employment research

Royal College of Nursing

Valued equally?

Results from the RCN membership survey 2002

Valued equally?

A summary

Introduction

Nursing is a diverse workforce. Nurses vary in respect of key demographic characteristics such as gender, ethnicity and age, and also in the variety of settings in which they work. The annual survey of RCN members provides unique information about the working lives of nurses across the UK and across all sectors of employment.

The 2001 RCN survey identified that *feeling valued* is an important feature of working life to almost all the nurses. It is the single most important variable in determining overall job satisfaction. Yet many nurses did not feel they were valued. The 2002 survey is the seventeenth survey of RCN members. It sets out to explore in more detail what *feeling valued* means to nurses. Who is it that nurses do or do not feel valued by? What could make nurses feel more valued? What are the factors associated with feeling valued or undervalued?

This report is based on a sample of 6,200 RCN members including a main random sample of 4,000 members. There are additional samples of men, minority ethnic and younger nurses. Of the nurses surveyed 70% returned the questionnaire that asked them core questions about employment and biographical data on demographic details, pay and grading, working hours, job change. It also included various attitude questions that relate to nurses' experiences of working life.

Each year the questionnaire also looks at special interest areas. This year the additional special interest areas in the survey were career breaks, workload, being valued, and bullying and harassment. The exploration of special interest areas is made possible by combining the sampling strategy with the additional question areas.

A diverse workforce

Male nurses account for 6% of all respondents in employment. The mean age of nurses responding to the survey is now 41 years. Fifty-five per cent of nurses have childcare responsibilities. Nearly a half of all respondents are staff nurses (48%) and a further 15% are sisters or equivalent.

While more than eight out of ten nurses qualified by the time they were 25-years-old (83%), those who qualified in the last five years tended to do so at a later average age (28 years). This compares to 23 years-of-age for the nurses who qualified more than ten years ago. Men tend to qualify later than women. The proportion of nurses reporting that their highest qualification is degree level continues to increase from 12% in 2001 to 17%

this year. In the survey 26% of respondents report that their highest qualification is at diploma level.

The ethnic composition of nurses working in the UK is changing as a result of changes to the UK population, and there is a marked increase in registration from nurses who initially qualified outside the UK. Of the respondents to the 2002 survey 6% classified themselves as belonging to minority ethnic groups. Nearly 40% of all minority ethnic nurses are Black, one in five are from Black African ethnic origins and a further 15% are from Black Caribbean origins. Nurses with Asian (including Chinese) origins account for around 30% of minority ethnic respondents.

Across the main sample 96% of nurses surveyed are employed and working, and 71% who are currently working in nursing indicate that their main employment is working in the NHS. While 7% of nurses say that their main employment is working for a GP practice, 8% work for an independent/private organisation, and a further 3% work for a charity or voluntary group. Universities and schools employ 2%. Older nurses are more likely to be working in the independent sector and other non-NHS settings, particularly GP practices.

Many more nurses who first qualified overseas work in independent nursing homes - 14% compared to 5% of UK-qualified white nurses. Also, more than one in four nurses (27%) who first qualified overseas work in older peoples' nursing. This compares with 13% of UK-qualified-nurses. Lower proportions of overseas-qualified nurses work in community health settings - 6% compared to 13% of UK-qualified nurses.

Working hours

Working patterns and hours are of central importance in a profession populated primarily by women, 62% of whom have children or other dependants who require care. The availability of suitable working hours and the degree of flexibility over those hours will affect the quality of working life for many nurses. Working hours is also an important factor influencing decisions to return to nursing.

The 2002 survey found that nearly four in ten nurses currently do not work full-time hours. Working part-time is most frequent among practice and community nurses. Nurses in NHS hospitals are much less likely to work part-time than their colleagues in independent hospitals (34% compared to 51%). In general, a smaller proportion of nurses in the NHS work part-time than is the case in other sectors. Nurses with children living at home (54%) are much more likely to work part-time than those without children at home. UK-qualified minority ethnic nurses (77%) are much more likely to work full-time than their white colleagues (59%).

Fewer than one in five (17%) senior nurses/matrons work part-time. One in four (26%) clinical nurse specialists do so, compared to 43% of staff nurses. The lowest proportions of part-time nurses are in specialties where men work in higher proportions such as mental health (13%) and learning disabilities (21%). Of the staff in older people's nursing 43% work part-time. Nurses who work part-time are less likely to be satisfied with career progression opportunities, but are more satisfied with their workload and their ability to balance their home and working lives.

A third of nurses work rotating shifts and 6% work permanent nights. This is down from 13% in 1992. The nature of shift patterns worked by respondents is closely related to

their field of work. UK-qualified minority ethnic nurses are more likely to be working the less popular shift patterns and are less satisfied with their working hours than other nurses. In addition, these nurses also work longer hours than their white colleagues, even after other factors have been taken into account.

The proportion of nurses who report they work in excess of their contracted hours has grown from 55% in 2001 to 63% in 2002. A quarter of time worked in addition to contracted hours by nurses is not reimbursed, either financially or with time off in lieu.

More nurses are working several shifts in excess of their contracted hours or more every week. This is up from 39% to 45% in the last year. There are also greater numbers working in additional jobs this year. The survey shows that minority ethnic nurses (particularly those of Afro Caribbean origin) are much more likely to have additional jobs than white nurses. Where nurses' families rely more heavily on respondents' income more time is spent working in additional jobs.

In the period between the 2001 and 2002 surveys there has been little change in the workloads reported by nurses as measured by nurse-to-patient ratios. There has also been little change in the views of nurses on their workload.

Nurses' pay and grading

Clinical grading is the current national pay and career structure for NHS nurses that was introduced in 1988. At the time of writing this report there are continuing negotiations over the development of an entirely new system of pay and conditions to cover all NHS staff. The 2002 survey demonstrates some of the inadequacies and misapplications of the clinical grading system.

Analysis of grade by job title shows that fewer senior nurses are employed on H grades or above now than has been the case in the past - 61% in 2002 compared to 80% in 1992. Similar reductions in the average grade level are also noticeable for ward managers (down from 64% graded G or above in 1992 to 48% this year), health visitors and district nurses.

After several years of reductions, this survey found a large increase of 39% to 49% in the proportion of D grades on the top increment of their salary scale. The proportion of nurses on grades other than D who are reporting that they are on the top increment continues to decline.

There has been a significant increase in the proportion of nurses saying that they are inappropriately graded. This is up from 38% to 48% in the last year. Nurses in GP practices, nursing homes and working for banks/agencies show the largest increases in numbers saying that they are inappropriately graded. The level of responsibility required in the job is the most important reason why nurses feel they are inappropriately graded, and 77% cited this factor. In the NHS nearly three-quarters (70%) of Afro Caribbean nurses say they are inappropriately graded compared to 51% of white nurses. Nurses who perceive they are inappropriately graded are much more likely to feel dissatisfied about their working lives than those who say they are appropriately graded.

Job change and career progression

Job change and career progression data enables analysis of the level, direction and reasons for job change. This in turn provides an insight into nursing labour force dynamics. The survey found that 25% of respondents had changed jobs in the preceding 12 months, half of whom had also changed employer. A larger proportion of men changed jobs than women (31% compared with 25%). Minority ethnic nurses were more likely to change jobs because of negative factors, and 14% say they changed jobs due to bullying or harassment.

Of the nurses who changed employer and who had been in the NHS, 85% continued to work for the NHS. Of those who left the NHS, half (52%) give workload and stress as a reason for changing jobs. In the NHS, more than half (58%) of all those who changed employer said they did so to get better working hours or to accommodate domestic circumstances.

In the survey 64% of women and 28% of men had taken some form of career break. The majority of respondents (65%) returned to the same employer after their last break, but in 11% of cases they returned to a lower grade. Access to suitable working hours is the most frequent suggestion (54%) to make returning after a break easier or more attractive.

Men are more likely to be in senior posts, and to have progressed more speedily up the career ladder than women. This holds true even when time out for career breaks is taken into account. White nurses had progressed to their current grades more quickly than minority ethnic nurses, but there is no difference in the proportions applying for or getting higher grade posts in the last 12 months.

Valuing nurses

The 2001 RCN survey reported that a sense of being valued, and all that entails, was considered the most important attribute of nurses' working lives. Yet many nurses reported that their experience of *feeling valued* did not match the importance they attached to it. Previous RCN research found that nurses' job satisfaction and psychological wellbeing are both strongly related with the extent to which they feel they are valued by their employer, and protected from unfair treatment, bullying and harassment. The 2002 survey confirms that overall job satisfaction is strongly related to nurses' perception that their work is valued (particularly by their employer) and that they are not exposed to bullying and harassment.

Most nurses (56%) feel *in general* that their work is valued. Feeling valued by employers contributes most to an overall sense of being valued. Yet 17% of nurses feel that their employer does not value their work at all, and 40% say their work is only valued a little by their employer. NHS hospital staff are least likely to feel their work is valued (34%), while practice nurses are most likely to feel valued (86%). The majority of staff (87%) who feel their employer values their contribution are satisfied with their jobs, compared with 38% of nurses who do not feel valued at all by their employers.

Nurses who have been bullied or harassed in the preceding 12 months (17% of all respondents) are less likely to feel their work is valued – and minority ethnic nurses are more likely to have been bullied or harassed than white colleagues are. Three-quarters of those who had been bullied or harassed were not satisfied with their employers' handling of the situation.

Quality of working life

There is general consensus about the aspects of their working lives that nurses are most and least satisfied with. Workload and pay are the issues that the majority of respondents are dissatisfied with, regardless of their background. Quality of care, relationships with colleagues and enthusiasm for the job are viewed positively across the board.

Just 7% of NHS nurses feel that they are paid well in relation to other professional groups. Pay is the most frequently cited improvement that nurses indicate would make them feel more valued. Apart from improved pay levels (cited by 42%), nurses would like to see improvements to the way they are managed to help them feel more valued (29%). A third (32%) referred to a desire for greater appreciation of nurses' roles and respect for the work they do, particularly from employers. One in five refer to improved staffing.

One in ten nurses plan to leave nursing in the next two years and one-third say they would leave nursing if they could. Desire to leave nursing is related to many factors, in particular the perception that work is valued. Just 34% of nurses say they would leave nursing if they could feel that their work is valued. This compares with 68% of those who do not want to leave nursing.

Variation in the experiences of different groups of nurses impacts on the views of subgroups in the nursing population. Overall, men are less satisfied than women. Minority ethnic nurses are more dissatisfied with bullying and harassment, job security and opportunities to progress.

Men are more likely than women to qualify as nurses late in life, work full-time, work in mental health and learning disabilities, be in senior positions, be on higher grades in those senior positions, progress quickly through the grades, and be paid for the overtime they work. Women are more likely than men to work in the community, work part-time, and have had a career break.

Nurses aged over 40 are less concerned with career progression than younger colleagues, and more concerned about the possibilities of redundancy and that nursing may not offer a secure job in the future. They are also more satisfied with the level of input they have in planning their off duty/times of work, and more likely than their younger colleagues to say that they would not want to work outside nursing even if they could.

Nurses from minority ethnic origins are more likely than white colleagues to work full-time, and to work a three-shift internal rotation. They are also more likely to be in a breadwinner role, have children, work longer hours, have additional jobs, feel their grade is inappropriate relative to their role and responsibility, have been bullied and harassed at work and have changed jobs due to negative pressures. Compared to 33% of white nurses, 46% of minority ethnic nurses would leave nursing if they could.

Conclusion: valuing nursing, valuing nurses

Today there are more female nurses than male, more white nurses than minority ethnic nurses, more nurses who work in the NHS than in other sectors, and just over half of all nurses work in hospital settings. Yet only about one quarter of the nursing workforce now fits the stereotypical image of nurses: white women in their 30s or 40s, with children, working in NHS hospitals. Two-thirds of all respondents report that their earnings account for half or more of their household income, so the notion that nursing provides a second income is redundant.

The 2002 survey has examined the theme of valuing nurses. It found that nurses' perceptions that their work is valued by their employers, and in general, is of central importance. Nurses who feel their work is valued are more likely to be satisfied with their jobs, want to stay in nursing, and with their current employer.

And yet nurses' experience of being treated fairly and valued equally in terms of career opportunities, pay and grading, and working hours is not consistent. There are clear differences in the experiences of different groups of nurse that impacts on the extent to which they feel valued.

While some differences relate to individual characteristics such as ethnicity and gender, the role of the employer is vital. Nurses in some settings feel their work is much more appreciated than in others. The extent to which nurses feel they are valued by their employer is critical, but this sense of being valued or undervalued is not predetermined.

This is important. Historically nursing has often been regarded as a low status profession. The reasons for this perception have deep historical roots. They relate to the cultural codes of gender that shaped nursing as a profession, and the way in which nursing work has been undervalued. The public, and nurses themselves, see the low levels of pay relative to other professions and the heavy workloads, and they conclude that nursing is a poorly valued, low status occupation. This makes the individuals doing the job appear all the more admirable. Hence an apparent paradox – nurses are regarded highly, but nursing often is not.

The 2002 RCN survey of nurses makes clear that nurses' views of the extent to which their work is valued is primarily a function of their employment experience. Despite the strong sociological factors that influence the way in which nursing may be viewed compared to other professions, in some employment situations nurses feel much more positive about the extent to which their work is valued than in others. This suggests that there is considerable scope to influence the extent to which nurses feel valued.

The survey suggests that nurses see increased pay as the single most important change that can be made to make them feel more valued. More than four out of ten nurses (42%) indicate that improved pay would make them feel more valued at work. A further 10% would like to see better prospects for nurses, while 7% would also like to see better terms and conditions of employment. A third of nurses want to see more appreciation of their roles, commitment and quality of work.

Messages here include the need for more and better feedback and communication, and greater respect accorded to nursing from within health care organisations and from patients and the general public. Nearly 30% of respondents highlighted better management and supervision.

One in five respondents report that an important way to help nurses feel more valued is to improve staffing levels, while others point to quality of care. They say that ensuring the resources to maintain a high standard of care would make them feel more valued as nurses.

The outcome of the current negotiations on NHS pay modernisation, and the impact of the variety of workforce initiatives around the UK will shape nurses perceptions of how they are valued in the future.

1. Introduction

1.1 The 2002 RCN Employment Survey

This is the seventeenth in the series of the annual survey of RCN members. It provides unique information about the working lives of nurses across the UK and across all sectors of employment. Employment Research was commissioned to conduct this year's survey, and to explore in detail issues relating to the value of nurses and nursing.

The previous RCN survey[1] identified *feeling valued* as an important feature of working life to almost all nurses. This emerged as the single most important variable in determining overall job satisfaction. Yet many nurses did not feel they were valued. A separate study[2] on nurses' wellbeing found that staff who felt their employer valued them and respected their needs were more likely to be satisfied with their jobs. Such nurses also had better scores on a validated scale of psychological wellbeing. In a recent human resource plan[3] the Department of Health (England) sets out a strategy for growing and developing the NHS workforce. The plan recognises the challenge of demonstrating that working for the NHS gives staff stimulating and varied careers.

This year's survey sets out to explore in more detail what *feeling valued* means to nurses. Who is it that nurses do or do not feel valued by? What could make nurses feel more valued? What are the factors associated with feeling valued, and with feeling undervalued?

The report describes the features of nurses' working lives – where and when they work, their pay, their careers and their views of life as a nurse. It also explores variation in nurses' experiences by demographic factors such as gender, ethnicity and age. The report examines how nurses feel that their work is valued in general, and looks at the consistency of nurses' experiences of being valued. Are nurses of different backgrounds valued equally in terms of their opportunities to progress and their work experiences? How do different groups of nurses perceive the extent to which their work is valued?

1.2 Method

Sample

Using a stratified sampling strategy the 2002 sample was drawn to give greater coverage of smaller but important subgroups of the nursing workforce. So together with the main random sample of 4,000 members, there are additional samples of men, nurses from ethnic minorities, and younger nurses. An extra sample of nurses from Scotland was drawn. Results from the Scottish sample are presented in a separate report: Delivering for Scotland. Results for nurses in Scotland of the RCN Employment Survey 2002.

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[1] Ball J and Pike G (2001) *Time to deliver: results from the RCN membership Survey 2001*. London: RCN.
[2] Ball J, Pike, G, Cuff C, Mellor-Clark J, & Connell J (2002) *Working well? Results from the RCN Working well survey.* London: RCN.
[3] *HR in the NHS plan* (2002). London: DH

The sample comprised:

- 4,000 RCN members selected randomly
- 750 additional men
- 1,250 additional RCN minority ethnic members
- 1,500 additional nurses from Scotland
- 200 additional nurses aged 25 and under.

Questionnaire

Each year the questionnaire includes core employment and biographical questions covering demographic details, pay and grading, working hours, job change, and various attitude items relating to nurses' experiences of working life. The questionnaire also addresses a set of issues of special interest that year. Additional themes in the 2002 survey are career breaks, workloads, being valued, and bullying and harassment. Combining the sampling strategy with special interest areas makes it possible to explore key themes.

Survey process

The survey was mailed out at the end of January 2002 to members' home addresses. The survey was held open for two months, during which time three reminders were sent. It should be noted that all questionnaires were returned before the 2002 budget that announced increases in NHS spending.

A total of 7,700 questionnaires were sent out and 5,431 (71%) were returned before the survey closed. A further 69 forms were returned by the Post Office as not being known at the address given, or were returned as inappropriate. A further 14 responses from nurses based overseas were subsequently excluded from the analysis. An overall response rate of 71.3% was achieved, with some variation by sample type (table 1.1). As in previous years, the response rate for younger nurses is lower, particularly in the 25-34 year old groups – they account for 23% of respondents but make up 27% of the survey population. Age is the main variable influencing the response rate, followed by gender and to a lesser extent ethnicity.

Table 1.1 Response rates by sample

	Sample	Post Office / Not applicable	Number of respondents	Usable response rate
Main random sample	*4,000*	*36*	*2,887*	*72.8%*
Men	750	4	467	62.6%
Young (<30 years)	200	5	130	66.7%
Minority ethnic	1,250	26	838	68.5%
Scotland	1,500	10	1,109	74.4%
Total sample	**7,700**	**81**	**5,431**	**71.3%**

Source: Employment Research/RCN 2002

1.3 Respondents and samples

Across the main sample 96% of respondents were employed and working (94% in employment, including self-employment, and 2% in semi-retirement but still working). A further 2% of respondents were on maternity leave at the time of the survey and 1% were on sick leave. These latter two categories of respondent are included as *nurses in employment*.

