able to cope when things go wrong	.73	1.05
I have been able to do most things I needed to	.67	.97

Source: PTRC University of Leeds/RCN Working well survey

The negatively framed items with a mean score exceeding 0.75 broadly cluster around common symptoms for depression and anxiety. This suggests some degree of stress is evident in the sample population as a whole. The work factors that may contribute to this overall profile are the subject of the remainder of this chapter, as we explore the differences in the psychological health and wellbeing of different groups of nurses, using the CORE-OM scores as one measure in these analyses.

How are CORE scores used in the analyses?

Respondents were grouped in three different ways according to their CORE-OM score. One regrouping divided respondents according to whether or not they were above or below the clinical cut-off. This is the approach that has been most extensively used in the past and is described above. The other two methods divided respondents into high and low scorers according to the mean score (one into four groups, the other into two groups). Using the CORE scores to produce variables in a number of different formats enabled a wider range of analyses to be undertaken.

10.3 Views of employer and outcome variables

The three new variables that address respondents' views of their employer ('Views of employer', 'Values' and 'Protects') are analysed to explore the relationships with the four main outcome variables ('Job satisfaction', 'Psychological wellbeing', 'Quality of care', 'Sickness absence'). Nurses' views of their employer are measured in terms of the extent to which they feel their views and needs are valued by their employer, and whether or not the employer offers protection and support.

The results show that nurses' views of their employer are significantly related to job satisfaction and psychological wellbeing. There is also a relationship with the perceived quality of care delivered.

The strongest of these relationships is between the nurses' overall satisfaction with their employer, and their satisfaction with their job. The two component factors of the overall Views of employer ('Values' and 'Protects') also demonstrate significant (but weaker) relationships with these three outcomes. Again the strongest correlation was with job satisfaction.¹⁹

Further analysis (T-tests and Analysis of Variance) confirmed that nurses' responses to the outcome variables differ significantly according to their views of their employer.

These relationships are illustrated in Table 10.4. Respondents have been categorised into two groups according to whether they score above or below 2.5 on each of the factors, and the proportion in each group are shown against the four outcome measures.

¹⁹ It should be noted however, that measures of job satisfaction and quality of care are based on items from the same section of the questionnaire and asked in the same format, and that this could have an influence on the correlations.

Table 10.4 : Impact of whether employer ‘values’ and ‘protects’, by nurse outcomes

		Employer ‘Values’		Employer ‘Protects’	
		Most positive (< 2.5)	Least positive (>=>2.5)	Most positive (< 2.5)	Least positive (>=>2.5)
Job satisfaction	Satisfied	96%	66%	95%	73%
	Not satisfied	4%	34%	5%	27%
	<i>Total (100%) N=</i>	<i>2132</i>	<i>1478</i>	<i>1733</i>	<i>1877</i>
Psychological wellbeing	Better (upper quartile)	34%	12%	34%	16%
	Middle	52%	52%	51%	53%
	Poorer (lower quartile)	14%	36%	15%	31%
	<i>Total (100%) N=</i>	<i>2205</i>	<i>1841</i>	<i>1822</i>	<i>2223</i>
Quality of care	Satisfied	92%	73%	93%	76%
	Not satisfied	8%	27%	7%	24%
		<i>2072</i>	<i>1583</i>	<i>1737</i>	<i>1914</i>
Sickness absence	No sickness leave taken	78%	69%	77%	72%
	Taken sick leave in last 3 months	22%	31%	23%	28%
	<i>Total (100%) N=</i>	<i>2243</i>	<i>1858</i>	<i>1846</i>	<i>2253</i>

(chi-square significance = 0.000 for all)

Source: RCN Working well survey

Stepwise linear regression was used to take this exploration one stage further and look specifically at the relationship between the variables and psychological wellbeing. The results demonstrate that both ‘Values’, ‘Protects’ and the overall ‘Views of employer’ scale, can be used to predict respondents’ CORE scores, indicating that these variables may have some effect on nurses’ psychological wellbeing. The overall ‘Views of employer’ scale is a better predictor of CORE scores than either of the constituent factors taken alone.

Interestingly, the extent to which nurses feel that they are protected and supported by their employer (‘Protects’) accounts for a greater degree of variation in psychological wellbeing than does the extent to which they feel valued (‘Values’). Thus whilst both are relevant, feeling supported and protected by the employer may have a greater effect on nurses’ psychological and emotional wellbeing than whether or not they feel their employer values their needs and wishes.

Logistic regression indicates that the three variables can be used to predict whether or not nurses have taken any sick leave in the last 12 months, as well as predicting job satisfaction and satisfaction with the quality of care. Whilst all the variables may be related to nurses’ estimation of the quality of care provided to patients, again, feeling protected by the employer has stronger influence on nurses’ evaluation of quality of care than does feeling valued.

All these analyses show clearly that where nurses give positive evaluations of their employers (perceiving that employers value and protect staff), they have better psychological wellbeing, lower sickness levels, higher job satisfaction and more favourable perceptions of the quality of care delivered. This is true to the extent that we can use nurses' evaluations of their employer to predict what these outcomes will be.

10.4 Employee-friendly services and facilities

The *Working well survey* also included a section on the availability of, and satisfaction with a range of employee services or practices. Chapter 4 described the responses to these questions, but we look now at how these items can be combined to explore the relationship between the employee-friendly facilities and services and nurses' wellbeing at work.