Just under 1% of respondents were either unemployed or on career breaks, 1.6% were fully retired, and 0.6% were students or nurses doing voluntary work. These groups of respondents are excluded from the remainder of the report, as are respondents currently working in non-nursing jobs. Only respondents currently in nursing employment (the top row of table 1.2) are included in the analysis in the rest of the report.

Table 1.2 Respondents by employment status – percentages by sample type (numbers in brackets)

	Main sample	Men	Top up samples minority ethnic	Young (25 & under)	All respondents
In nursing employment	96%	96%	98%	94%	96%
(inc maternity, sick leave, and semi-retirement)	*(2,735)*	*(453)*	*(826)*	*(122)*	*(4,136)*
Not employed	2%	2%	1%	2%	2%
(inc career breaks and fully retired)					
Working in non-nursing jobs	2%	2%	1%	4%	2%
Base N (unweighted)=100%	*2,852*	*470*	*849*	*130*	*4,314*

Source: Employment Research/RCN 2002

1.4 Response weighting

Responses are weighted to make full use of the data. Using top up samples and then weighting the data enables more reliable analysis and ensures that the results, particularly those concerning men and ethnic minorities, are a more accurate reflection of the experiences and views of RCN members.

Each case is given a weight to make up for the fact that they are over/under represented. For example, 17.4% of all respondents are men, but the true population proportion is 5.9%. This means that each male case is given a weight of 0.33. The same process is conducted by ethnicity and age where each ethnic origin and age group is assigned a different weight depending on the population proportion (taken from the full RCN membership records). Finally, all three weights are combined to provide one compound weight to each case.

All the following analyses and reporting are based on the weighted data. However, to provide an idea of the numbers on which the analysis is based table 1.3 shows the numbers of cases included in the final response set by gender, ethnicity and age, before and after weighting.

Table 1.3 Numbers of cases before and after weighting

	Before weighting		After weighting	
	cases	percentage	cases	percentage
Men	715	17	245	6
Women	3,395	83	3,861	94
Afro Caribbean	495	12	100	3
Asian	372	9	82	2
White (British)	2,822	70	3,551	88
Under 40	1,889	47	1,960	48
Over 40	2,177	53	2,115	42
All cases	**4,136**	**100**	**4,136**	**100**

Source: Employment Research/RCN 2002

1.5 Report structure

The findings in the report are based on all respondents currently employed in nursing (4,136 cases) weighted as above. Very occasionally unweighted data is used to describe sub-populations.

The results from this year's survey are presented as follows:

Chapter 2 examines the demographic profile of nurses in 2002, and shows where nurses work. A key aim of this year's survey is to explore variation between groups of nurses in respect of equality issues. Understanding the personal characteristics of respondents is an essential first step in a consideration of variations in nurses' views and experiences in the workplace.

Chapter 3 describes working hours, shift patterns and workloads, and nurses' views of working hours and workload.

Chapter 4 considers pay and grading, presenting data on grade profiles of different groups of nurses, and examining the varying proportion of household income nurses' pay represents. Nurses views of their pay and grading are discussed.

Chapter 5 describes the survey findings on job change and career progression. The chapter considers the number of years individuals have spent nursing, and time taken out of nursing for career breaks. The combination of this data with information on grading and demography provides indicators of variation in relative career progression.

Chapter 6 focuses on nurses' perceptions of how they are valued by different groups including employers, other staff and colleagues, politicians and society. The section then looks at nurses experience of bullying, harassment, and assault, and explores the relationships between these variables and perceived value.

Chapter 7 is concerned with nurses' attitudes to their jobs and levels of job satisfaction. The section presents a summary of the key findings for the major subgroups and explores variations in attitude, future intentions, and areas where perceptions of value might be improved.

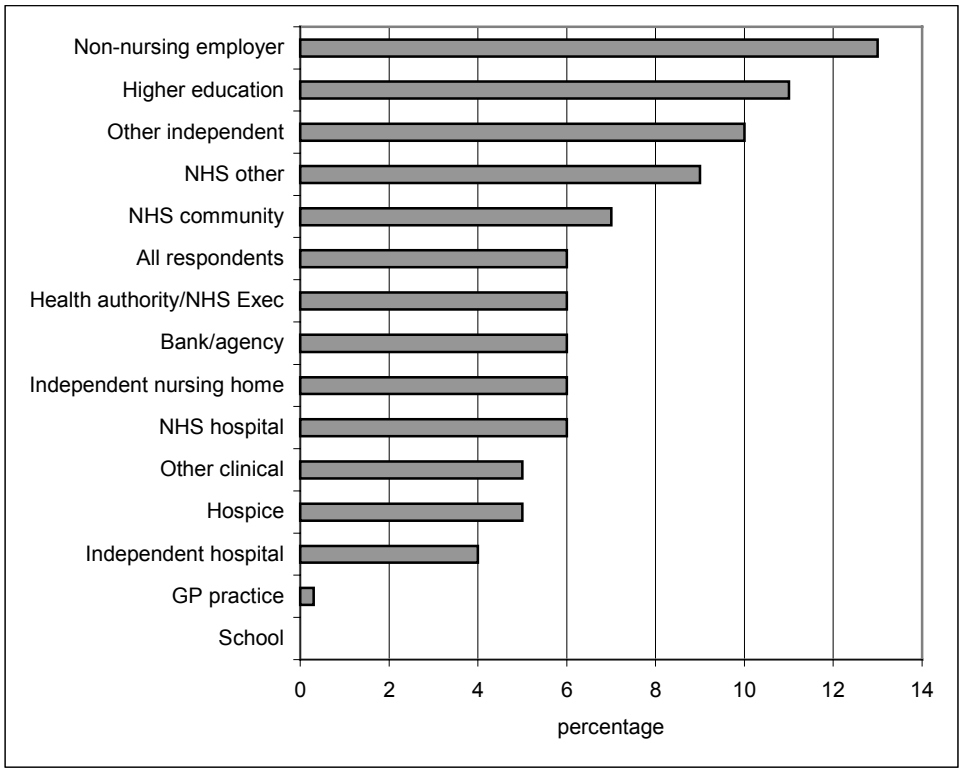
2. Demographics and employment

The diversity of RCN membership reflects the diversity of the nursing workforce. Growth in internationally recruited nurses has added a further dimension to this historical diversity. Enhanced samples of minority ethnic members, men and younger members mean this 2002 report provides a fuller understanding of the diversity of employment experience and opinion among RCN members. This chapter provides data on age, ethnicity, and employment as a backdrop to subsequent exploration of differences between groups of nurses.

2.1 Gender

Male nurses account for 6% of all respondents in employment (unchanged since 1990). This is slightly lower than the figure for the membership as a whole (7%) and that for male nurses on the UK nursing register (9%)[4]. Figure 2.1 shows the proportion of men employed in each of the key employment sectors. The many differences between men and women in their nursing work and careers are highlighted throughout this report.

Figure 2.1 Men as a percentage of respondents employed in each sector



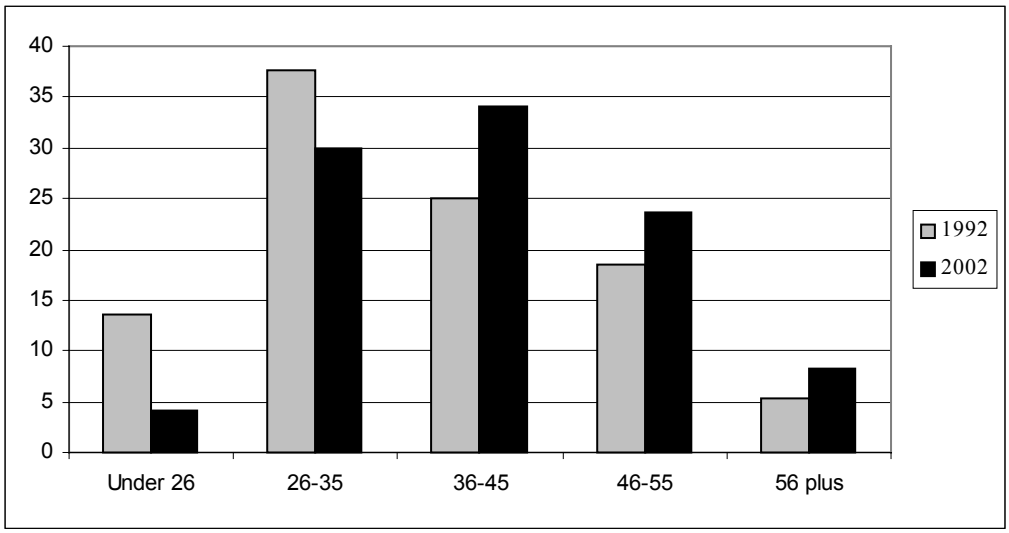
Source: Employment Research/RCN 2002

[4] Buchan J and Seccombe I (2002) *Behind the headlines: a review of the nursing labour market in 2001.* London: RCN

2.2 Age

The *greying* of the nursing workforce has been reported for more than a decade now[5]. Comparing the age profile of nurses this year with that reported ten years ago, just 34% are aged under 36 compared to 51% in 1992 (figure 2.2). The mean age of nurses responding to the survey has increased from 37 to 41 years. The age profile of different ethnic groups varies markedly.

Figure 2.2 Age profile of nurses in 1992 and 2002 – percentages



Source: Employment Research/RCN 2002

Table 2.1 Age, gender and ethnicity – percentages

Age band	Women	Men	Minority ethnic	White	All 2002	All 2000
20-24	3	1	2	3	3	4
25-29	11	10	12	11	11	11
30-34	17	21	19	17	17	14
35-39	18	20	14	18	18	21
40-44	17	16	14	17	17	18
45-49	14	15	13	14	14	13
50-54	11	9	15	11	11	12
55 plus	11	9	11	10	11	8
Weighted cases	*3,829*	*243*	*768*	*3,794*	*4,017*	*3,875*

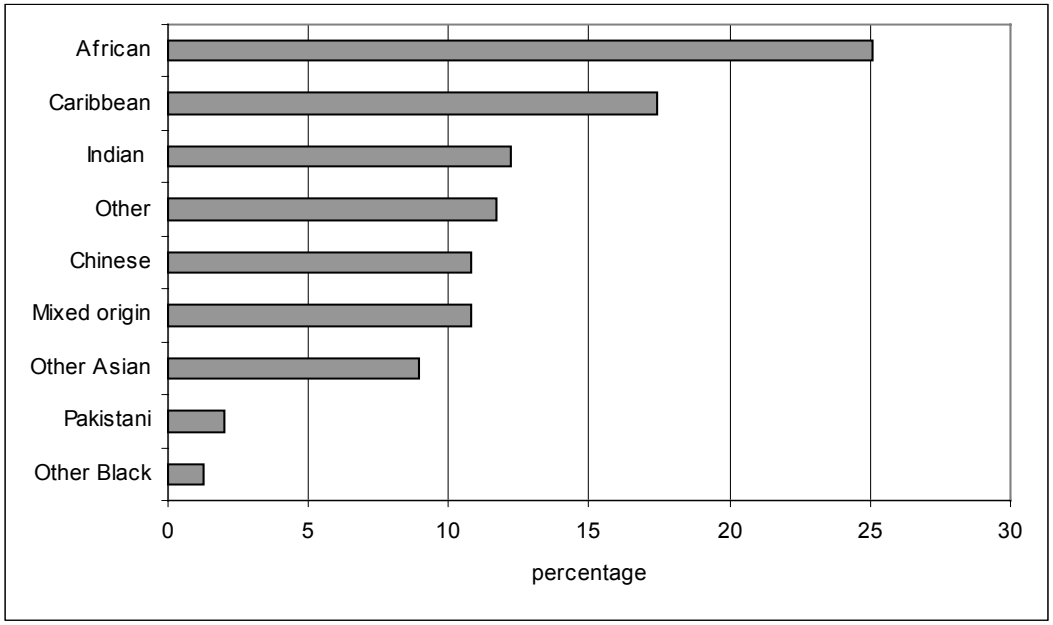
Source: Employment Research/RCN 2002

[5] Seccombe I and Ball J (1992) *Motivation, morale and mobility: a profile of qualified nurses in the 1990s.* Brighton: IMS Report 233

2.3 Ethnicity

The ethnic composition of nurses working in the UK is changing as a result of changes to the UK population and a marked increase in registration from nurses who initially qualified outside the UK. These changes are reflected in the membership profile of the RCN, and in the survey response. In 1999 4% of respondents classified themselves as of minority ethnic origin. This year the figure is 6%. Figure 2.3 examines the ethnic composition of all respondents classifying themselves as of minority ethnic origin.

Figure 2.3 Composition of minority ethnic respondents – percentages



Source: Employment Research/RCN 2002

Nearly 40% of all minority ethnic nurses are Black, one in five are from Black African ethnic origins and a further 15% are from Black Caribbean origins. Nurses with Asian (including Chinese) origins account for around 30% of minority ethnic respondents. To analyse further differences by ethnicity a new variable is used to break down the above categories into Afro Caribbean, Asian, mixed origin and other. This allows sufficient responses in each broad category to ensure reliable analysis.

Of the white respondents questioned 4% classified themselves as White Irish and 2% White other, with the remaining 94% White British.

In addition to ethnicity, nurses were also asked whether or not they considered themselves to be a member of another minority group. Four per cent did feel part of another minority group with most mentioning other ethnic groups or religious/cultural affiliations.

2.4 Country of qualification

Over sampling nurses from minority ethnic origins allows more in-depth analysis of nurses who first qualified outside the UK. This group includes both recent international recruits and nurses who are resident in the UK and have been for some time. There is no precise means to separate these groups in the analysis this year, but respondents have been classified into four groups according to ethnicity and country of qualification:

- UK-qualified white nurses
- UK-qualified minority ethnic nurses
- overseas-qualified white nurses
- overseas-qualified minority ethnic nurses.

This variable combines ethnicity with country of domicile at the time of initial nursing qualification. It helps to provide further insight into the experience and working lives of different nurses in the UK. There has been a marked increase in the numbers of respondents who indicate that they first registered as a qualified nurse in another country, from just under 2% in the 2001 survey to 5.2% this year (506 respondents across all the samples[6]). These nurses are marginally younger than their colleagues who first registered in the UK, with an average age of 40 compared to 41 years. The proportion of men and women in the group initially qualifying overseas is similar to that of those qualifying in the UK. Nurses initially qualifying overseas account for 38% of all minority ethnic nurses, and 42% classify themselves as from a minority ethnic origin.

Using the combined classification of ethnicity and overseas qualification, table 2.2 highlights some of the key differences between nurses by ethnicity and where they qualified. Much of the data is relevant to later sections of the report but is presented here for ease of comparison.

Table 2.2 Biographical data by ethnicity and qualification domicile – percentages

	UK-qualified white	UK-qualified minority ethnic	Overseas-qualified minority ethnic	Overseas-qualified white
Percentage men	6	8	7	4
Age percentage < 36 years	34	28	48	41
Age percentage >45 years	31	43	25	35
Percentage with children	55	59	45	41
Percentage with other caring responsibilities	16	16	18	13
Percentage with a degree	16	14	28	22
Percentage working in London	6	33	36	31
Mean time since qualification	17	18	15	18
Weighted cases (unweighted) – maximum	*3,701 (3,008)*	*145 (560)*	*86 (307)*	*120 (156)*

Source: Employment Research/RCN 2002

[6] Note that this group is not representative of all such nurses as the samples have not been set up to ensure a random cross section of qualified nurses registering first outside the UK.

The key differences to note are that among the higher proportion of minority ethnic men there is a slightly older age profile, and a much higher proportion work in London than elsewhere in the UK. Among overseas qualified nurses there is a younger age profile, fewer have children, they are more likely to be working in London and more hold a nursing degree level qualification.

2.5 Dependants

Fifty-five per cent of nurses have childcare responsibilities. In 2000 the figure was 59%. There are 16% who have other caring responsibilities, and 9% have both. There is little difference by ethnicity in the percentages having and not having child and other caring responsibilities. Fewer nurses who first registered as a nurse outside the UK have childcare responsibilities (43% compared to 55% of UK-qualified nurses).

Table 2.3 Age and childcare responsibility – percentages by age band

Age band	Childcare (all ages) 2002	*Weighted cases*	Percentage of each age band with children at home by age of child		
			Pre-school	School age	Older
20-24	6	*130*	3	0	0
25-29	23	*427*	20	6	0
30-34	56	*672*	41	29	0
35-39	74	*715*	28	63	4
40-44	76	*680*	8	68	19
45-49	69	*547*	1	42	46
50-54	44	*438*	<1	13	35
55 plus	24	*279*	<1	3	21
All	55	*4,038*	16	36	17

Source: Employment Research/RCN 2002

2.6 Qualifications and experience

The proportion of nurses reporting that their highest qualification is degree level continues to increase. It rose from 12% in 2001 to 17% this year. In addition, 26% report that their highest qualification is at diploma level, also slightly higher than last year. Three per cent of respondents hold higher degrees. Table 2.4 highlights these figures by age.

Men, nurses without children and, particularly, nurses under 40 are all more likely to hold nursing degree level qualifications. Nurses who report that that their earnings form less than half of their household income are least likely to hold nursing qualifications at diploma, degree or higher degree level, although this is partly age-related.

In general, nurses who first registered outside the UK are more highly qualified than nurses who qualified and first registered in the UK. Twenty-five per cent hold a degree or higher degree level qualification compared to 16% of UK-qualified nurses. Of those nurses without a degree 13% are currently studying for one.

Table 2.4 Highest qualifications held by age % (2001 figures in brackets)

Age band	Nursing diploma held	Nursing degree held	Higher degree held	*Weighted cases*
20-24	68 (69)	20 (23)	0 (0)	*130*
25-29	55 (55)	29 (15)	0 (2)	*428*
30-34	30 (28)	18 (14)	2 (2)	*679*
35-39	21 (20)	19 (13)	3 (3)	*717*
40-44	22 (21)	15 (13)	4 (6)	*683*
45-49	19 (20)	14 (10)	5 (4)	*552*
50-54	19 (14)	12 (6)	4 (5)	*436*
55 plus	13 (9)	8 (4)	2 (2)	*429*
All respondents	**26 (25)**	**17 (12)**	**3 (3)**	***4,054***

Source: Employment Research/RCN 2002

More than eight out of ten nurses qualified by the time they were 25 (83%). However, those who qualified more recently qualified at a later average age (28 years for those who qualified in the last five years compared to 23 years for those who qualified more than 10-years-ago). Men tend to qualify later than women: fewer than two-thirds of men qualified by the time they were 25. The average age at qualification for male respondents is 26 years compared to 23 years for women (table 2.5).

Table 2.5 Mean age at qualification by time since qualification and gender

Time since qualification	Men	Women	All	***Weighted cases***
1-5 years	31	26	27	*569*
6-10 years	27	25	26	*686*
11-15 years	25	24	24	*666*
16-20 years	24	22	23	*657*
21-25 years	24	22	22	*508*
26-30 years	24	21	22	*408*
31 years plus	23	21	21	*517*
All	**26**	**23**	**23**	***4,011***

Source: Employment Research/RCN 2002

2.7 Country and region

Of the survey respondents 82% were from England, 9% from Scotland, 5% from Wales and 4% from Northern Ireland. Key differences in the biographical profile by country are:

- in Wales and Scotland there is a slightly higher proportion of men working in nursing: 8% compared to a UK-wide average of just 6%
- in Scotland, Wales and Northern Ireland there are proportionately more nurses with children living at home with them than in England (60% or more compared to 55% in England). A similar difference is apparent in respect of nurses with other caring responsibilities
- in Scotland, Wales and Northern Ireland only around 1% of respondents are from minority ethnic origins

- Scottish nurses are more likely to hold a degree level qualification (22%) than the UK average (17%).

Table 2.6 presents nurse profile information for each of the nine English regions and the four home nations. One of the main features of the distribution of nurses across the UK is the very high concentration of minority ethnic nurses in London.

Table 2.6 UK nations and NHS regions – biographical profile

	Percentage of data set	% minority ethnic	% under 40	% men	% degree	% diploma	*Weighted cases*
London	11	21	53	8	19	24	*446*
South East	15	5	38	5	17	24	*601*
Eastern	8	7	48	6	10	29	*321*
South West	10	3	39	6	12	23	*387*
East Midlands	6	4	51	6	18	24	*241*
West Midlands	8	8	48	5	18	30	*329*
Northern	4	2	46	7	23	24	*176*
North West	10	3	47	6	14	27	*416*
Yorkshire and Humberside	9	3	47	6	14	27	*345*
All England	**82**	**6**	**46**	**6**	**17**	**25**	***3,262***
Scotland	9	1	48	8	22	20	*356*
Northern Ireland	4	1	60	3	16	18	*146*
Wales	5	1	46	8	11	28	*216*
All UK	**100**	**6**	**46**	**6**	**17**	**25**	***3,979***

Source: Employment Research/RCN 2002

2.8 Employers and location

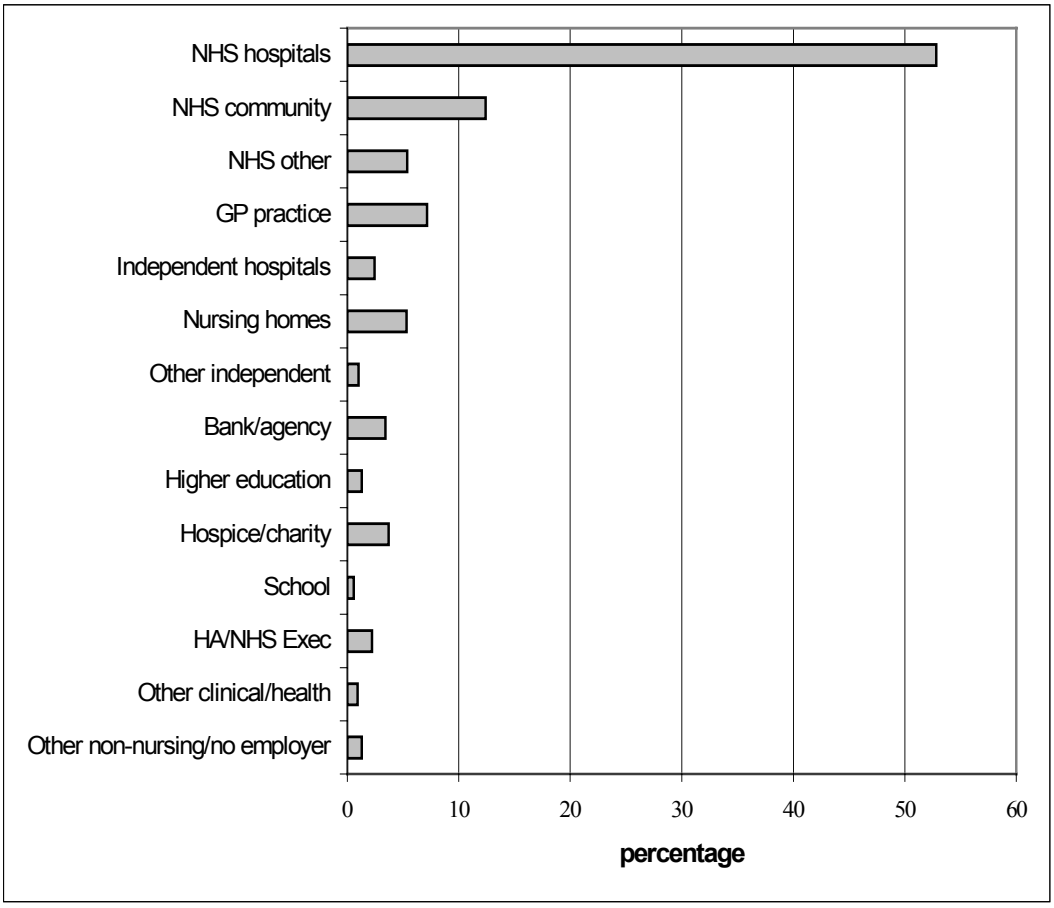
In the 2002 survey 71% of respondents currently working in nursing indicate their main employment as working in the NHS, with 2% working for the NHS Executive or a health authority. A further 2% indicate their main employment as working for an NHS nursing bank and 2% more as working for other banks/agencies. Seven per cent of nurses indicate their main employment as working for a GP practice and 8% for an independent/private organisation. This year the questionnaire also gave charity/voluntary group as an option, and 3% indicated this as their main employer. Universities employ 1.4% of respondents, schools/local education authorities 0.6%, and other health settings or non-nursing employers account for 2.5% of those responding.

The key differences between the main employer groups are that:

- non-NHS nursing has recruited more nurses who first registered as a qualified nurse outside the UK. One in ten non-NHS nurses initially qualified overseas compared to 4% in the NHS
- older nurses are more likely to be working in the independent sector and other non-NHS settings, particularly GP practices
- a lower proportion of nurses in the independent sector hold nursing degrees than is the case elsewhere

- many more nurses who first qualified overseas work in independent nursing homes - 14% compared to 5% of UK White nurses. Also, more than one in four nurses (27%), who first qualified overseas, work in older peoples' nursing compared with 13% of UK-qualified nurses. Lower proportions of overseas-qualified nurses work in community health settings. This figure is 6% compared to 13% of UK-qualified nurses.

Figure 2.4 Percentage in each employment sector/setting



Source: Employment Research/RCN 2002

2.9 Job title and specialty

Nearly a half of all respondents are staff nurses (48%), 15% are sisters or equivalent, 8% clinical nurse specialists and 5% senior nurses/matrons. A further 6% are practice nurses and 4% district nurses. The main biographical differences between nurses in relation to their job title (table 2.7) are that:

- men are more likely to occupy senior nurse positions or be managers/directors
- overseas-qualified nurses are generally towards the younger and less experienced end of the spectrum, and so more are employed as staff nurses than is the case among UK-qualified nurses
- health visitors, practice nurses and senior nurses are, on average, older than others
- very few practice nurses and district nurses are from minority ethnic origins

- health visitors, district nurses and clinical nurse specialists are all more likely to hold degree level qualifications than other nurses
- higher proportions of UK-qualified minority ethnic nurses work in mental health (16% compared to 6% of white nurses)
- more male than female respondents are employed in mental health (27%), adult critical care (8%) and learning disabilities (21%). Nurses in older people's nursing and women's health are less likely to hold degrees than nurses in other fields (see table 2.7).

Table 2.7 Job title and biographical details – percentages

	% of total	*Weight N=*	% men	Mean age	% under 40	% minority ethnic	% degree
Staff nurse	48	*1,965*	6	38	59	7	12
Enrolled nurse	4	*151*	3	48	17	5	0
Sister/charge nurse	15	*604*	7	42	45	5	18
Senior nurse/matron	5	*205*	10	43	37	6	20
CNS/nurse practitioner	8	*331*	8	42	46	4	32
District nurse	4	*181*	3	43	38	2	30
Health visitor	1	*34*	0	46	24	3	41
Practice nurse	6	*254*	<1	45	27	4	13
Manager/director	3	*117*	14	44	30	6	17
Research/education	3	*105*	7	42	35	3	28
Total (100%)	**100**	***4,083***	**6**	**41**	**48**	**7**	**17**

Source: Employment Research/RCN 2002

An important issue is variation in the age profile of each field of practice. The numbers of nurses approaching retirement age is a pressing issue facing the NHS and other nursing employers. However, considering this issue in aggregate conceals major variation in the degree to which demography is likely to affect different fields. For example, nearly 70% of nurses in older people's nursing are aged over 40, as are 70% in primary care and 63% in rehabilitation/longer term care. The preponderance of older nurses in these areas that have, perhaps, been traditionally viewed as being of lower status, has been described as exemplifying a degree of ageism in the health service (Buchan J, 1998)[7].

Employers of nurses in these specialties are likely to experience more staffing problems over the next ten years as a result of the retirement bulge than those recruiting into other specialties.

One in six nurses in independent nursing homes and other settings are aged over 55 (table 2.9), and a further third are aged between 46 and 55. No other employer group would seem to be facing the same need to replace staff in the next ten years as the independent older people's nursing sector. This effect can be expected to increase competition for younger nurses as these sectors are forced to widen their recruitment.

[7] Buchan J (1998) *Carry on nursing? The implications of the ageing workforce for employees and employer.* London: RCN

Table 2.8 Specialty biographical details – percentages

	Base N=	% men	Mean age	% over 40	% minority ethnic	% degree
Older people's nursing	*481*	4	46	69	8	11
Mental health	*246*	27	41	52	10	13
Adult critical care	*527*	8	36	33	5	18
Adult general	*801*	4	39	45	7	14
Rehab/longer term care	*94*	7	44	63	7	15
Paediatric critical care	*120*	3	36	29	7	19
Paediatric general	*184*	2	37	38	3	20
Women's health	*91*	0	41	45	8	15
Learning disabilities	*71*	21	40	51	6	10
Oncology/palliative	*212*	3	40	52	1	22
Education/research	*75*	8	41	59	4	31
Community/primary care	*577*	2	43	70	5	22
Several fields	*181*	7	44	65	4	19
Other	*361*	6	42	59	4	17
Total (100%)	***4,020***	**6**	**41**	**52**	**6**	**17**

Source: Employment Research/RCN 2002

Table 2.9 Employer and setting by age group – percentages

	Under 26	26-35	36-45	46-55	56 plus	*Base N=*
NHS hospital settings	9	36	31	18	6	*2,158*
NHS community	3	24	40	27	6	*511*
NHS other	1	19	43	26	10	*219*
GP practice	2	15	36	37	9	*293*
Independent hospital	0	24	45	24	8	*101*
Independent nursing homes	1	19	28	35	17	*219*
Other independent settings	2	15	32	34	17	*41*
Bank/agency	6	20	36	19	19	*142*
Hospice/charity	1	20	33	34	12	*153*
All respondents	**6**	**28**	**34**	**24**	**8**	***4,096***

Source: Employment Research/RCN 2002

2.10 Key points

The main purpose of this chapter has been to provide a respondent profile. This introduces some of the key variables with which we will be exploring differences between subgroups of nurses in their perceptions and experiences of working life in the later sections of the report.

It is true to say that there are still more female nurses than male, more white nurses than nurses from minority ethnic origins, more nurses who work in the NHS than in other sectors, and just over half of all nurses who work in hospital settings. But only about one-quarter of the nursing workforce today conforms to the stereotypical image of a nurse: white women, in their 30s or 40s, with children, working in NHS hospitals. Three-quarters of nurses do not.

Some of the key differences and trends that have emerged in recent years are:

- The age distribution of the nursing workforce continues to move upwards year-on-year with a higher proportion of nurses in the 55-plus age group this year than in recent years. However, the average has not changed noticeably in the last two years as increases in the supply of new registrations have increased. Nevertheless it remains the case that ten years ago the average age of a nurse was 37 years compared to 41 today.

- The average age at which nurses qualify has increased steadily. Today nurses typically qualify at the age of 28 (men 30 and women 27). Ten years ago the average age was 24, and 20 years ago it was 22 years-of-age.

- The ageing of the nursing workforce represents the main obstacle to increasing the nursing headcount. This problem is most acute in older people's nursing and the independent nursing home sector where between 60% to 70% of nurses are aged 45 plus. In NHS acute specialties there is a comparatively younger age profile.

- Numbers of nurses who first qualified overseas have increased markedly (to 5% in 2002) reflecting large scale international recruitment. A corollary to this is that the number of minority ethnic nurses has also increased in recent years.

- Each year increasing numbers and proportions of nurses hold degree level qualifications. This year 17% of respondents hold a nursing degree as their highest nursing qualification – last year the figure was 12%.

3. Working hours

3.1 Introduction

In a profession populated primarily by women, 62% of whom have children or other dependants requiring care, working patterns and hours are of central importance. The availability of suitable working hours and degree of flexibility will affect the quality of working life for many nurses.

Working hours is also an important factor influencing decisions to return to nursing. In the NHS Executive's 1999 return to nursing survey[8], suitable working hours was most frequently cited as the single measure that would encourage nurses back into nursing. The report estimated that of the 140,000 nurses, midwives and health visitors not working in nursing in England, half were not doing so because of family commitments. In initiatives such as *Improving working lives* (IWL) the Department of Health recognises that making working patterns more acceptable to nurses is a major plank in a campaign to attract and keep nurses in the profession, and in the NHS.

This chapter examines the working patterns of respondents and examines the degree of choice and control nurses have over their working lives, and sets this in an equal opportunities framework.

3.2 Part-time working

Just under two-fifths of all respondents work other than full-time hours. The survey found that 37% work part-time, 1% as part of a job share, and 2% report working occasional/various hours[9]. Bank and agency nurses account for most of those who work occasional/various hours, while job sharing is most common in NHS community settings. The level of job sharing has not altered in the past decade.

Table 3.1 Part-time working by employer group – percentages

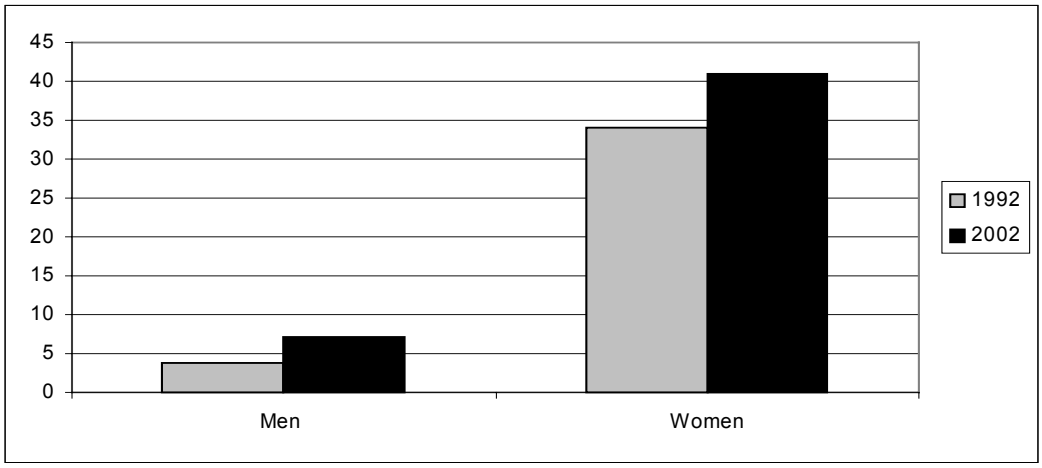
	Full-time	Part-time	Job share	Occasional/ various	*Weighted cases*
NHS hospital settings	66	32	1	<1	*2,168*
NHS community	66	30	4	0	*507*
NHS other	63	36	1	0	*218*
GP practice	21	78	1	0	*293*
Independent hospital	50	47	0	3	*99*
Independent nursing homes	63	35	0	2	*218*
Bank/agency	33	32	1	34	*140*
Hospice/charity	49	44	1	6	*151*
All respondents	**60.7**	**36.1**	**1.3**	**1.9**	***4,094***

[8] *Return to nursing survey* GSS (1999). London: NHS Executive
[9] Throughout the remainder of this report part-time refers to all nurses working other than full-time

Part-time working is most common among practice nurses (79%). It is least common among nurses in NHS hospitals and in higher education (34% and 23% respectively).

Childcare responsibilities, gender, age and grade are key variables correlated with the likelihood of individuals working part-time. In total, 41% of women work part-time compared to 7% of men. In the NHS slightly fewer nurses work part-time (36% of women and 4% of men). Although working part-time is relatively rare among men, it is more common now than it was in 1992. More than half of all respondents with children work part-time (54%), compared to a fifth (21%) of nurses without children.