Two new variables were generated to examine whether the range and quality of services provided might have any influence on nurses' working wellness. The first of these variables ('Services') simply counts the number of services available at work for each individual nurse. The second variable ('Satisfaction with services') provides a mean score of satisfaction for each individual nurse, where at least one service is provided.

The number of services or working practices provided by employers ('Services') is correlated weakly with the three main outcome variables. Job satisfaction has the strongest correlation, indicating that nurses' overall job satisfaction is linked with the provision of employee-friendly facilities and practices.

The range of services provided is also correlated with nurses' views of their employer (as defined by the variables described in section 10.3) particularly in terms of the 'Protects' factor. In other words, nurses who report that they are satisfied with their employers' response to bullying and harassment and the support offered to those who have been sick, are also more likely to report that they work for an employer that endorses a wide range of employee-friendly practices.

Satisfaction with employee-friendly services is more strongly correlated with the outcome variables than is the overall number of services provided. Although once again, the relationships are weak. The strongest of these weak relationships is between 'Satisfaction with services' and 'Job satisfaction'. In a linear regression, the scores for both the provision and satisfaction with services can be used to predict scores for job satisfaction, although once again, satisfaction with services accounts for more variation in job satisfaction than simply looking at the number of services provided.

Satisfaction with the employee-friendly services also demonstrated a weak, but statistically significant, relationship with the number of shifts taken off sick in the last 3 months. When put into a logistic regression equation, satisfaction with services is found to be a predictor of whether or not nurses have taken any sick leave in the last 12 months.

As with the number of services, satisfaction with services is strongly correlated with nurses' satisfaction with other attitudinal items, hence it is correlated with 'Views of employer', and both the constituent factors, Values and Protects. Overall then, there is some evidence that service provision and satisfaction with the service provided may have a stronger relationship with nurses' evaluation of general employee-friendliness than they do with the specific outcomes.

Table 10.5: Range and satisfaction with employee-friendly services and facilities, by nurse outcomes

Outcome	Number of Services (mean)	Dissatisfaction with services (mean, high is more dissatisfied)
Job satisfaction		
Satisfied	10.35	2.27
Not satisfied	9.23	2.92
Psychological wellbeing		
Better (top quartile)	10.16	2.14
Poorer (bottom quartile)	9.31	2.69
Quality of care		
Satisfied	10.2	2.32
Not satisfied	9.87	2.79
Sickness absence		
No sickness leave taken	10.03	2.38
Taken sick leave in last 3 months	10.16	2.52

Source: RCN Working well survey

Nonetheless, further analysis establishes that there are significant differences in the number of services reported, and the level of satisfaction with services reported, in relation to the CORE grouping and according to job satisfaction. Thus, nurses who report suffering poorer psychological wellbeing, and nurses who report lower job satisfaction, also report having fewer services and being less satisfied with the services that are provided. (See Table 10.5).

Stepwise linear regression also establishes that the scores for both these variables ('Services' and 'Satisfaction with services') can be used to predict respondents' CORE scores. Again satisfaction with the services provided was a better predictor of CORE scores than the number of services provided. This suggests that the quality of services provided may be more important in explaining variation in psychological wellbeing than simply the number of services employers provide.

The two variables taken together, however, account for greater variation in CORE scores than does 'Satisfaction with services' in isolation.

In conclusion, it is evident that employee-friendly service provision has some relationship with the nurse outcomes considered. In particular, it is nurses' satisfaction with the services provided, rather than the number or range of services provided, that appears to be most influential. Greater satisfaction with services is associated with better psychological and emotional wellbeing, lower sickness levels, higher job satisfaction and more favourable perceptions of the quality of care delivered.

In some instances, the number of services provided is also associated with more favourable outcomes, but not in relation to sickness levels and perceived quality of care. The results of the analysis for this section were not as dramatic as those produced in the previous section when we looked at the relationship between employees' views of the approach taken by their employer and working wellness. This may indicate that the overall approach taken by employers to issues such as working hours and bullying and harassment is more important to 'working wellness' than the number services or facilities provided.

However, there is some relationship between the service provision variables and overall employee-friendliness variables. Thus nurses who are satisfied with their employer's attitude to issues such as choice over working hours and response to bullying and harassment are also more likely to be positive about the specific services provided by their employer.

10.5 Employer practice typology and working wellness

The *Working well* questionnaire included several themes focusing on specific aspects of working life. Questions were combined (see 10.1 above) to produce composite variables summarising the following areas of working practice:

- Shift patterns
- Degree of employer consultation
- Mode of working
- Choice over work time
- Family friendly working
- Professional development and support
- Response to bullying

These 'themes' were combined into a single employer typology that splits respondents into two groups – good or bad.

Correlation analysis revealed that there are many statistically significant relationships between the variables listed above and the target outcome variables. Chi-square tests confirm that there are significant differences in the numbers of respondents reporting favourable working practices between groups divided according to CORE scores, job satisfaction and satisfaction with perceived quality of care. Thus, nurses who report suffering poorer psychological wellbeing, nurses who report lower job satisfaction, and nurses who have more negative perceptions of the quality of care delivered also report more negatively about the working practices captured by all variables entered into this analysis.

Table 10.6 summarises the findings. Each aspect of working life is divided into 'good' and 'bad' groups, and then the proportion reporting favourable outcome situations in each is reported.