Figure 3.1 Men and women working part-time – percentages 1992 and 2002



Source: Employment Research/RCN 2002

Table 3.2 below shows that whether men have children or not this does not significantly affect their decisions to work part-time. Indeed, inasmuch as there is a difference, men who do not have children are more likely to work part-time. Conversely, just over a fifth (22%) of women who do not have children living at home work part-time compared to 58% of those with children. Clearly, the reasons people work part-time vary, and working hours and the availability of part-time work is an issue for many staff, not just women with children.

Table 3.2 Percentage of respondents working part-time by age, gender[10] and with/without childcare responsibilities – percentages

Age	Women		Men		All		*Weighted cases*	
	With	W'out	With	W'out	With	W'out	*With*	*Without*
20-24	25	4	0	0	25	4	*8*	*122*
25-29	65	5	5	0	61	5	*100*	*327*
30-34	67	7	0	3	63	7	*373*	*296*
35-39	64	14	4	5	61	13	*528*	*181*
40-44	56	19	10	15	54	19	*514*	*160*
45-49	47	23	0	7	45	21	*374*	*170*
50-54	46	37	0	7	44	35	*191*	*245*
55+	51	52	33	36	50	52	*101*	*324*
All	**58**	**22**	**5**	**9**	**55**	**21**	***2,189***	***1,825***

Source: Employment Research/RCN 2002

[10] Data for men includes top up sample

Grade is also strongly correlated with part-time/full-time working. The proportion of nurses working full-time increases with grade. It remains the case that men occupy a disproportionate number of higher graded management positions in nursing. One important possible explanation for this is the lack of flexible working patterns in senior NHS posts and other employment settings. Table 3.3 show that, although women without children are more likely to work full-time than colleagues with children at all grades, the gap narrows markedly as grade increases. It is difficult to draw any inference other than that caring responsibilities for children hamper grade progression because access to part-time working is increasingly limited at higher grades.

Table 3.3 Working full-time by grade and with/without childcare responsibility (NHS women-only) – percentages

Grade	With	Without	All women in NHS	*Base N*=
D	36	83	57	*556*
E	37	79	56	*1,045*
F	44	90	67	*415*
G	67	90	77	*468*
H	73	95	84	*145*
I	92	86	89	*26*
All	**46**	**85**	**64**	***2,698***

Source: Employment Research/RCN 2002

Working hours and ethnicity

Previous RCN surveys have highlighted differences between the working hours of white and minority ethnic nurses. The additional samples allow further insight into these differences. Analysis based on the ethnicity and country of qualification variable introduced in Chapter 2 shows that UK-qualified minority ethnic nurses are much more likely to work full-time than their white colleagues. High proportions of overseas-qualified nurses also work full-time, resulting from a younger age profile and a comparatively low incidence of childcare responsibilities (see table 3.4).

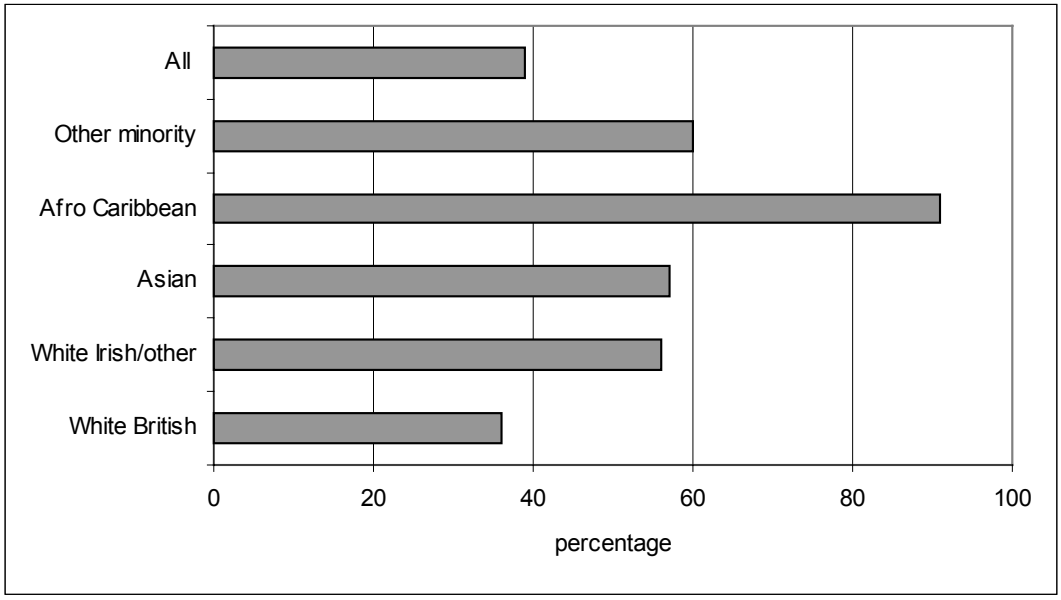
Table 3.4 Mode of working by ethnicity and where qualified – percentages

	UK-qualified white	UK-qualified minority ethnic	Overseas-qualified minority ethnic	Overseas-qualified white	All
Full-time	59	74	90	81	**61**
Part-time	41	26	10	19	**39**
Base N=	*3,679*	*144*	*84*	*119*	***4,026***

Source: Employment Research/RCN 2002

Chapter 2 identified that minority ethnic nurses as a group have a marginally older age profile and are slightly more likely to have dependant children than white nurses. However, an analysis of the working patterns of staff nurses that takes into account other explanatory factors demonstrates that nearly two-thirds of UK-qualified minority ethnic staff nurses (63%) work full-time compared to just 36% of white UK-qualified staff nurses. More striking still, 91% of Afro Caribbean nurses in this category work full-time, as do 57% of Asian nurses.

Figure 3.2 NHS, female, staff nurses with children working full-time – percentages by ethnic group



Source: Employment Research/RCN 2002

Possible explanations for these differences include:

- **Economic activity** – the economic activity rates of women vary by ethnic group, as does the size of family and likelihood of being lone parents.[11] Other surveys have found that minority ethnic nurses are much more likely to be working full-time than their white colleagues[12].
- **Greater financial need** – for example, two-thirds (70%) of all female, Afro Caribbean staff nurses working in the NHS are the major breadwinner (accounting for more than half their household income – see below). This compares to 44% of the equivalent white group of nurses.
- **Access to part-time working –** certain specialties where high proportions of minority ethnic (particularly Afro Caribbean) nurses work exhibit far lower levels of part-time working.
- **Discrimination** – all staff do not have equal access to part-time working. Discrimination may play a part in this.

Working hours and household income – the breadwinner role

The 2002 survey sought information on the proportion of household income represented by respondents' earnings. It also examined relationships between earnings as a proportion of household income and aspects of nurses' working lives. Not surprisingly, the earnings of those working full-time are much more likely to account for a higher proportion of household income than is the case among nurses working part-time.

[11] Jones T (1993) *Britain's ethnic minorities.* London: PSI.
[12] Beishon S, Virdee S and Hagell A (1995) *Nursing in a multi-ethnic NHS.* London: PSI.

For example, six out of ten (61%) nurses working full-time are the major breadwinner and contribute more than half of their household income. However, while the figure for part-time nurses is lower, nevertheless one in five (21%) part-time nurses are still the major breadwinners. Where nurses have children, they are less likely to be the major breadwinner. Chapter 4 looks in more detail at nurses' contribution to household income.

Differences in attitudes between part-time and full-time nurses

The 2002 questionnaire sought a range of attitudinal data. When examined by full and part-time working the following differences emerge:

Career progression – full-time nurses respond more positively when considering issues related to their career than is the case among part-time nurses. Typically, full-time nurses are more *interested in career progression*, they are more likely to say they have *a good chance to get ahead in nursing*, and perceive it as *not difficult to progress from their current grade*. They also seem to have a positive view about the security of their job and have a clearer idea of *where their career in nursing is going*.

Workload and flexible working – on the other hand part-time nurses are significantly more likely to say they are *satisfied with choice over the length of shifts* they work and are *able to balance their home and work lives*. Also more part-time nurses say that they do *not feel under too much pressure at work* and that their *workload is not too heavy*.

These differences are summarised in figure 3.3 (the higher score represents a more positive view).

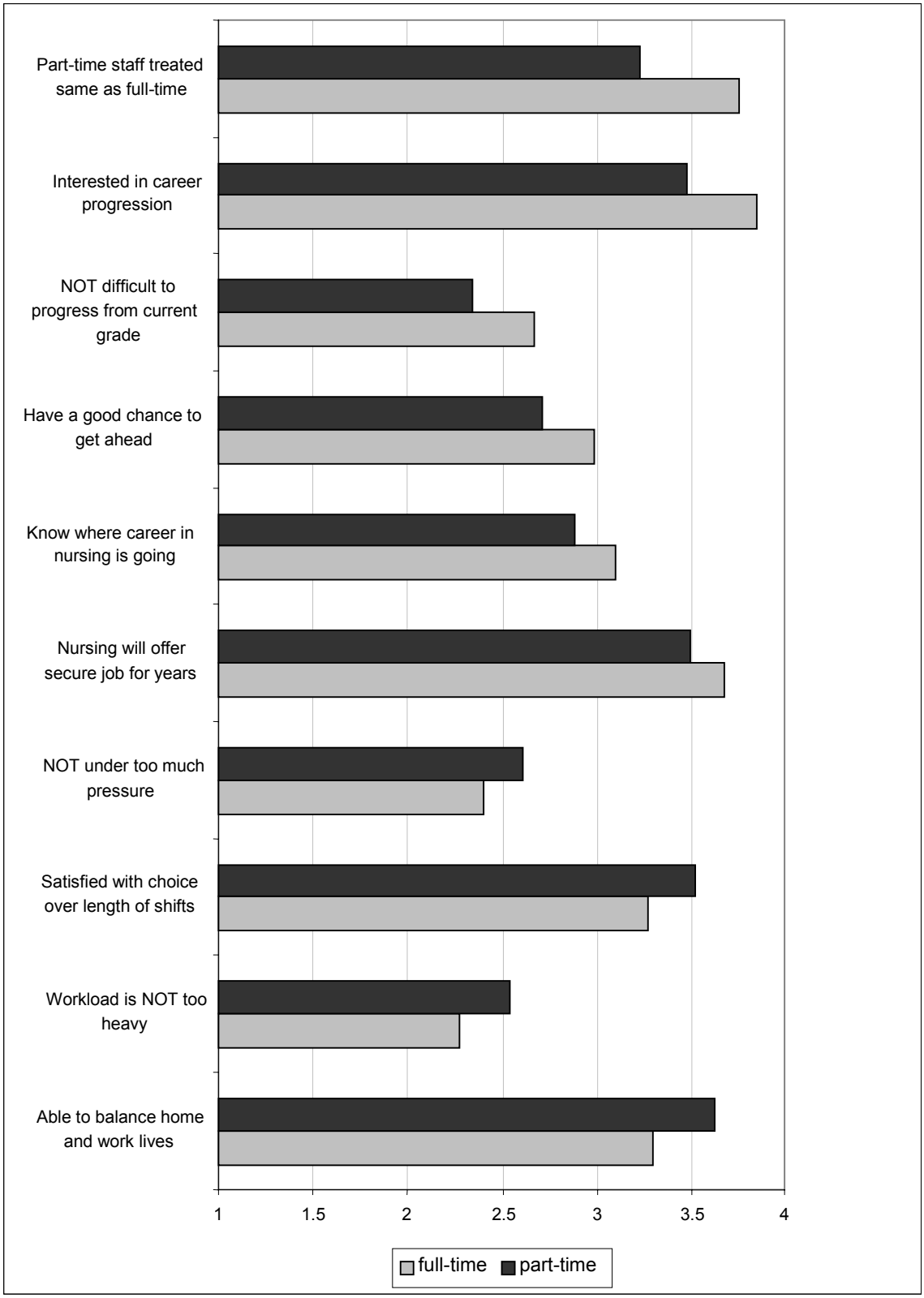
Generalising, it seems that many part-time nurses are more positive about flexible working issues than full-time nurses, but they feel less positive about their career progression. On the other hand, full-time nurses, in focusing perhaps more on their careers, are more likely to suffer in relation to workload and flexibility in their working lives. The challenge to employers and nurses is how to balance these apparently conflicting needs.

3.3 Patterns and shifts

The necessity to provide nursing services 24-hours a day and all year round makes shift working an essential feature for many nurses working in hospitals and, to a lesser extent, other settings. Managing shift patterns to provide effective and continuous care while ensuring choice over working hours has always been a key challenge for employers.

Table 3.5 highlights biographical characteristics of nurses in relation to the range of shift patterns. The main points to note from this are that nurses with young children are more likely to work nights, while those with school age children work school hour days more frequently. More young nurses work either form of rotation. Minority ethnic nurses more frequently report working internal rotation shift patterns than white colleagues.

Figure 3.3 Differences between part-time and full-time nurses in views about work



Source: Employment Research/RCN 2002

Table 3.5 Shift patterns by biographical characteristics – percentages

	% Men	% with children < 5 years	% with children 5-16 yrs	% minority ethnic	% under 40	*Wtd cases*
Mix of early, late and nights	7	15	28	8	62	*964*
Mix of long days/nights	9	19	19	9	78	*321*
Early and/or late (no nights)	4	14	35	5	39	*653*
Long days (no nights)	5	17	26	6	40	*239*
Permanent nights	4	22	54	7	42	*299*
Days only (9-5 equivalent)	6	14	39	4	40	*1,197*
School hour days	1	17	86	5	49	*94*
Flexi-time	8	10	36	6	28	*92*
Split shifts	0	7	43	5	30	*21*
Other	6	21	43	4	39	*145*
All	**6**	**15**	**36**	**6**	**48**	***4,025***

Source: Employment Research/RCN 2002

Table 3.6 analyses shift patterns further using a simplified range of patterns. Full three-shift rotation responses were combined with responses indicating a mix of long days and long nights to form a general rotation category. Respondents working long days only, and early/late shifts only were combined into a single days only category. Office hours include nurses working 9am to 5pm or equivalent. Finally school hours with flexi-time were combined as forms of flexible working.

The table shows that half of all NHS hospital staff work a combination of day and night shifts – a much higher proportion than in the other settings. More staff in nursing homes (23%) work permanent nights compared to NHS hospital staff (8%).

Looking at all respondents in the NHS (hospital and other settings), 39% of respondents work a mix of day and night shifts. Ten years ago in 1992, slightly fewer NHS nurses (32%) reported working a mix of day and night shifts.

Table 3.6 Shift patterns by employer/setting – percentages 2002

	NHS hospital	Indep hospital	Nursing home	Bank/ agency	Hospice	All NHS
Rotation (day and night shifts)	50	19	12	29	28	39
Day shifts only (including long days)	22	54	50	25	23	19
Permanent nights	8	12	23	16	18	6
Office hours	16	5	11	19	23	29
Flexible (including school hour days)	2	9	1	7	6	4
Mixed/other	2	0	2	5	3	3
Base N=100%	*2,142*	*97*	*209*	*135*	*149*	

Source: RCN Membership Survey 2001

The RCN *Working well* survey[13] found that 43% of all nurses are not working the shift pattern they would like. This figure rises to 68% of those working internal rotation. Furthermore, the same study found that whether or not nurses work their preferred shift pattern was more broadly indicative of how they viewed their employer. For example, those nurses not working their preferred shift pattern were less likely to feel positive about the degree to which they were consulted and the support they received from their employers after they have been ill.

Shift patterns and job title/field of practice

Over the last decade there has been a steady reduction in the proportion of respondents working nights only. In 1992 13% of NHS nurses worked permanent nights. In 2002 the figure is 6%. Higher proportions of nurses in the independent sector work nights only and 22% of those nurses are based in nursing homes.

Table 3.7 Shift patterns by job title NHS-only – percentages

	Staff nurses	Sister	Senior nurse	CNS	District nurse	All NHS nurses
Rotation	55	35	15	6	0	39
Long days/early/lates (no nights)	19	34	24	9	6	19
Permanent nights	8	3	5	2	3	6
Days only (9-5 equivalent)	14	22	49	70	80	29
Flexi-time (inc school days)	1	3	7	11	5	4
Other	3	3	1	2	6	3
Base N=	*1,566*	*486*	*106*	*238*	*156*	*2,872*

Source: Employment Research/RCN 2002

Staff nurses and sisters undertake most of the rotating shiftwork in the NHS, while more senior staff and district nurses are more often working days only/office hours or flexi-time.

Patterns of work also vary by field of practice. Table 3.8 shows the differences by key specialties. More than two-thirds of nurses in adult critical care (69%) work a form of rotation with just 5% working nights only.

Table 3.8 Shift patterns by specialty NHS-only – percentages

	Older people nursing	Mental health	Adult critical care	Adult general	Paeds general	Oncology/ palliative	All NHS nurses
Rotation	23	33	69	42	55	27	39
Long days/early/lates (no nights)	26	17	15	24	17	17	19
Permanent nights	16	5	5	8	5	6	6
Days only (9-5 equivalent)	31	38	7	20	20	47	29
Flexi-time (inc school days)	2	3	1	3	3	3	4
Other	1	4	4	3	1	0	3
Base N=	*259*	*214*	*474*	*715*	*174*	*120*	*2,843*

Source: Employment Research/RCN 2002

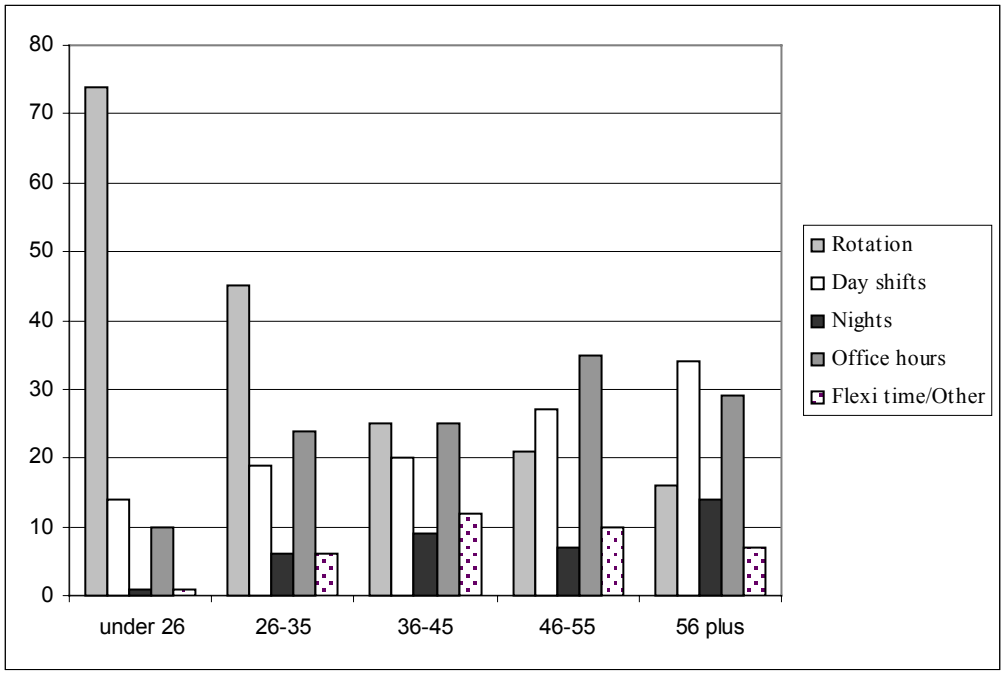
[13] Ball J et al (2002*) Working well? Results from the RCN working well survey in to the wellbeing and Working lives of nurses*. London: RCN

The nature and level of job are the key determinants of the shift pattern worked by nurses. However, it is also the case that younger nurses and those with children work different shift patterns than their older colleagues and those without children. One in four nurses with children work rotating shifts compared to 39% of those without children. 10% of nurses with children work nights and 6% work flexi-time compared to 4% and 3% respectively of those without children.

Figure 3.4 highlights the differences by age in the percentage working a form of rotation, nights and office hours. It is interesting to note that the oldest age group (56 years plus) are those most likely to work permanent nights (14%).

Finally, it seems that UK-qualified minority ethnic nurses are more likely to work rotating shifts (46%) compared to UK white nurses (39%), after controlling for other factors. In addition, 71% of overseas-qualified minority ethnic nurses work rotating shifts.

Figure 3.4 Shift patterns by age – percentages (all respondents)



Source: Employment Research/RCN 2002

3.4 Time spent working

Most full-time nurses covered by the survey are contracted to work 37.5 hours per week. Part-time nurses are contracted to work an average of 23 hours per week - the same figure reported in each of the last two years.

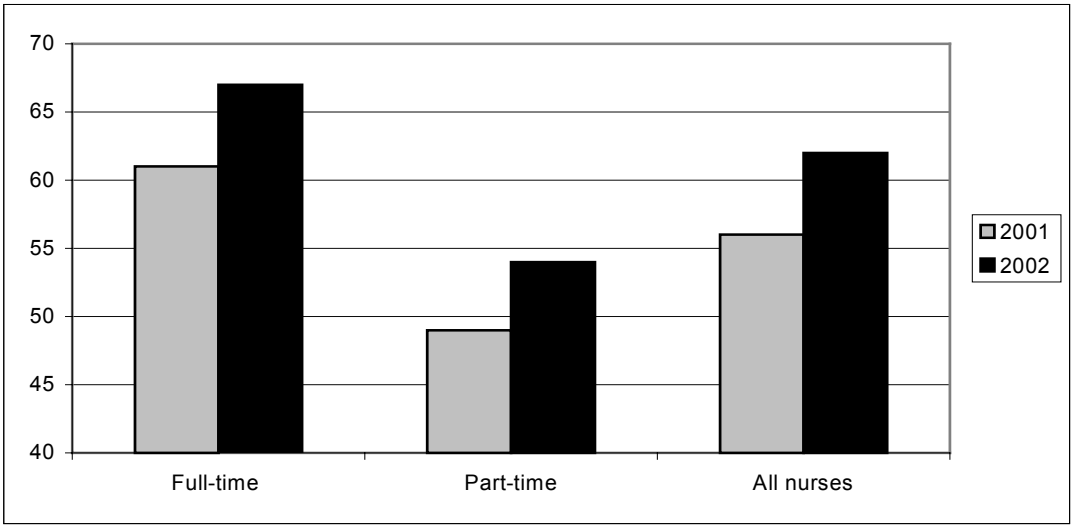
Working more than contracted hours

As patterns of work vary between nurses, so does the number of hours spent at work. A large number of nurses work extra hours each week. Many have second and even third jobs.

There has been a rise in the proportion of nurses who report that they worked more than their contracted hours in their last week at work prior to completing the survey – up from 55% last year to 63% this year. Figure 3.5 shows the growth in the proportion of nurses working extra hours for part-time and full-time nurses in 2001 and 2002. Given that this figure had remained unchanged in the previous five years this seems a significant step change in the hours worked by NHS nurses. Of those nurses that reported working extra hours in their main job the average number of additional hours they work is 6.7.

There has also been an increase in the frequency with which nurses are working these extra hours. Nine per cent of NHS nurses are now working extra hours on every shift, more than one in three (35%) worked extra hours several times per week and a fifth once a week. Last year 41% worked extra hours less than once per week or never, this year the equivalent figure is 36%.

Figure 3.5 Nurses working in excess of their contracted hours 2001 and 2002 – percentages by mode of working



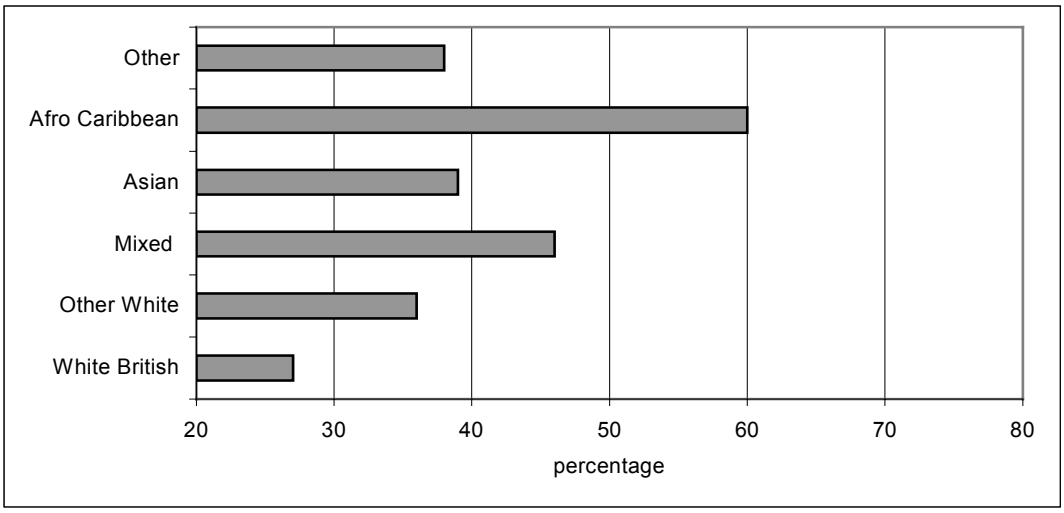
Source: Employment Research/RCN 2002

Additional jobs

The 2002 survey also shows a rise in the proportion of nurses reporting that they have additional jobs (29% up from 26% last year). In 2002 28% of part-time and 31% of full-time nurses say they have an additional job. This compares with equivalent figures of 23% and 27% in 1996. The relationship between grade and nurses having additional jobs has been identified in previous surveys. Approximately one-third of nurses in grades D-F have additional jobs compared to about one in five nurses in grades G-I.

Nurses working in additional jobs are not evenly distributed. In London 45% of all nurses have additional jobs, compared to 28% elsewhere. However, the largest differences relate to ethnicity. For example, 60% of Afro Caribbean nurses have second jobs (figure 3.6). More Afro Caribbean nurses are main breadwinners than is the case among other minority ethnic groups, including white nurses.

Figure 3.6 Nurses with additional jobs by ethnic origin – percentages



Source: Employment Research/RCN 2002

Nurses in Northern Ireland are least likely to have second jobs (16%). This data may relate to the extent to which variations in living costs influence nurses' decisions about their working patterns and income needs. Nurses working rotating shifts (35%) and nights only (33%) are also more likely to have second jobs, as are respondents whose earnings account for all their household income (35%).

Just over half of those with additional jobs work as bank nurses (53%). Nurses having additional jobs are also more likely to be NHS nurses on grades D-F, who work in London, and be on a full three-shift rotation. One in four nurses with additional jobs works for an agency. Nine per cent of those with additional jobs indicate that this is with *NHS Professionals,* the English initiative established to provide an NHS in-house framework for the employment of non-core staff. The initiative is still quite new. Our survey will monitor developments in subsequent years.

Nearly three-quarters of respondents indicate that the main reason they work in additional jobs is to increase household income. Nine per cent report increasing nursing skills, 8% say that they want to widen their experience, while 14% mention other reasons, of which maintaining staffing levels is cited by more than half the respondents. Increasing income is more important for full-time nurses than part-time, while senior grades are more likely to refer to maintaining staffing levels or providing an interest/change.

For nurses who are the main breadwinner, where their earnings account for more than half of their household income, additional income is more likely to be the main reason they take additional jobs (nearly 80% compared to 60% where earnings account for less than half household income).

On average among the 29% of nurses working in additional jobs, 11 hours per week is spent in these jobs. There is little difference between full-time and part-time respondents. This is slightly lower than the figure reported last year. This indicates that although more nurses are working extra hours both in their main job and in their additional jobs, the average number of hours worked in these ways has declined slightly.

Where nurses' earnings account for most of the household income more hours are worked in additional jobs (13 hours compared to 8 hours where earnings account for less than half household income).

Total working time

Table 3.9 summarises average data on contracted hours, and additional hours from main and other employment The average total hours worked for full-time nurses is approximately 44 hours per week, while that of part-time nurses is approximately 28 hours. Clearly there are marked variations around this average data.

Diversity and working hours

There is very little difference in average total working hours when examined by gender. However, this is not the case when data is examined by ethnicity. On average UK-qualified minority ethnic staff nurses in the NHS on full-time contracts work 5.2 hours per week more than their white UK-qualified colleagues. Afro Caribbean nurses work about 6.5 hours more than their white colleagues (figure 3.7). This difference is primarily accounted for by differences in the hours worked in additional jobs for different ethnic groups.

Also nurses in England work an average of four more hours per week more than nurses elsewhere in the UK, and nurses in London work three hours longer than nurses in the rest of England (47.3 hours). The data also shows that for part-time nurses there is a clear relationship between earnings as a proportion of household income, and the number of hours worked. Where this proportion is less than a half, average hours are 24.7 per week. But for part-time nurses whose earnings account for more than half their household income, the average time worked each week is more than 33 hours.

Fifteen per cent of nurses whose main employment is in the NHS work more than 50 hours per week.

3.5 Views of working hours

Recent surveys have collected data in relation to three attitude statements:

- I feel able to balance my home and work lives
- I am satisfied with the choice I have over the length of shifts I work
- I am satisfied with my input in planning my own off duty/times off work.

Responses to these statements for NHS nurses are summarised in figure 3.8 below.

The majority (approximately 60% for each statement) of NHS nurses report satisfaction with the degree of choice they have over their working hours. However, there are marked differences related to shift pattern. Of the nurses working a full three-shift rotation 34% are dissatisfied with the length of shifts they work. This compares with 10% of those working flexi-time, 15% of those working office hours and 17% of those working nights only.

It should be noted that women in the NHS tend to be more satisfied with their ability to balance their home and work lives than men (62% agreeing with this statement compared to 49% of men). But this is primarily to do with the higher proportion working part-time – there is little difference in satisfaction of full-time male and female nurses.

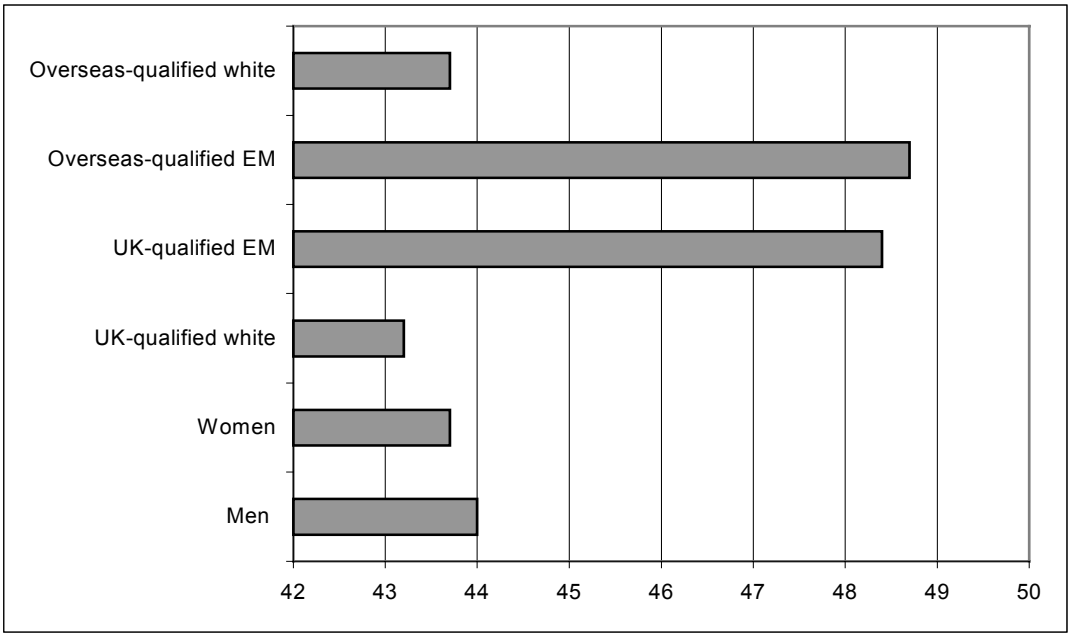
Table 3.9 Additional hours, additional jobs and hours worked by employer setting (full-time/part-time) – percentages and means

FT = full-time PT = part-time	Sector and base													
	NHS hospital		NHS community		Independent hospital		Independent nursing home		GP practice		Hospice		All nurses	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT
Mean contracted hours in main job[14]	37.5	23.8	37.5	21.4	37.5	22.2	37.5	21.1	37.5	21.2	37.5	23.2	37.5	22.6
% working excess hours in last week	67	55	62	61	69	55	70	58	56	66	62	39	67	54
% working in excess of contract several times per week or more	54	30	49	37	50	44	51	27	44	33	57	28	53	31
Average excess hours in main job *(ALL)*	4.8	3.0	3.2	4.0	5.5	3.0	7.4	3.9	3.7	2.2	5.4	2.6	4.9	2.8
Average excess hours in main job *(for those that worked excess hours)*	7.3	6.5	5.2	6.7	7.9	6.3	10.7	7.0	6.9	3.4	8.7	7.0	7.5	5.3
% with additional jobs	32	26	20	41	39	27	18	24	32	39	13	27	28	31
Average hours worked in additional jobs *(ALL)*	2.4	2.0	1.2	3.2	3.6	1.9	1.7	1.9	2.0	2.5	0.4	1.3	2.0	2.2
Average hours worked in additional jobs *(for ALL with additional jobs, including those whose hours = 0)*	8.3	8.6	6.5	7.9	9.4	8.7	11.8	9.9	6.7	6.6	3.2	5.4	8.1	7.9
Average TOTAL hours worked in last week *(all respondents)*	44.5	29.0	41.7	28.9	46.5	26.0	48.0	26.7	42.6	26.0	43.3	26.5	44.4	27.7
Weighted cases (all respondents)	*1,426*	*728*	*334*	*171*	*49*	*51*	*132*	*79*	*61*	*227*	*74*	*76*	*2,449*	*1,586*

Source: Employment Research/RCN 2002

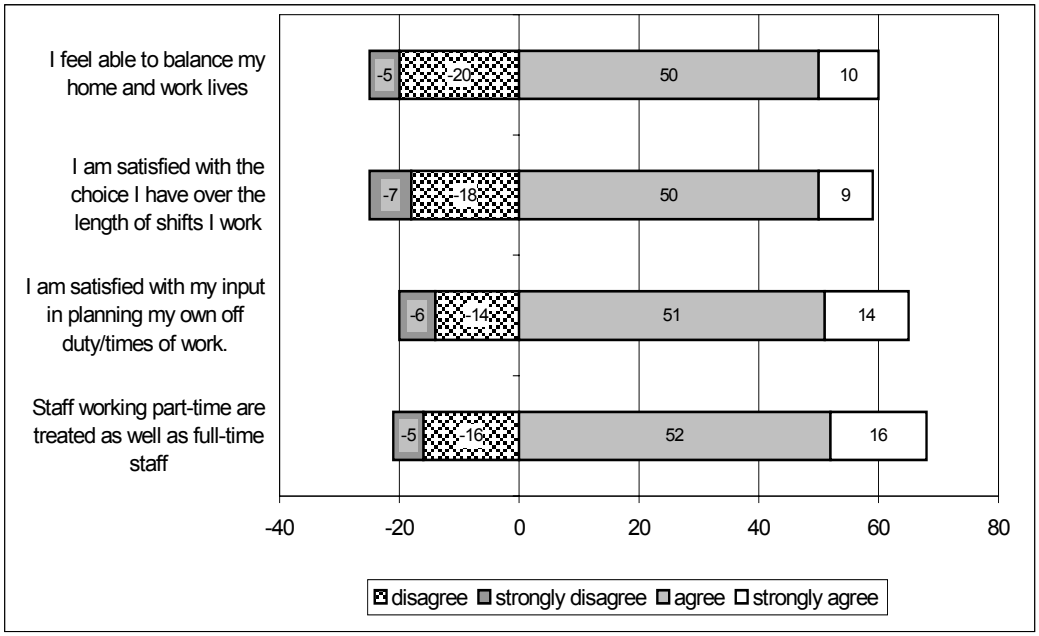
[14] Full-time contracted hours have used the median figure as it is clear that in many cases hours worked have been given rather than contracted hours.