Table 10.6: Incidence of positive outcomes by features of working life (percentages)

		Satisfied with job	'Good' psychological wellbeing	Satisfied with quality of care	No sickness absence
Shift patterns	+	88	27	85	75*
	-	47	8	67	68
Employer consultation	+	94	32	89	77
	-	46	7	64	66
Mode of working	+	84	24	84 (ns)	74 (ns)
	-	46	0	72	74
Choice over when work	+	88	27	87	75*
	-	50	8	69	68
Family-friendly working	+	85	25	85	74 (ns)
	-	56	13	56	70
Professional dev't and support	+	84	24*	85	74 (ns)
	-	47	11	59	76
Response to bullying	+	88	26	87	75
	-	21	1	38	57

*(chi-square significance = 0.000 for all except: * = 0.00 ns = no significance)*

Source: RCN Working well survey

The bigger differences are indicated on the table by shading. The first thing that emerges is that all the different aspects of employer practice have a significant impact on job satisfaction and on psychological wellbeing, and to a lesser extent on perceived quality of care. The second point to note is the consistent effect of employers' response to bullying and harassment. The importance of this variable echoes earlier findings regarding the 'Protects' factor.

We'll now look at each of the outcome variables individually, before looking across all relationships to identify those that appear most important.

Job satisfaction

Job satisfaction is significantly correlated with the composite variable 'Employer practice', showing that there is a clear relationship between how satisfied nurses are with their jobs and the level of good employment practice undertaken.

Looking in more detail, the extent to which nurses feel their employer has consulted them ('Consult') achieves the second highest correlation with job satisfaction (as well as with psychological wellbeing and perceived quality of care). In regression analyses, we find perception of employer consultation has some predictive value for job satisfaction, as does the extent to which employers protect nurses from bullying and harassment. Job satisfaction is also related to the level of professional development and support available.

Job satisfaction is also significantly correlated with nurses' intention to leave, and indeed intention to leave nursing can be used as a predictor of job satisfaction.

Psychological wellbeing and health (CORE-OM scores)

The combination of factors covered by 'Employer practice' correlate more strongly with psychological wellbeing (and with perceived quality of care) than any of the individual aspects of working practice.

Whether or not respondents were bullied or harassed in the last 12 months is the best predictor of CORE scores. 'Employer practice', work-related injury or illness, and 'Protects' can also be used to predict CORE scores, although they account for less of the effect than does the incidence of bullying/harassment. These variables, particularly the incidence of bullying and harassment, can therefore be viewed as having an effect on nurses' emotional and psychological wellbeing.

Sickness absence

Again, the degree of employer consultation emerges as a key variable. It is significantly correlated with sickness levels (number of shifts off sick in the last 3 months). Values for sickness levels can also be predicted by intention to leave, work-related injury or illness and the incidence of bullying and harassment. Thus, the incidence of bullying, harassment and work-related injuries/illness not only impact on nurses' emotional and psychological health; they also effect nurses' capacity to work.

Quality of care

Quality of care is significantly (but weakly) correlated with 'Consult'. Thus nurses who are satisfied with the extent to which they are consulted about various aspects of their working lives are more likely to report that they are satisfied with the quality of care provided where they work. The level of choice over working hours ('Choice') and employers' attitude to bullying also show weak correlations with perceptions of quality of care.

Which factors are most important?

From the analyses presented in this section it is evident that in addition to nurses' evaluations of employee-friendliness and service provision, there are other key employment practice variables that may have an important influence on the nurse outcomes considered.

The incidence of bullying and harassment and work-related injuries both impact on nurses' health and psychological wellbeing. The level of consultation by employers has a significant relationship with outcomes, particularly with nurses' job satisfaction, and so is a key variable in terms of 'working well'.

In most cases, the results of the analysis for this section were not as dramatic as those produced by either the investigation of nurses' views of their employers, or the investigation of employee-friendly services. However, when considered in combination with the preceding sections, the results are more meaningful. For example, to be well at work, nurses not only need to *feel* protected by their employer (as measured by 'Protect'), they also need to *be* protected by their employer (ie. the incidence of bullying and harassment is lower).

10. 6 Defining a 'good' employer

Defining a 'good' employer

Much of the analysis described in this chapter has aggregated variables to produce a representation of whether or not employment practice is 'good' overall. The rationale for using the data in this way is that in many cases where one aspect of employment practice is viewed positively, others are too – many of the individual variables measuring nurses' views and experiences of employment practice are correlated.

We have established a clear link between employment practice and nurses' well being, but what are the components that define a 'good' employer?

Our analyses show that the key characteristics of good employment practice associated with better nurse outcomes are:

1. Providing a safe environment – a fundamental aspect of good employment practice that is closely correlated to nurses' satisfaction and wellbeing is the safety of the environment in which they work. Nurses who are less at risk of bullying, harassment and assault are more likely to be positive about other aspects of their work.
2. Protected and supported - employees need to feel confident that employers take bullying and harassment seriously and that they will be supported if they become a victim. Likewise, they need to feel that employers will respond supportively if they suffer illness or injury.
3. Valued – staff who feel their employer values them and respects their needs are more likely to be satisfied with their jobs and to have higher psychological wellbeing scores. Enabling staff to organise their working time in a way that suits them and treating all staff fairly (including those who work part-time or permanent nights) are indicators of the extent that nurses feel that they are valued.
4. Consultation – clearly linked to the idea of being valued, the extent to which staff are consulted about means of balancing home and life needs is another key strand in 'good' employment practice. Consultation explains more variation in job satisfaction scores than any other specific aspect of working life.
5. Quality of employee-friendly services – the overall amount of employee-friendly initiatives (in terms of total number of services) appears to be less important than the quality of the services offered, and whether or not they relevant to employees' needs. It is the difference between, for example, simply having a workplace crèche or ensuring staff can organise their childcare in a way that best suits them.