Figure 3.7 Total hours worked for full-time NHS staff nurses by ethnicity and gender (hours)



Source: Employment Research/RCN 2002

Figure 3.8 Attitudes to working hours (NHS-only)



Source: Employment Research/RCN 2002

Nurses working rotating shifts are the most dissatisfied with working hours. For example, 27% of nurses working internal rotation say they are unable to balance their home and work lives compared to 14% of nurses working nights and 24% of all NHS nurses. A third (31%) of respondents working full rotation are dissatisfied with the level of input they have in planning their off-duty/times off work. Across all NHS nurses 21% are dissatisfied with this aspect of their working hours.

However, the main variable correlated with lack of satisfaction in respect of working hours is the frequency with which nurses have to work excess hours. For example, 41% of nurses who report working excess hours every shift are dissatisfied with the degree of choice they feel they have over the length of shifts they work, compared to 25% of all NHS nurses who report dissatisfaction.

Longitudinal research (Robinson et al[15]) has found that 31% of staff returning to work after a career break are working more hours than they would prefer, and 23% are not working their preferred pattern of hours.

Nurses who feel inappropriately graded (see Chapters 4 and 5) tend to be more dissatisfied with a range of aspects of their working lives.

3.6 Workloads and staffing

Two types of data were collected to explore workloads: nurse-to-patient ratios; and perceptions of both workload and adequacy of staffing. The 2002 and 2001 surveys asked individuals working in in-patient settings to give details of the number of staff (registered nurses and health care assistants or auxiliaries) and patients. This data was then used to calculate patient-to-staff ratios.

These crude figures do not take account of the variety of factors that affect workload intensity. For example, the dependency of patients cared for, or the other demands on nurse time for clinical supervision, mentoring, administration and so on. However, they do provide a straightforward indicator of workload that is easily replicated and easily understood. This allows some investigation of differences between groups of nurses, and analysis of changes through time.

Table 3.10 shows that nurses working in NHS hospital wards typically care for 11 patients each during a day-time shift, and that there are an average of eight patients per member of staff on duty. The difference between these numbers is because one of the members of staff reported to be on duty will be in charge of the ward for the shift, and will have fewer or no patients in their care. There has been no change in staffing relative to patient numbers since last year's survey.

[15] Robinson S, Marsland L, Turrells T, Tingle A & Smith R (2001) *Careers of RGNs. Combining work and family: nurses experiences four to eight years after qualification.* London: NRU King's College

Table 3.10 Average staffing and patient data for NHS hospital wards

	2001		2002	
	Day	**Night**	**Day**	**Night**
Number of beds	24		24	
Total number of patients	22		22	
Number of registered nurses (RNs)	3.2	2.3	3.2	2.4
Number of HCAs/auxiliaries	2.1	1.3	2.2	1.3
Mix - % of nursing staff that are RNs	62%	65%	61%	65%
Patients cared for by respondents	10.6	14.6	10.6	14.7
Patients per RN (across ward)	8.0	11.1	8.0	11.5
Patients per nursing staff (across ward)	4.4	6.3	4.4	6.6

Source: Employment Research/RCN 2002

Views of workload

There has been little change in the proportion of NHS nurses reporting that their workload is too heavy. However, workload issues continue to draw most negative opinion among all nurses. For example, only 14% feel that that their workload is not too heavy, 13% report that nurse staffing levels have got better in the last year and just 17% say that they are not under too much pressure at work.

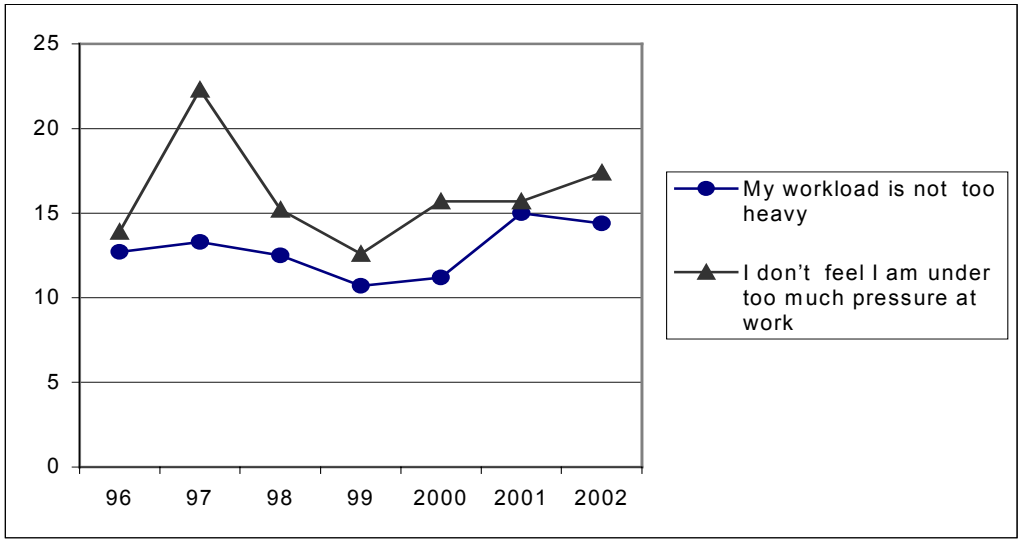
Creating a compound variable that takes all the workload attitude statements together, we can explore differences in response between groups of nurses in their views of workload. The statements used are:

- NOT too much of my time is spent in non-nursing duties
- I have sufficient time to do my job properly
- nurse staffing levels have got better in the last year
- there are sufficient staff to provide a good standard of care
- I am NOT under too much pressure at work
- my workload is NOT too heavy.

Nurses in hospital wards feel most under pressure in terms of their workload while, importantly, nurses who feel that they are inappropriately graded are most likely to feel negative about workload issues. Full-time nurses feel more negative about their workloads than part-time.

Figure 3.9 below shows changes in nurses' views of their workload over the last six years, highlighting a small increase in the proportion of nurses responding positively in more recent years.

Figure 3.9 Attitudes to workload – 1996-2002 (NHS-only)



Source: Employment Research/RCN 2002

3.7 Key points

Lack of flexibility over working hours is acknowledged as an obstacle in returning to nursing by individuals and employers alike. The following list highlights some of the main features of working hours and nursing employment:

- Nurses in NHS hospitals are much less likely to work part-time than their colleagues in independent hospitals (34% compared to 51%). In general, a smaller proportion of nurses in the NHS work part-time than is the case in other sectors.
- Nearly four in ten nurses currently work other than full-time hours. This is mostly part-time. Although 1% work as part of a job share and 2% work occasional or various hours. Working part-time is most frequent among practice and community nurses.
- Fewer than one in five (17%) senior nurses/matrons work part-time, one in four (26%) clinical nurse specialists do so compared to 43% of staff nurses.
- Lowest proportions of part-time nurses are in specialties where men work in higher proportions such as mental health (13%) and learning disabilities (21%). Of staff in older people's nursing 43% work part-time.
- Nurses with children living at home (54%) are much more likely to work part-time than those without children at home. However, for men there is little difference between those with and without children.
- UK-qualified minority ethnic nurses (77%) are much more likely to work full-time than their white colleagues (59%). These differences widen among those staff nurses in the NHS with children living at home.

- Nurses who work part-time are less likely to be satisfied with career progression opportunities, but are more satisfied with their workload and ability to balance their home and working lives.

- A third of nurses work rotating shifts and 6% work permanent nights (down from 13% in 1992). The nature of shift patterns worked by respondents is most closely correlated with their field of work.

- Each year more nurses are working in excess of their contracted hours, up from 55% in 2001 to 63% in 2002. More nurses are working in excess of their contracted hours several shifts or more every week (up from 39% to 45% in the last year).

- More nurses are also working in additional jobs this year (29% compared to 26% in 2001). Minority ethnic nurses (particularly those of Afro Caribbean origin) are much more likely to have additional jobs than white nurses.

- Where nurses families rely more heavily on respondents' income, more time is spent working in additional jobs (13 hours compared to 8 hours overall).

- Minority ethnic nurses are more likely to be working rotating shifts than white nurses are. UK-qualified minority ethnic nurses are more likely to be working the less popular shift patterns, and are less satisfied with their working hours than other nurses. In addition, these nurses also work longer hours than their white colleagues, even after other factors have been taken into account such as working in London).

- There has been little change in the workloads reported by nurses as measured by patient-to-staff ratios. On average each respondent cared for eight patients during day shifts and 11.5 during night shifts. There has also been little change in the views of nurses of their workload.

4. Nurses' pay and grading

4.1 Introduction

Clinical grading, the current national pay and career structure for NHS nurses was introduced in 1988. Since the implementation of clinical grading, there has been a series of interventions in relation to NHS nurses' pay:

- 1988-89: Department of Health-inspired pilot attempts at local pay supplements
- 1991: creation of NHS trusts with the status of separate employers able to introduce their own terms and conditions, outside of those negotiated nationally
- 1995- 96: attempted introduction of local pay by the Pay Review Body
- 1997: local pay policy abandoned
- 1999: three discretionary increments introduced for grades F to I
- 1999: in response to recruitment difficulties, two points from the bottom of grade D were dropped and one added to the top. Salary increase of 8%-12% for D grade staff
- 1999: Government publication *Agenda for Change* proposed a new pay system for NHS staff and marked the beginning of NHS pay modernisation negotiations
- 2000: Pay Review Body award recognised problems in retention and added one point to the top of grade C and one to the top of grade E
- 2000: introduction of consultant nurse posts
- 2001: Pay Review Body recommendation that one of the three discretionary points at each of the grades F to I be consolidated into the main scale
- 2002: Pay Review Body further consolidated discretionary points for so-called modern matrons. It recommended that the national rates of psychiatric lead and regional secure unit allowance be increased by 32%, and recommended that the national rates of on-call and stand-by allowances be increased by 50%.

At the time of writing negotiations are continuing over the development of an entirely new system of pay and conditions to cover all NHS staff..

The centrality of pay to recruitment and retention of nurses was acknowledged by the Pay Review Body in its 2002 report when it said:

"Nursing must capture a greater share of a generally tight labour market."

The report also acknowledged the reality of recruitment and retention pressures stating:

"There are major risks in adopting too cautious a stance on pay…on balance, we believe the evidence points to a need to improve the competitive position of the NHS in the labour market."

The importance of pay in achieving the NHS plan is explicit in *HR in the NHS plan*[16]. The aim is ensure that staff are given proper incentives for developing their roles and that the pay system recognises the responsibilities, knowledge and skills of their roles.

The 2002 RCN survey demonstrates some of the inadequacies of the current clinical grading system, and its apparent misapplication in 2002. This section examines grading issues, the extent to which staff feel their grades are appropriate, views of pay, and the importance of pay to household income.

4.2 Grading

Over the past 12 months the survey indicates there has been a slight decrease in the proportion of respondents on C and D grades, and a small increase in the proportion employed on E and F grades. Table 4.1 shows this change and highlights differences between full-time and part-time women and men. It demonstrates that men are slightly less likely to be on D and E grades, and are more likely to be on F to I grades than is the case for women who are employed full-time. Nearly three-quarters of all women employed part-time are on C to E grades. The issue of gender and representation in senior grades is looked at more fully in Chapter 5.

Table 4.1 Grade distribution by FT/PT and gender – percentages (NHS-only)

	Women		Men	All NHS[17]	
	Full-time	Part-time		2002	2001
C/D	19	25	18	21	23
E	34	47	31	39	36
F	16	14	17	16	14
G	21	11	17	18	19
H	7	2	10	6	6
I	1	<1	2	1	2
Other	2	1	5	-	-
Weighted cases	*1,718*	*980*	*186*	*2,861*	*1,924*

Source: Employment Research/RCN 2002

More revealing than the simple distribution of grades is the data relating to grade relative to job title. By comparing this year's data with that of 1992 we can see how differently jobs are graded now compared with ten years ago. Table 4.2 shows the proportion of staff in each job that are being paid on the higher grades for given job titles.

Table 4.2 Jobtitle by grade 1992 and 2002 – percentages (NHS-only including GP practice)

	1992		2002	
	%	*n=*	%	*Weighted n=*
Senior nurses H or above	80	*62*	61	*100*
Ward managers G or above	64	*413*	48	*491*
Staff nurses E or above	71	*973*	67	*1,577*
Health visitors F or above	100	*32*	97	*28*
District nurses F or above	84	*105*	70	*159*
CNS/nurse practitioners H and above	n/a	*n/a*	39	*240*
GP practice nurses G and above	n/a	*n/a*	54	*254*

Source: Employment Research/RCN 2002

[16] *HR in the NHS plan. More staff working differently* (2002). London: DH
[17] All NHS figures exclude other grades

The table shows very clearly that in all of those jobs where comparisons can be made fewer nurses are in higher grades now that ten years ago. That is, nurses with the same job titles are apparently rewarded less well than they were a decade ago. For example, less than half of all ward managers are on grade G or above. The clinical grading guidelines state that a G grade is appropriate for staff with ongoing responsibility for a ward such as a ward sister or charge nurse. Despite the fact that this role has, in many cases, become more complex with increasing levels of management and budgetary responsibilities, the proportion who appear to be graded below the recommended grade has risen from 36% in 1992 to 52% today.

On top increment of grade

In 1999 in response to recruitment difficulties, two points were dropped from the bottom of grade D and one added to the top. This had the desired short-term impact of improving salary progression for D grade nurses. However, after several years of sustained reduction in the proportion of D grades at the top of their salary scale the trend has now reversed with a rise from 39% last year to 49% this year.

For all other grades there are now fewer respondents indicating that they are at the top of their salary scale than there were 12 months ago (see table 4.3). Indeed, across all NHS nurses 46% report that they are at the top of their salary scale, compared to 63% in 1996 and 53% in 2001. The addition of a point to the top of grade E in 2000 and the consolidation of one discretionary point for grades F to I (2001) has clearly has a short-term impact on 'headroom'. The long-term solution to frustrated salary progression and associated problems of retention problems lies with NHS pay modernisation.

Table 4.3 Percentage of nurses at the top of their salary scale – 1996, 2000 and 2002 (NHS-only)

	1996	2000	2001	2002	*Weighted cases 2002*
D	57	45	39	49	*585*
E	65	53	56	46	*1,102*
F	54	46	46	33	*447*
G	73	63	64	53	*498*
H	66	55	67	45	*163*
I	71	73	71	50	*30*
All grades	**63**	**56**	**53**	**46**	***2,834***

Source: Employment Research/RCN 2002

Nurses who hold diploma or degree level qualifications are less likely to be at the top of their salary scale than those with no academic nursing qualifications (33% compared to 58%). Also, partly as a function of time since qualification, nearly two-thirds (61%) of nurses aged over 40 are at the top of their scale compared to 33% of nurses aged under 40. There is no discernible difference overall by ethnicity or gender in the likelihood of nurses being on the top increment of their salary scale.

Acting up

The 2000 questionnaire asked respondents to say whether or not they were acting up, that is covering the responsibilities of a higher grade member of staff pending recruitment to that post. They were also asked if they were paid for this acting up responsibility. Across all NHS nurses approximately one in ten nurses were acting up to a higher grade at the time of the survey, and 1% did not know. This figure is slightly higher in the independent nursing home sector at 13%, but otherwise there is little difference between nurses in terms of their employment sectors. In the NHS senior nurses and those employed in older peoples' nursing and rehabilitation/longer term care are most likely to say they are acting up to a higher grade (18%). Also, full-time staff (12%) are more likely to be acting up than part-time staff (7%). Some groups of minority ethnic nurses are more likely to be acting up than white nurses, particularly in the case of Afro Caribbean and Asian nurses (19% and 15% respectively compared to 10% of white nurses). Of those who indicated that they were acting up to a higher grade, two-thirds said they were not being paid for it.

4.3 Inappropriate grading

Last year respondents were asked if they felt their grade was appropriate given their role and responsibilities. Of all the respondents to the 2001 survey 38% considered their grade inappropriate (41% in the NHS). This year there has been a significant increase in this proportion to 48% (49% in the NHS).

The employment sectors with biggest changes in the numbers reporting that they are inappropriately graded are bank/agency nurses (up from 23% to 42% this year), GP practice nurses (up from 33% to 45%) and respondents working in independent nursing homes (34% to 48%). The data in relation to bank nursing is of particular concern because there has been a long-standing issue about inappropriate grading of bank staff, which the NHS, urged on by the Pay Review Body, is supposed to be addressing.

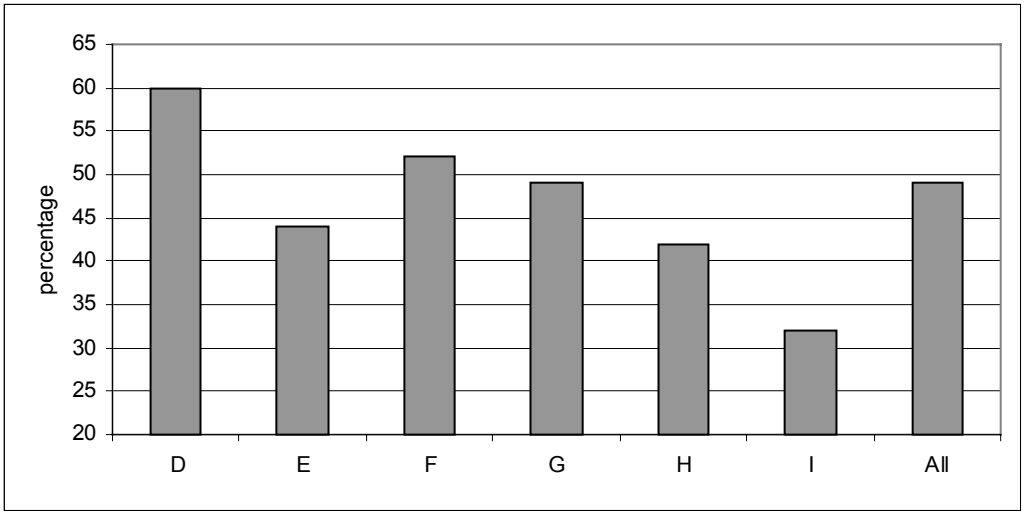
In the NHS inappropriate grading varied by current grade. D grade nurses are most likely to feel inappropriately graded (60%) followed by F grades (52%) (see figure 4.1). Fifty-nine per cent of clinical nurse specialists and 51% of senior nurses/matrons consider themselves inappropriately graded, compared with 49% of staff nurses and sisters.

A much lower proportion of Afro Caribbean nurses in the NHS feel they are appropriately graded than is the case among other minority ethnic nurses and white nurses (30% compared to 49% of white and 40% of all UK-qualified minority ethnic nurses). This difference is wider still among D to F grades in NHS hospital settings.

More nurses in their late 40s and early 50s feel inappropriately graded than is the case among other age groups. The age and grade of individuals are the two main factors influencing whether or not NHS nurses feel inappropriately graded.

Across all respondents, full-time nurses who have children appear more likely to feel inappropriately graded than others (56% compared to 48% of those that do not have children).

Figure 4.1 Percentage feeling that grade is inappropriate by current grade (NHS-only)

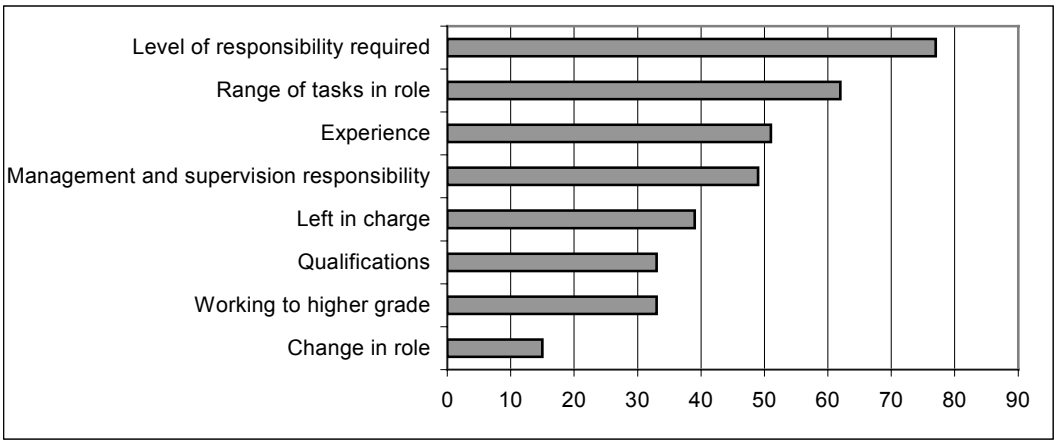


Source: Employment Research/RCN 2002

When asked why they felt their current grade was not appropriate, the level of responsibility held is the main reason given by 77% of respondents. This is particularly the case with community and practice nursing where more than 80% cited this aspect of their role as a reason why they felt their grade was inappropriate. Higher proportions of these nurses also cited the range of tasks and activities required in their role as well as their experience. NHS nurses mentioned management and supervision responsibility more often than non-NHS nurses, and respondents in hospital and nursing homes were much more likely to highlight being left in charge as a reason to be upgraded.

When asked which grade respondents feel they should be on, the vast majority (95%) of D to G grades indicated a single grade increase, while 4% felt they should be on a grade two up from their current grade.

Figure 4.2 Reasons for indicating current grade not appropriate – percentages (all respondents)



Source: Employment Research/RCN 2002

Doing work of a higher grade

To explore the issues of appropriate grading from a different angle, respondents were asked to indicate how often, if at all, they did work that they considered should be undertaken by staff paid at a higher grade. Across all nurses higher grade work is done:

- very often by 26% (27% NHS)
- quite often by 25% (27% NHS)
- occasionally by 33% (32% NHS)
- never by 16% (14% NHS).

When looking in more detail at the types of nurses that are working more often to a higher grade, it is F grade ward sisters and clinical nurse specialists (CNS) who perceive themselves to be working to a higher grade most often. For example, 64% of F grade CNSs say they are working to a higher grade *very often*. The same is true for 38% of F grade ward sisters.

This finding, together with reduction in the proportion of ward managers at grade G and above, reinforces the picture that many F grade ward sisters consider that they are not appropriately graded, and as a result are working to a grade higher than they are paid for.

In NHS hospital settings there is little difference between men and women. UK-qualified minority ethnic nurses are more likely to perceive themselves to be undertaking work that is paid at a higher grade at least *quite often* (61% compared to 51% of UK-qualified white nurses).

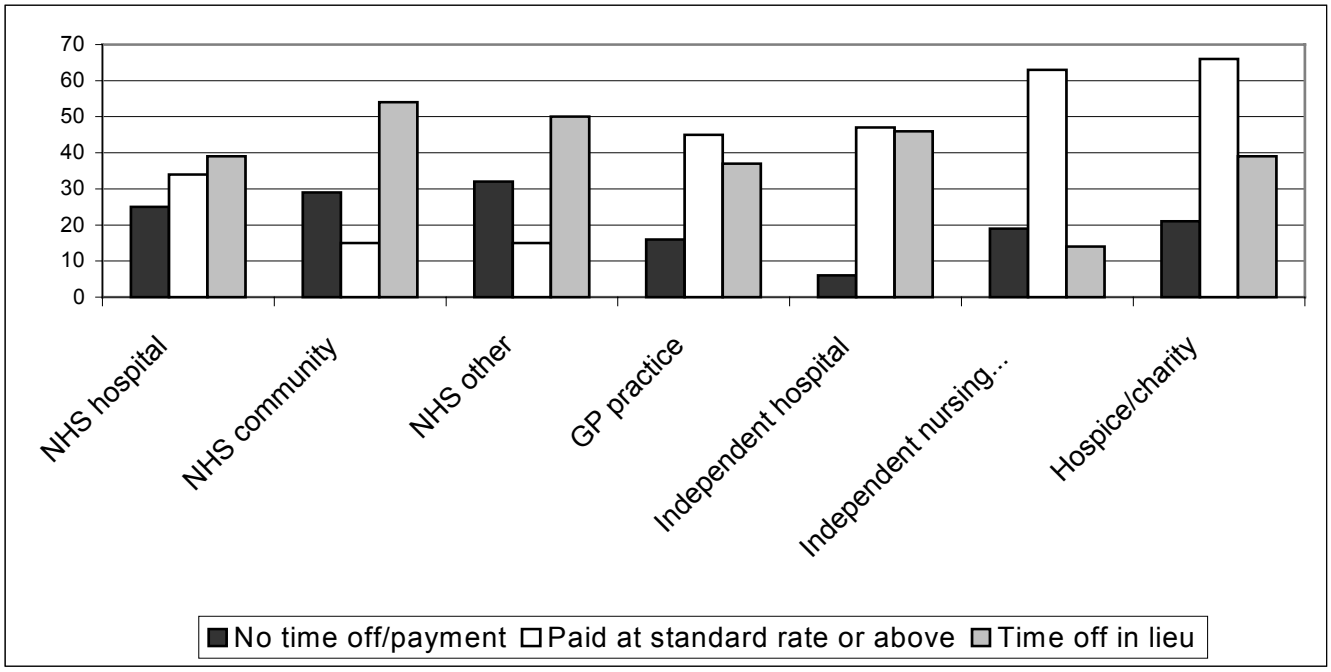
4.4 Reimbursement for additional hours

Chapter 3 presented data on working hours, and described the amount of contracted hours and additional hours worked by respondents and how this varied. Approximately 62% of all nurses worked more than contracted hours in their main job in the week preceding the survey. This section looks at what remuneration respondents receive for the additional hours they work. Respondents were asked roughly what proportion of their overtime was reimbursed through pay, time off in lieu, or not reimbursed at all.

Just over a third (36%) of the excess hours worked by respondents is paid: 24% at standard rate, 10% at a higher rate, and 2% at a lower rate. More frequently (40% of the time worked) nurses are reimbursed for the excess hours worked with time off in lieu. A quarter of all additional working is not reimbursed at all, and nurses receive neither time off in lieu nor payment for the hours worked.

In the NHS 18% of additional working time is paid at the standard rate, 11% at a higher rate and 43% is given as time off in lieu. This leaves 26% of the time worked neither paid for nor given as time off. Only a third (34%) of the additional hours worked by nurses in NHS hospital settings is paid at or above the standard rate. In GP practices the equivalent figure is 45%, while in independent hospitals it is 67%, and in independent nursing homes it is 63%.

Figure 4.3 Reimbursement for additional hours worked by employer group



Source: Employment Research/RCN 2002

Time worked by NHS nurses in London is much less likely to be paid at or above the standard rate. Only 13% of the additional time worked by nurses in London is paid, and 38% is not rewarded at all. This compares to a third of the excess hours worked by NHS nurses elsewhere in the UK being paid, and only 25% not rewarded with either pay or time off in lieu.

Interesting differences are also noticeable between men and women in the NHS. More than a fifth (21%) of the time worked by men is paid at higher than the standard rate compared to 10% of the time women work in excess of contracted hours. There is little difference by ethnic origin.

4.5 Household income

The reality of the gender pay gap is widely acknowledged. Data from the Office of National Statistics[18] indicates that women working full-time in the UK earn on average 81% of the average pay of men working full-time. This amounts to one of the widest gender pay gaps in the European Union (EU). Research from the United States into comparable worth[19] supports the view that such large differentials cannot readily be attributed to the concentration of women in jobs that require less cognitive, social or physical skills, less effort, are more pleasant or involve less supervisory responsibility.

[18] Reported in *IDS Report 848* (January 2002). London: Incomes Data Services
[19] England, Paula (1992) *Comparable worth: theories and evidence*. United States: Aldine de Gruyter

Rather, part of the explanation as to why female occupations attract lower pay is discrimination in respect of comparable worth. Nurturing and social skills are deemed less valuable than authority skills. Moreover, the author suggests that more minority ethnic women are attracted to work in traditional female jobs, which in itself may depress wages as a result of bias. One of the principal outcomes of the *Agenda for Change* negotiations will be a job evaluation mechanism which will, for the first time, lay bear and hopefully rectify gender pay anomalies in the NHS.

This section is concerned with exploring the extent to which nurses' earnings contribute to household income. If the pay of nurses has been suppressed in the past for reasons that can no longer be justified, and if the importance of nurses' income to their households is now greater than might have been supposed a generation ago, then in the context of a tightening labour market it is logical that nurses' earnings must rise if health care provision is to expand as the Government intends.

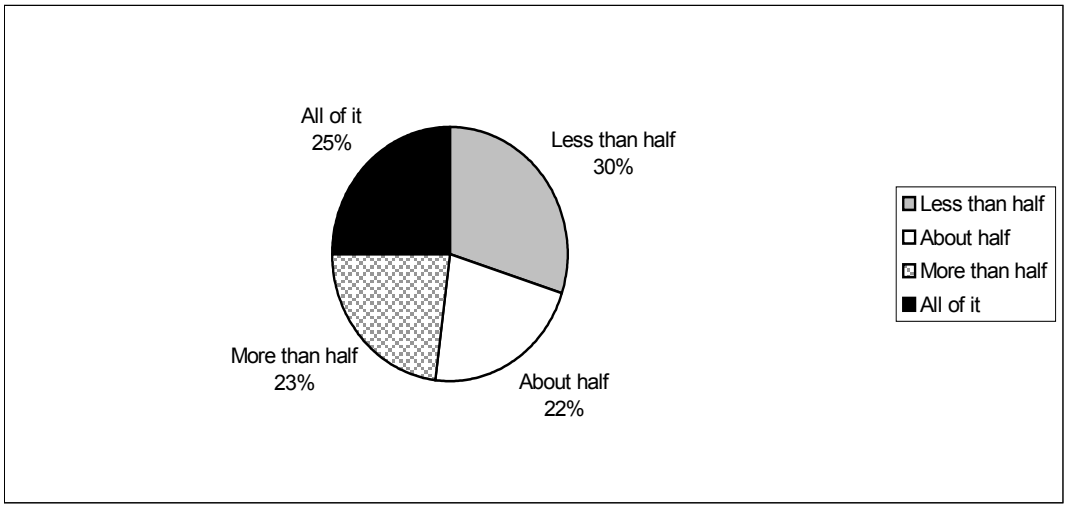
An important new question was introduced to the survey this year. It asked respondents:

"Roughly what proportion of your total household income do your earnings represent?"

To explore this complex issue fully we would need to know much more about other sources of income, expenditure and domestic circumstance. However, this question does provide a rough indicator of the extent to which nurses' earnings contribute to household income, and provides an insight into an important issue.

Across all respondents 45% report that their earnings account for more than half of their total household income. We refer to these nurses as *breadwinners*. Approximately one-third of respondents say that their earnings account for less than a half of their household income and 22% about a half. Thus two-thirds of all nurses are contributing a half or more to total household income.

Figure 4.4 Earnings as a proportion of household income (NHS-only)



Source: Employment Research/RCN 2002

Whether or not nurses work full-time or part-time is the key determinant of the proportion of income accounted for by respondent earnings. Nearly two-thirds of nurses working full-time (61%) are the main breadwinner. This means that their earnings account for more than half of the household income, compared to a fifth of part-time nurses (21%). As a result nurses who work flexi-time are also less likely to be the main breadwinner. As most nurses who work part-time have children living at home, this means that nurses aged 26-45 are less likely to be the main breadwinner than both older and younger age groups.

Table 4.4 shows that the earnings of male nurses are more likely to represent all, or more than half, of their total household income than is the case among women. Similarly, the income of white nurses is twice as likely to account for less than half their household income than is the case among minority ethnic nurses (both those who qualified in the UK and overseas). Afro Caribbean nurses are most likely to be in the breadwinner role (70%). Nurses who qualified overseas are also more likely to fall into the breadwinner role (52%).

Table 4.4 Earnings as a proportion of household income – percentages

	Women	Men	Minority ethnic	White	All respondents
All of it	23	26	29	23	23
More than half	21	44	28	22	22
About half	22	21	26	21	22
Less than half	34	10	17	34	33
Weighted cases	*3,774*	*242*	*215*	*3,759*	*3,992*

Source: Employment Research/RCN 2002

Other differences between nurses in terms of their earnings compared to household income include:

- the more highly qualified the nurses are, the more likely they are to contribute a major share of household income
- GP practice nurses and those working for banks/agencies (largely due to the higher density of part-time working) are much more likely to earn less than half their total household income than other nurses.

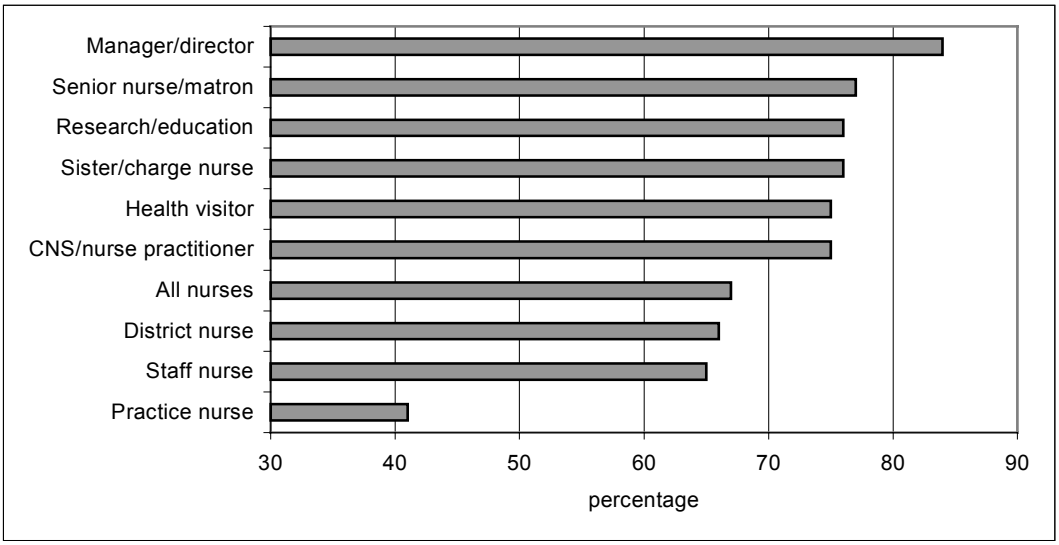
Figure 4.5 shows the proportion of nurses by job title where earnings account for a half or more of their household income.

4.6 Pay satisfaction

As in previous years the aspect of work that nurses are most consistently dissatisfied with is their pay. Figure 4.6 shows the percentages of nurses responding positively or negatively to each of three pay-related issues. More than nine out of ten nurses in the NHS feel that "*nurses are not well paid in relation to other professional groups"* and three-quarters (73%) say that "*considering the work I do I am not well paid"*.

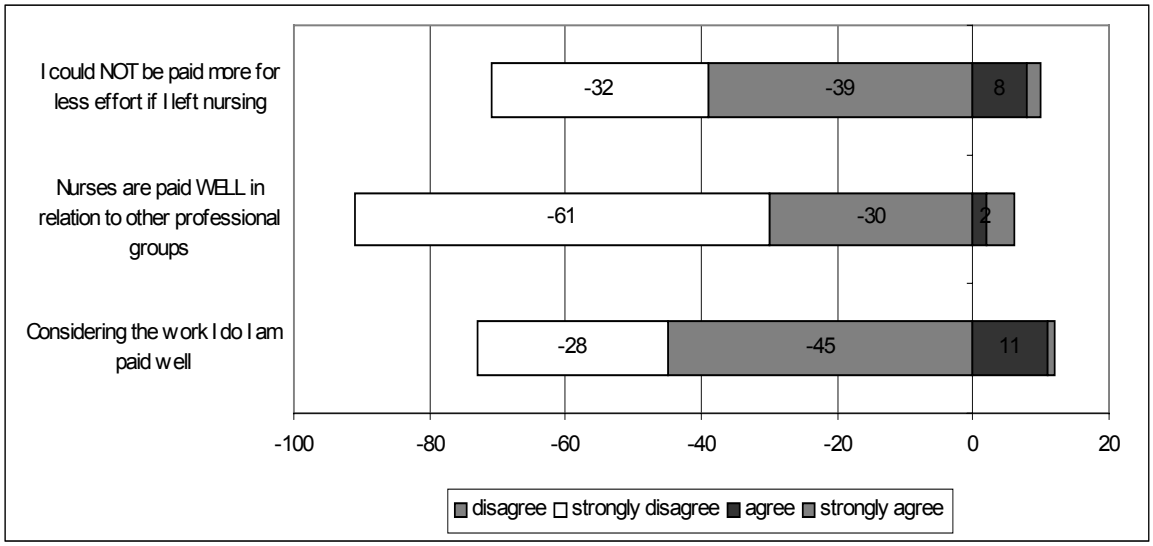
Where respondents feel that their grade is inappropriate for the work they do they are much more likely to disagree with the statement *"considering the work I do I am well paid"* (87% compared to 59% of nurses who say their grade is appropriate). Younger and more recently qualified nurses are also more critical of their pay in relation to the work they do. In terms of the nature of the work, nurses in adult critical care are most likely to disagree with the statement (81%). Nurses in paediatric critical care and women's health are also more likely to feel they are not well paid for the work they do compared to other NHS nurses.