10. 7 Summary

This chapter has explored different ways of summarising the employment practice environment within which nurses work, and looked to see what impact employment practice has on a number of different outcomes.

The overall message that emerges is that employment practice makes a clear difference to nurses' job satisfaction and psychological wellbeing. To a lesser extent, the nature of the employee-employer relationship also has a bearing on nurses' views of the quality of care provided and on their level of sickness absence.

- Employee-friendliness, as gauged through nurses' views of their employer, has the most significant impact on nurses working wellness.
- Views of employers in relation to employee friendliness can be grouped according to two main factors. Firstly, the extent to which nurses' wishes and needs are valued and respected by the employer. Secondly, the level of protection and support offered by employers.
- The range of employee-friendly services and facilities provided also has some impact on nurses working wellness. However, it is nurses' satisfaction with the services provided, rather than the number provided, which is most relevant to nurses' working wellness.
- In terms of nurses' psychological wellbeing, the incidence of bullying, harassment and work-related injuries/illness has a greater effect than employee-friendly service provision.
- The incidence of bullying/harassment and work-related injuries/illness are better predictors of sickness levels than any other variables considered in this analysis.
- The employer typology is the best predictor of nurses' satisfaction with the perceived quality of care delivered, but nurses' evaluations of the employer across a combination of different aspects of working practice are also relevant.
- Job satisfaction is strongly related to nurses' views of their employers and the employee-friendly services provided.
- Job satisfaction also appears to be influenced by other factors, such as the level of employer consultation and the level of professional development and support available.
- Nurses who are satisfied with their jobs are less likely to report that they intend to leave their current position.

Appendix A: Measuring psychological health and wellbeing

This section explores the use of the CORE Outcome Measure (CORE System Group, 1998) to profile the psychological wellbeing of nurses who responded to the *Working well survey*. We cover:

- (i) an introduction to the structure and profile of the CORE-OM
- (ii) the rationale for including CORE-OM in the *Working well survey*
- (iii) the strengths and weaknesses of using CORE-OM in the *Working well survey*.

A.1 The CORE Outcome Measure: structure and profile

The CORE Outcome Measure (CORE-OM) is a single-sheet, 34-item client self-report questionnaire, which assesses the psychosocial domains of subjective wellbeing (self-confidence/esteem), symptoms (common problems), and life, social and relational functioning. It also contains four items on risk to self, and two items on risk to others. The individual question items of CORE-OM and the psycho-social domains they assess are provided in Table A.1.

The structure of the CORE questionnaire was informed by a large-scale survey of psychological therapists²⁰. That survey sought to quantify the life aspects which therapists routinely assessed in determining the type and extent of their patients' psychosocial difficulties and subsequent post-therapy improvement. The four most common aspects assessed are now reflected in the four questionnaire domains.

The core measure shows the level of problems the respondent might be experiencing, from mild depression through to severe anxiety and even harm to self or others. (Coincidentally, these mirror the phase model theory of Howard *et al*²¹ in their descriptions of the affects of adverse life events on psycho-social functioning.)

The CORE-OM, in measuring subjective wellbeing, symptoms, functioning and risk, is able to help assess not only if a person is psycho-socially unwell, but the extent and severity of that illness relative to a population of psycho-socially well individuals. As a consequence, when used in psychological therapy practice, the measure is administered immediately prior to first contact (for example, assessment or first therapy session), and again at the last therapy session in order to determine levels of illness post-therapy compared with pre-therapy.

²⁰ Mellor-Clark, J., Barkham, M., Connell, J., Evans, C. (2000) Practice-based evidence and need for a standardised evaluation system: Informing the design of the CORE System. *European Journal of Psychotherapy, Counselling, and Health*, 2, 3: 357-374.

²¹ Howard, K.I., Leuger, R.J. et al (1993) A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology* 61, 678-685.

Table A.1: The content and itemised domain structure of the CORE Outcome Measure

Dimension	Item
Subjective wellbeing	I have felt OK about myself
Subjective wellbeing	I have felt like crying
Subjective wellbeing	I have felt optimistic about my future
Subjective wellbeing	I have felt overwhelmed by my problems
Symptoms – anxiety	I have felt tense, anxious or nervous
Symptoms – anxiety	Tension and anxiety have prevented me from doing important things
Symptoms – anxiety	I have felt panic or terror
Symptoms – anxiety	My problems have been impossible to put to one side
Symptoms – depression	I have felt totally lacking in energy and enthusiasm
Symptoms – depression	I have felt despairing or hopeless
Symptoms – depression	I have felt unhappy
Symptoms – depression	I have thought I am to blame for my problems and difficulties
Symptoms – physical	I have been troubled by aches, pains or other physical problems
Symptoms – physical	I have had difficulty getting to sleep or staying asleep
Symptoms – trauma	I have been disturbed by unwanted thoughts and feelings
Symptoms – trauma	Unwanted images or memories have been distressing me
Functioning – general	I have felt able to cope when things go wrong
Functioning – general	I have been happy with the things I have done
Functioning – general	I have been able to do most things I needed to
Functioning – general	I have achieved the things I wanted to
Functioning – close relationships	I have felt terribly alone and isolated
Functioning – close relationships	I have felt I have someone to turn to for support when needed
Functioning – close relationships	I have felt warmth or affection for someone
Functioning – close relationships	I have thought I have no friends
Functioning – social relationships	Talking to people has felt too much for me
Functioning – social relationships	I have felt criticised by other people
Functioning – social relationships	I have been irritable when with other people
Functioning – social relationships	I have felt humiliated or shamed by other people
Risk/Harm to self	I have thought of hurting myself
Risk/Harm to self	I have hurt myself physically or taken dangerous risks with my life
Risk/Harm to self	I made plans to end my life
Risk/Harm to self	I have thought it would be better if I were dead
Risk/Harm to others	I have been physically violent to others
Risk/Harm to others	I have threatened or intimidated another person

Source: CORE System Group (1998) CORE System User Manual. Leeds: PTRC

The psychometric properties of the CORE-OM have been detailed elsewhere (see Evans et al., 2000²²; Barkham et al, 2001²³). In brief, highly significant differences have been found between clinical and non-clinical population samples for CORE-OM dimensions. Alpha coefficients for dimensions and item totals have been calculated for clinical and non-clinical samples, and test-retest stability has been demonstrated. Convergent validity has been established with a range of well-validated psychometric measures, giving CORE-OM clinical and academic credibility. A sample of correlations with other well established measurement questionnaires in common use in UK clinical and research practice are summarised in Table A.2.

Table A.2: Convergent validity correlations between the CORE Outcome Measure and other well-established referential measures

Referential Measures	Sample n	Correlation
Symptom Checklist 90R (SCL90)	34	.88
Beck Depression Inventory (BDI)	251	.85
Brief Symptoms Index (BSI)	97	.81
Beck Anxiety Inventory (BAI)	218	.65
GHQ-28	69	.75
Inventory of Interpersonal Problems (IIP-32)	246	.65

Source: CORE System Group (1998) *CORE System Information Management Handbook*. Leeds: PTRC

The model of reliable and clinically significant change (Evans *et al*, 2000)²⁴ has been adopted for statistical analysis of the measure which calculates clinical cut-offs for males (M) and females (F) for the routine assessment of psychological therapy effectiveness. If an individual scores above the clinical cut-off (of 1.28) they are determined to be in a clinical population, and thus more akin to individuals in receipt of NHS psychological therapies. As these clinical cut-offs are central to the analysis presented in the report they are summarised in Table A.3.

²² Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., McGrath, G. (2000) Clinical outcomes in routine evaluation: The CORE outcome measure. *Journal of Mental Health*, 9: 247-255.

²³ Barkham, M., Margison, F., Leach, C., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K. & McGrath, G. (2001) Service profiling and outcomes benchmarking using the CORE-OM: Towards practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology*, 69, 2, 184-196.

²⁴ Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., McGrath, G. (2000) Clinical outcomes in routine evaluation: The CORE outcome measure, *Journal of Mental Health*, 9: 247-255.

Table A.3: Male and female cut-off scores between clinical and non-clinical populations

Dimension	Male	Female
Wellbeing	1.37	1.77
Problems	1.44	1.62
Functioning	1.29	1.30
Risk	0.43	0.31
All Items	1.19	1.29

Source: CORE System User Manual (CORE System Group, 1998)

Why was the CORE Outcome Measure developed?

The CORE-OM was developed over a three-year period by a group of multi-disciplinary research-practitioner experts in providing psychological therapy. The measure is a pragmatic tool with high clinical utility for assessing psychological health and wellbeing, and it is available in the public domain.

The measure was developed firstly to offer NHS practitioners free access to a high quality, sensitive instrument for quantifying and defining the antecedents of psychological distress. Secondly, it means that in management, research, and clinical governance, staff could have free access to a robust and pragmatic instrument capable of evaluating the relative effectiveness of a range of therapies (for example, CBT, psycho-dynamic, person-centred counselling), service delivery domains (for example, primary care, secondary care, specialist care), and therapists. A fuller rationale of CORE-OM in the context of evidence-based practice and clinical governance can be found in Mellor-Clark and Barkham (2000)²⁵.

At the time of development, only 16% of practitioners routinely used measures in their work with patients (Mellor-Clark et al., 2000)²⁶. The evolving climate of evidence-based practice exerted considerable pressure on service providers to monitor therapy effectiveness but the high quality measures available were prohibitively expensive for routine use. In addition, the majority of the measures were designed by U.S. researchers and only had normative data available for American sample populations.

Who uses the CORE Outcome Measure?

Partly due to its free availability, CORE-OM is now widely used within (and beyond) NHS psychological therapy service provision. Since its launch in June 1998, over 2,500 practitioners have requested or received copies of it, and follow-up surveys show only 16% of users found it to be inapplicable in their setting. As a consequence, the CORE System (design) Group estimates that this is now the most widely used measure used in UK mental health care.

²⁵ Mellor-Clark, J. & Barkham, M. (2000) Quality evaluation: methods, measures & meaning. In C. Feltham & I. Horton (eds.), *The Handbook of Counselling and Psychotherapy*, London: Sage Publications.

²⁶ Mellor-Clark, J., Barkham, M., Connell, J., Evans, C. (2000) Practice-based evidence and need for a standardised evaluation system: Informing the design of the CORE System. *European Journal of Psychotherapy, Counselling, and Health*, 2, 3: 357-374.

Acting as the co-ordinating centre, the Psychological Therapies Research Centre at the University of Leeds has processed data for in excess of 20,000 clients to date. From this, it is anticipated that there will be created the single largest, standardised and co-ordinated dataset collected in the UK to profile the psycho-social health of clinical populations undertaking psychological therapy.

Although largely used by psychiatrists, psychotherapists, psychologists and counsellors working in the NHS, CORE-OM is also increasingly used in higher education and workplace settings. Indeed, the RCN Counselling Service has now been using it for over two years. During this time the Counselling service has amassed a comprehensive dataset profiling the vast majority of clients seen during that time. Using the CORE measure, the Service has been able to demonstrate clinical and/or statistically reliable change for over 80% of clients who reach mutually planned endings of their counselling service contacts.

Drawing on the positive experience of the RCN Counselling Service, an increasing number of other counselling and psychological therapy services used by NHS staff are beginning to use CORE-OM. This growth of interest has led to a new initiative to promote CORE-OM as a recommended measure to help monitor services which provide psychological therapies to NHS staff.

A.2 The rationale for including CORE-OM in the *Working well survey*

The decision to incorporate CORE-OM in the *Working well survey* was guided by four principle interests of the RCN Counselling Service and the RCN as a whole:

1. to identify the proportion of nurses who may be in need of counselling interventions or support, but who are not currently attending a psychological therapy service or alternatively receiving prescribed appropriate medication.
2. to establish some occupation-specific norms for the nursing population. In the development of CORE-OM, the 'normative' population used to establish the non-clinical group norms were largely (and traditionally) made-up of students and a sample of convenience drawn from the general public. The RCN Counselling Service was interested to establish population-specific norms that would enhance their use of CORE-OM in exploring the effectiveness of counselling for problems presented by nurse clients.
3. to profile response to CORE-OM at an individual item level, to help the Counselling Service understand the types of subjective wellbeing, symptoms and functioning impairments that are commonly experienced in the nursing environment.
4. to explore whether there are identifiable occupational stressors that impact on the psycho-social wellbeing of nurses.

A selection of examples of the range of interests expressed at the early planning stages included the following:

- Do some clinical areas of nursing have a greater impact on wellbeing than others?
- Do working hours impact on wellbeing?
- What is the impact of bullying and harassment on nurses' wellbeing?

- If bullying or harassment is experienced by nurses, does the manner with which it is dealt have a differential impact on wellbeing?
- What impact does management support have on wellbeing?
- Are there any significant variations in wellbeing across the four countries represented in the sample?
- Are there significant variations in wellbeing across nursing grades?
- Does the availability of services/facilities offered on-site impact on wellbeing?
- Overall, using all the environmental and experiential variables in the survey, is it possible to identify what factors are most likely to predict best and worst wellbeing?

A.3 Strengths and weaknesses of using CORE-OM in the *Working well survey*

The use of the CORE-OM in the *Working well survey* has provided a unique and interesting insight into the psychological health and wellbeing of a large sample of NHS nursing staff. This is the first time such a detailed psychometric questionnaire has been included in the RCN annual membership survey, and the consistently high response rate suggests that CORE-OM was an acceptable inclusion. Detailing CORE-OM scores independently of other variables has given us some useful highlights:

- 99% of returned CORE-OMs were appropriately completed and scorable.
- Of the valid responses, 448 (11%) of nurses were on or above the clinical cut-off and therefore of a similar profile to people receiving NHS psychological therapies. As only 239 nurses (53%) were either currently receiving counselling or other treatments for psychological problems, this suggests that the RCN Counselling Service may only be meeting the needs of a sample of those that might benefit from counselling.

Overall, the use of CORE-OM in the *Working well survey* has set an important precedent in using the first UK measure to be supported by a specialist research centre. Traditional approaches to profiling and monitoring wellbeing use a variety of different measures, so it is difficult to make direct comparisons between studies. As an increasing proportion of occupational health services (within and beyond the NHS) look for appropriate tools to assess population needs in psychological therapy services, we hope the RCN precedent will provide a useful resource for mutual gain and interest.

However, the use of CORE-OM has its limitations. The proportion of nurses (11%) who have psychological health profiles similar to NHS (mental health service) clinical populations must be set in the context of the prevalence of disorders in the general population and other occupation-specific population surveys. However, as this is the first survey to use CORE-OM for profiling psychological health for a specified occupation, comparative data is as yet unavailable.

Appendix B: Construction of new variables

This appendix describes how working practices and aspects of the working environment over which the employer has some influence or control have been isolated and combined to form new variables.

Employee-friendliness

A number of new variables have been generated in order to complete this analysis.

The first and most significant of these is a composite variable derived from all items on Question 62 (“Your Views”). Reliability analysis confirmed that the 19 items making up Question 62 can be used as a scale ($\alpha = .92$). Question 62 encapsulates many aspects of working practice that also appear on other sections of the questionnaire, and gives a general measure of nurses’ satisfaction with the ‘employee-friendliness’ of their employers. Seventeen of the items that make up Question 62 concern also nurses’ satisfaction with aspects of working practice over which the employer has some control or influence.

The remaining two items: Question 62f (which measures nurses’ satisfaction with their perceptions of the quality of care delivered), and Q.62k (which measures nurses’ overall job satisfaction) are not easily regarded as variables that the employer has any control over, but rather as nurse outcomes which will also be examined separately. However, because these two items are presented alongside the remaining seventeen and respondents have been focused on the incumbent themes, they are initially included in the new variable on the basis that they may be representative of nurses’ satisfaction with employee-friendliness and related issues. This new key scale variable (respondents’ mean scores across all 19 items on Q.62) will hereafter be referred to as ‘Views of employer’.

Three other variables were derived from ‘Views of employer’ (Q.62). In an attempt to isolate any underlying operant mechanisms, factor analysis was carried out on the new scale variable, revealing how the items cluster together. Factor analysis is a technique that allows researchers to examine whether a number of variables within a dataset are reflecting a smaller number of broader latent variables (i.e. underlying psychological dimensions). The factor analysis generated three new factors or sub-scales of ‘Views of employer’. Factors 1 and 2 also proved to be reliable as scales ($\alpha = .88$ and $.85$ respectively). Factor 3 was not reliable as a scale ($\alpha = .34$).

Factor 1 (‘Values’) is comprised of nine items from ‘Views of employer’ (c, d, e, i, l, n, o, q, and s). Many of these items refer to whether or not respondents find their employer to be flexible and responsive about working patterns and balancing work and home commitments. However, Factor 1 also incorporates items concerning the degree of autonomy, control and degree of individuality afforded to respondents by employers. If there is an underlying mechanism for Factor 1 that encapsulates all the themes of the nine items, it seems to reflect whether or not respondents feel that they are valued and that their input is valued by their employer.

Thus, whether or not employers afford flexibility in working patterns may be regarded by nurses as a reflection of that same employer perspective or approach - as does whether or not employers value the input of permanent night nurses, or whether or not employers treat all staff as individuals. Factor 1 can be regarded as a measurement of working practice over which the employer has some control. It concerns the extent to which employers make nurses feel valued as individuals, reflected in part by their preparedness to listen and respond to nurses' needs.

Factor 2 ('Protects') is comprised of six items from 'Views of employer' (a, b, j, m, p, r). It concerns nurses' perceptions of how well employers support and protect nurses, particularly in terms of bullying and harassment, but also in terms of support afforded to nurses to help them return to work after illness or injury. This protection and support can be regarded as another important aspect of working practice over which the employer has some control.

Factor 3 incorporates four items (f, g, h, and k) that do not have such a cohesive underlying theme. If anything, they concern nurse outcomes rather than employer input. One item measures nurses' job satisfaction, one measures nurses' perceptions of quality of care, one nurses' satisfaction with the degree of mutual respect between management and staff. The last item measures nurses' satisfaction that bullying and harassment is not a serious problem in their workplace (contrasted with items in Factor 2, which concern nurses' satisfaction with how well bullying and harassment are dealt with when they arise). Because of its lack of reliability and because the items appear to concern issues that are not necessarily under the employers control, Factor 3 is not regarded as a reliable measure of working practice. However, two of the items from Factor 3 were extracted as 'nurse outcomes' to be used in further analysis.

Provision of services and nurses' satisfaction with services

Question 20 addresses the quantity and quality of services provided by the employer. Two new variables were generated to examine whether the range and quality of services provided might have any influence on nurses' working wellness. 'Services' counts the number of services available at work for each individual nurse. 'Satisfaction with services' provides a mean satisfaction score for each individual nurse, where at least one service is provided. 'Satisfaction with services' is not reliable as a scale because the response rate is so variable; not all services are provided at each location, therefore the responses to this section are necessarily patchy. However, the mean score is a reflection the satisfaction of the 4,083 nurses who provided at least one answer to questions regarding satisfaction with whatever services are provided.

Composite variables

A series of questions addressing various themes were systemically extracted from different sections across the questionnaire, in order to generate a number of new composite variables reflecting different aspects of working practice over which the employer may have some control. The following list details the composition of the new variables and the variable names:

Shift patterns ('shifts')

- Current shift pattern is the preferred choice (computed from Q11 and Q12)
- Q13 'Could you change your shift pattern if you wanted to?'
- Q20-r 'Offered flexible working'
- Q62-o 'I am satisfied with the level of choice I have over the shifts I work'

Employer consultation ('consult')

- Q21 'Employer has consulted you about how best they can help you balance your work and life needs?'
- Q62-d 'My manager helps me balance my work and home commitments'
- Q62-l 'My employer respects my wishes about when and how I wish to work'

Mode of working ('mode')

- Q20-h 'Opportunities to work part-time'
- Q20-i 'Opportunities to job share'
- Q62-i 'Staff working part-time are treated as well as full-time staff'

Choice over when work ('choice')

- Q20-j 'Opportunities to self-roster'
- Q62-c 'I am generally able to get the off-duty/time-off I want'
- Q62-s 'I am satisfied with the level of input I have in planning my own off-duty/time-off'

Family friendly working ('family')

- Q20-g 'Access to parental leave'
- Q20-k 'Access to term-time or school holiday contracts'
- Q20-o 'Workplace nursery or crèche'
- Q20-r 'Flexible working'
- Q62-t 'Dependent leave'

Professional devt/support ('devt')

- Q20-v 'Opportunity for staff training and development'
- Q20-q 'Careers guidance'
- Q20-u 'Clinical supervision'

Health and wellbeing ('health')

- Q26 Access to occupational health service
- Q28 Access to counselling service
- Q30 Enable to get treatment needed after sickness or injury (eg. fast tracking)
- Q16 Access to rest breaks if work over 6 hours
- Q62-b 'Colleagues are given the support they need to help them back to work after injury or illness'

Facilities ('facility')

- Q20-a Catering facilities in the day
- Q20-b Catering facilities at night
- Q20-c Staff rooms for taking breaks
- Q20-d Breaks/rest-times
- Q20-s Changing facilities
- Q20-f Car parking

Response to bullying and harassment ('bully')

Q62-a 'I am confident I would be treated fairly if I reported having been harassed at work by a colleague'

Q62-g 'Management and staff respect each other where I work'

Q62-h (reversed) 'Bullying and harassment is a serious problem in my workplace'

Q62-j 'I am confident that the organisation is taking steps'

Q62-m 'I believe that staff who have suffered harassment and bullying are supported'

Scores for new variables were determined on the basis that if respondents said that ALL aspects of working practice incorporated by the variables included were 'bad', they were awarded a '1'. If they said that at least one aspect of working practice from the target list was 'good', they were awarded a '0'.

A further composite variable was created incorporating many of the variables listed above. 'Employer Practice' is a composite of 'shift', 'consult', 'mode', 'choice', 'family', 'devt' and 'bully'. Scores for 'employer practice' were determined on the basis that if respondents said that ALL aspects of working practice incorporated by the variables included were 'good', they were awarded a '0'. If they said that at least one aspect of working practice from the target list was 'bad', they were awarded a '1'.

Single variables

A number of isolated variables were also selected for inclusion in the analysis. These include: 'Intention to leave', 'Number of shifts off in the last 12 months', 'Number of times off sick in the last 12 months', 'Recent injury or illness work-related?', 'Bullied or harassed by a member of staff in the last 12 months?'. Three of these are regarded as nurse outcomes in this analysis: 'Job satisfaction', 'Perception of quality of care', and 'Sickness levels'.

Outcome variables

Nurses' wellbeing is measured by four key variables:

- sickness levels
- job satisfaction
- perceived quality of care
- psychological wellbeing.

This analysis relies heavily on the use of respondents' CORE scores as a measurement of nurses' emotional and psychological wellbeing. CORE is well established as a reliable scale and it is the only strictly non-categorical outcome variable available (important in linear regression analysis). Early exploration of the data indicated that other likely variables (e.g. intention to leave) were unlikely to demonstrate statistically significant results. Additionally, it was difficult in some cases to determine whether or not certain variables are more appropriately viewed as 'outcomes' or as aspects of working practice. For example, needlestick injuries and intention to leave could be viewed as both a cause and an effect of job dissatisfaction and of poor emotional and psychological wellbeing. It is also not possible for us to factor in nurses' reasons for intending to leave, which may or may not be related to negative aspects of working practice. Thus it was determined that job satisfaction, perceived quality of care, sickness levels and CORE scores were likely to be more valid and reliable outcome measures. In order not to exclude them from the analysis, those variables which were initially viewed as possible outcomes but rejected as such, are examined as aspects of working practice.

An important area of concern about two of the outcome variables is their positioning in the questionnaire. 'Job satisfaction' and 'Perceived quality of care' were extracted from the "Your Views" section (Question 62) of the questionnaire. This section was used in its entirety to generate 'Views of employer' and the three derived factors (only Factors 1 and 2 were used). These new variables were intended to measure aspects of working practice that could then be compared with outcomes. Hence, when examining the relationship between 'Views of employer', 'Job satisfaction' and 'Perceived quality of care', even after removing the two items from 'Views of employer', it is possible that results may be confounded. That is, because respondents are necessarily focused on issues concerning the employee-friendliness of their employers, their answers to these two items may reflect their satisfaction with related aspects of their work, rather than a true 'overall' satisfaction. However, the appearance of these two items in the (now excluded) Factor 3 is reassuring: this indicates that these items do not correlate as well with other items within 'Views of employer' as they do with each other.

Another important note regarding outcome variables is that, for the purposes of isolating significant differences between respondents' scores, scores too have been transformed into additional new variables. These variables constitute a re-grouping of the outcomes into positive and negative answers or high and low scores. Respondents' CORE scores can be grouped in a number of different ways. In this analysis, the following three methods were used: 1) dividing respondents according to whether or not they were above or below the clinical cut-off (two groups), 2) dividing respondents into quartiles around the mean (four groups) and 3) dividing respondents into to high and low scorers above and below the mean (two groups). With regard to sickness, respondents were divided according to whether or not they were off sick in the last 12 months (two groups). Likewise, 'Job satisfaction' and 'Satisfaction with the quality of care' were reorganised into groups of those who are satisfied, those who are dissatisfied and those who are neither satisfied or dissatisfied (three groups).

Appendix C: Questionnaire



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