Figure 4.5 Earnings representing a half or more of household income by job title – percentages



Source: Employment Research/RCN 2002

Figure 4.6 NHS pay satisfaction – percentages agreeing/disagreeing with each statement



Source: Employment Research/RCN 2002

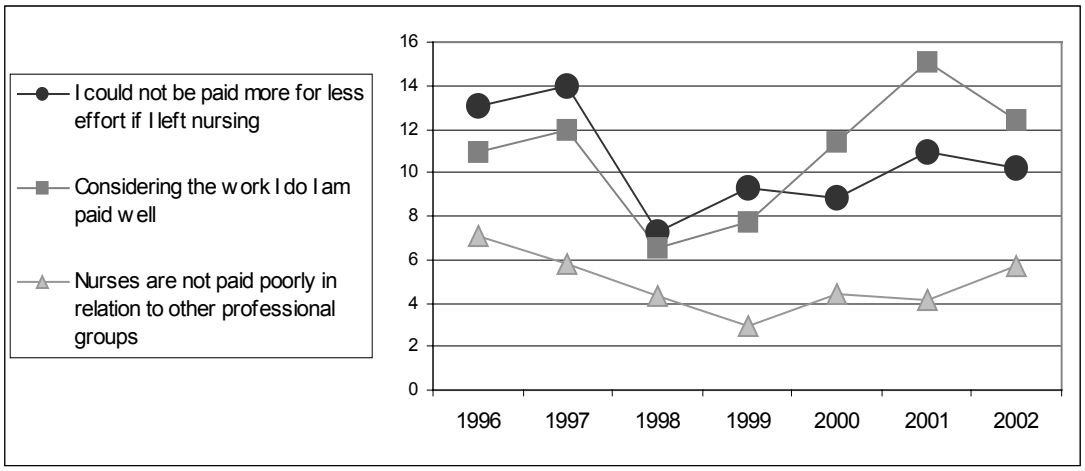
Dissatisfaction with pay in relation to the nature of work is also linked to the shift pattern worked. Nurses working full three-shift rotation and two-shift rotation are more dissatisfied than nurses working other patterns.

There is also a large difference between nurses on grades D to G (75%) and those on H to I (48%) in relation to their dissatisfaction with pay when they consider the work that they do.

There is little or no difference in views between men and women and between white and minority ethnic nurses in relation to pay satisfaction.

Figure 4.7 shows how the proportion of respondents agreeing with each of the pay satisfaction item has changed since 1996. The figure indicates that the upward trend in pay satisfaction of recent years has not been sustained in 2002.

Figure 4.7 Views of pay 1996-2002 – percentages agreeing



Source: Employment Research/RCN 2002

4.7 Key points

HR in the NHS plan emphasises the importance of pay in the recruitment and retention of staff in the NHS. Last year the RCN membership survey demonstrated the vital influence of perceptions of pay in nurses' sense of feeling valued in their work. In 2002 attitudes towards pay remain more negative than is the case for other aspects of nurses' working lives. The following highlights the key findings:

- analysis of grade by job title shows that fewer senior nurses are employed on H grade or above now than has been the case in the past (61% in 2002 compared to 80% in 1992)
- similar reductions in the average grade level are also noticeable for ward managers (down from 64% graded G or above in 1992 to 48% this year), health visitors and district nurses
- after several years of reductions, a large increase in the proportion of D grades on the top increment of their salary scale is reported this year (up from 39% to 49%). However, there have been reductions in the proportion of nurses on other grades reporting that they are on the top increment

- one in ten nurses report that they are acting up to a higher grade – approximately a third of these nurses are paid for their additional responsibilities
- data shows a significant increase in the proportion of nurses saying that they are inappropriately graded (up from 38% to 48% in the last year). Nurses in GP practices, nursing homes and working for banks/agencies show the largest increases in numbers saying they are inappropriately graded. Level of responsibility required in the job is the most important reason why nurses feel they are inappropriately graded (77% cited this factor)
- in the NHS nearly three-quarters (70%) of Afro Caribbean nurses say they are inappropriately graded compared to 51% of white nurses
- nurses who are inappropriately graded are much more likely to feel dissatisfied about their working lives than those who say they are appropriately graded
- although nurses are habitually working in excess of their contracted hours, a quarter of the additional time worked by nurses is not reimbursed, either financially or with time off in lieu
- two-thirds of all respondents report that their earnings account for half or more of their household income. The image of nursing as a second income is redundant
- just 27% of all NHS nurses say "*considering the work I do I am well paid*". Three-quarters of nurses can be said to be dissatisfied with their pay in relation to their work. Nine out of ten nurses say that they do not feel well paid in relation to other professional groups.

5. Job change and career progression

Job change and career progression data enables analysis of the level, direction and reasons for job change, which in turn provides an insight into nursing workforce dynamics. The findings show the extent to which nurses are moving between employment sectors and how much job change and turnover there is in sectors such as the NHS. The additional samples in the 2002 survey enable us to contrast the experiences of different groups of nurses – men and women, white and minority ethnic nurses.

Do these demographic characteristics influence nurses' career progression?

5.1 Careers in an equal opportunity context

The largest survey to date that has looked specifically at ethnicity and nursing careers in the UK, undertaken by PSI[20], found that nurses' chances of reaching F, G or H grades are influenced by their ethnicity. The authors point to limitations of the study design, in that the findings cannot explain why ethnicity affects career progression, simply that it does. Several possible explanations for the difference in career progression between white and minority ethnic nurses were put forward in the PSI report. For example:

- that career motivation may be less among minority ethnic nurses (perhaps through disillusionment)
- that minority ethnic nurses may be less likely to apply for a higher grade post
- that minority ethnic nurses are less successful in applications to higher grade posts due to active discrimination.

The 2002 RCN survey has collected data on each of these three issues – career motivation, application rates for higher-grade posts, and success in getting higher-grade posts.

Women have historically been under-represented in senior nursing posts[21]. Research conducted for the NHS Women's Unit [22] identified the barriers that senior women in nursing felt had obstructed their career paths. The main barriers that hindered career progression to senior nursing posts were identified as:

- gender (for both men and women)
- lack of employee-friendly working arrangements
- discrimination against part-time workers
- lack of careers advice.

[20] Beishon S, Virdee S and Hagell A (1995) *Nursing in a multi-ethnic NHS.* London: Policy Studies Institute (PSI)
[21] Finlayson L and Nazroo J (1998) *Gender inequalities in nursing careers.* London: PSI
[22] Ball J et al (1995) *Creative career paths in the NHS*. Report 4 (senior nurses). London: IHSM Consultants for the NHS Women's Unit, DH

A limitation of the retrospective design of the NHS Women's Unit study is that it included only those nurses who have been able to overcome the barriers they encountered on their way up the career ladder. The characteristics of the successful women nurses are revealing:

- 20% are single
- 49% are without children.

However, we are still left wondering at what stage in nurses' careers domestic circumstances impact on progress. Are female nurses merely less career-motivated and less likely to apply for higher-grade posts, or are they less successful in getting higher-grade positions once they have applied?

Rather than asking senior nurses to look back on their careers, this survey provides a snapshot of the experiences of both men and women at different points in their careers. We can look at career motivation and progress, and at propensity to apply for and succeed in achieving higher-grade jobs for men and women at different ages and in different grades. The proportion of men and women in senior grades is also explored, and grade relative to years since qualification is used as an indicator of the rate of career progress.

5.2 Changing jobs

The proportion of nurses who changed jobs in the last 12 months is 25% (with little difference between sectors). This figure has increased slightly since the mid-1990s. In 2000 the equivalent figure was 23%, and in 1997 21% had changed jobs in the preceding 12 months. One in eight (13%) of all nurses had changed employer in the last 12 months, which is consistent with last year's survey findings.

Half (52 per cent) of all those who changed jobs also moved employers, although not necessarily sectors. This figure varies between the NHS and non-NHS nursing largely because of the size of employer. In the NHS there is more opportunity for job change without changing employer. Of those currently in the NHS who changed jobs, 41% involved a change of employer, while in the independent sector 71% changed employer.

Entries to UK nursing

The questionnaire asked all respondents to indicate where they worked a year ago, regardless of whether they perceived they had a job change. The answers to this question enable us to get a better idea of the numbers of nurses in the survey who have returned to nursing employment in the last 12 months.

Nearly 3% of respondents who were working in nursing in 2002 were not working in nursing 12 months earlier. A further 1% were working as nurses outside the UK, just under 2% were on maternity leave or on a career break, and 2% were students a year ago. In total 8% of those currently working in nursing were not doing so a year before.

Movement between sectors

Although a half of all job changes involve a change in employer, the movement between sectors is relatively small. For example, 85% of nurses who reported that they worked in the NHS a year ago, but had changed jobs in the last 12 months, were still working in the NHS. A further 9% are in NHS-related employment; 4% are in GP practices; 3% are in NHS bank working; and 2 % work for the NHS Executive or a health authority. So of those who were in the NHS and who had changed jobs, just 3% took up work in the independent sector, 2% did agency work and 1% moved to charity/voluntary sector employment.

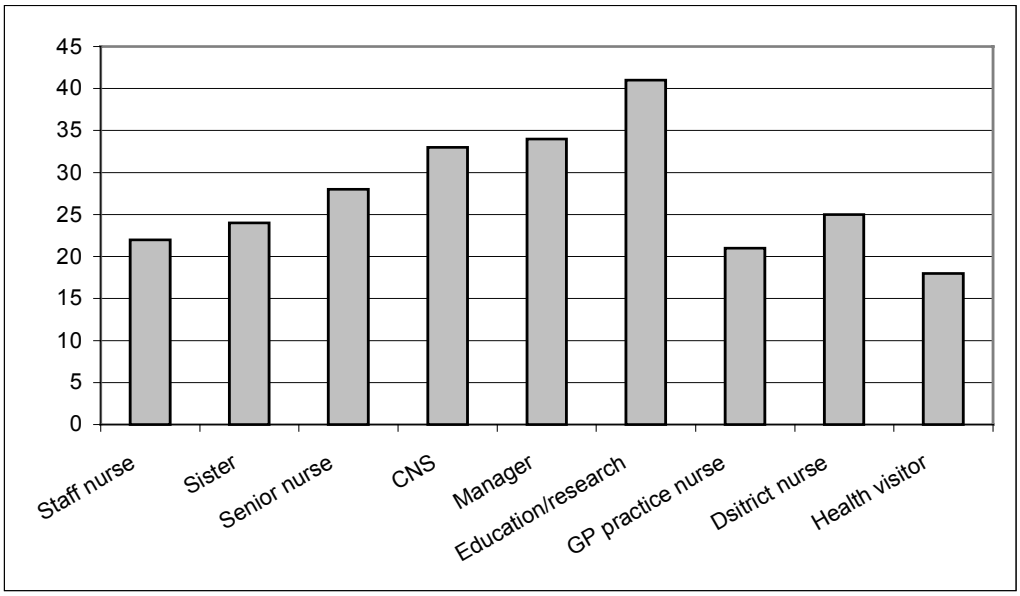
Of respondents who were in the independent sector a year ago, 52% were still working in that sector and 11% had moved to the NHS at the time of the 2002 survey. Of those currently in the independent sector one in four changed jobs in the previous 12 months, of those 71% changed employer and a third of the nurses had moved from the NHS.

Of those nurses who were in the NHS a year ago but had changed employer in the last 12 months, 69% moved to another NHS employer, 8% to a GP practice, 7% to the independent sector and 8% to bank/agency nursing.

Other relevant findings include:

- a clear relationship exists between job title and level of reported job change (see figure 5.1). In the NHS, nurses on more senior grades are more likely to have changed jobs
- although job change is age-related it is stage of career that determines most job changes. Just under 38% of nurses in the first five years of their career changed jobs in the previous year, compared to 25% of those who had been qualified for between six and 20 years, and less than 20% of those who had been qualified for more than 20 years
- partly related to age and seniority, nurses with diploma and degree qualifications are also more likely to have changed jobs (30% compared to 19% of those without diploma or degree qualifications in nursing)
- full-time nurses are more likely to have changed jobs than those working part-time (27% compared with 20%)
- men are more likely than women to have changed jobs in the last 12 months (31% compared with 25%)
- there is no difference by ethnicity in the proportions changing jobs in the previous 12 months.

Figure 5.1 Percentages changing jobs in last 12 months by job title



Source: Employment Research/RCN 2002

Reasons for job change

Table 5.1 reports nurses' reasons for moving job. The questionnaire asked respondents which of 12 categories best described their main reasons for changing jobs. Respondents were asked to indicate all the reasons that applied to them, so the number of responses given exceeds the number of people responding. The proportion citing each reason of all those who changed job, those who changed employer, those who changed employer within the NHS, and those who left the NHS, are presented.

Table 5.1 Main reason for changing jobs/employer – percentage of cases

	Change job	Change employer	Change employer in NHS	Leave NHS
Promotion	36	24	28	27
Better prospects	26	30	32	31
Better pay	24	25	14	37
Widen experience/ more challenging	48	44	53	47
To get a change in hours/terms	25	29	30	39
Dissatisfied with previous job	31	40	36	59
Stress/workload	24	29	26	52
Distance-to-work	11	17	23	15
Workplace closed/redundancy	3	2	2	-
Bullying/harassment	9	12	11	14
Personal/family reasons	13	16	19	14
Other	12	14	11	6
Number weighted cases	*945*	*516*	*184*	*85*
Number responses	*2,484*	*1,458*	*526*	*291*

Source: Employment Research/RCN 2002

Differences in the reasons given by leavers from the NHS and others who changed jobs/employers are striking.

- stress and workload were given as a main reason for changing jobs by a quarter (26%) of all respondents changing jobs. However, workload is twice as likely to have been cited by NHS-leavers, with 52% giving this as a reason that they changed employer
- the most frequently cited reason for leaving an NHS employer to work outside the NHS is dissatisfaction with previous job (59%).

The reasons given for changing jobs were subsequently summarised into four main categories:

1. career factors (experience, promotion, prospects)
2. pay-related factors
3. work/life balance factors (change in hours, family circumstances)
4. negative factors related to previous job (dissatisfaction, bullying and harassment, closure of workplace).

Results by gender and ethnicity are presented in table 5.2. Men are more likely to cite career and pay related factors than women, while women are much more likely to mention working hours and general work/life balance issues than men (40% compared to 24%). A higher proportion of minority ethnic nurses than white nurses also mention work/life balance factors, and they are also more likely to change jobs as a result of dissatisfaction with their previous work.

Table 5.2 Summarised reasons for job change by gender/ethnicity

	Men	Women	White	Minority ethnic	All job changers
Career (positive pulls)	72	67	68	58	67
Pay	29	24	24	25	24
Dissatisfaction (negative pushes)	43	44	44	52	44
Work/life balance	24	40	38	46	39
Other	13	12	13	10	12
Number weighted cases	*72*	*870*	*853*	*34*	*945*
Number responses	*129*	*1,623*	*1,585*	*65*	*1,760*

Source: Employment Research/RCN 2002

The importance of working hours, described in Chapter 3, is confirmed by this data. One half (51%) of all nurses leaving the NHS for employment elsewhere gave work/life balance as one of the reasons, and 58% of those moving jobs in the NHS reported this reason. The factors that motivate job change are also the factors that other research has found would most encourage nurses who are currently outside of nursing, to re-enter the profession. In 1998 a survey of nurses not working in nursing[23] found working hours to be the single most frequently cited measure that would most encourage nurses to return to the profession.

The importance of this factor had already increased since a previous survey[24] using 1991 census data. Although it was the highest ranked factor in both surveys, the proportion citing working hours increased from 17% in 1991 to 27% in 1998. In the seven years between the surveys, reducing personal workload also becomes a more frequently given motivating factor. This rose from 6% in 1991 to 12% in 1998.

[23] *Return to nursing survey* (1998). London: Department of Health/ NHS Executive
[24] Lader D (1995) *Qualified nurses, midwives and health visitors*. London: OPCS.

Positive career factors are less likely to be the cause of a job change for minority ethnic nurses than is the case for white nurses. Table 5.3 shows more detail on the different motivations of white and minority ethnic nurses changing jobs.

Table 5.3 Main reason for changing jobs – percentage of cases

	White (UK)	Minority ethnic (UK)	All job changes
Promotion	37	29	36
Better prospects	26	29	26
Better pay	24	25	24
Widen experience/more challenging	49	37	48
To get a change in hours/terms	25	25	25
Dissatisfied with previous job	30	34	31
Stress/workload	24	25	24
Distance-to-work	11	16	11
Workplace closed/redundancy	3	2	3
Bullying/harassment	9	14	9
Personal/family reasons	13	17	13
Other	13	10	12
Number weighted cases	*853*	*34*	*945*
Number responses	*2,233*	*90*	*2,484*

Source: Employment Research/RCN 2002

These more detailed results show that minority ethnic nurses mention bullying and harassment, personal reasons and distance-to-work more frequently than white nurses, and that fewer report changing jobs because of promotion.

5.3 Grade change

The survey asked nurses for their grades both now and a year ago. The results for NHS staff (figure 5.2) show that the proportion of staff in D grade posts has decreased since a year ago, and the proportion on higher grades has increased[25]. Approximately one in five (19%) of NHS nurses have had an increase in grade in the last 12 months, with about three-quarters (76%) remaining on the same grade. Five per cent are on a lower grade now than they were 12 months ago. In 2001 18% of NHS respondents reported a grade increase in the preceding 12 months, an increase from 17% in 2000.

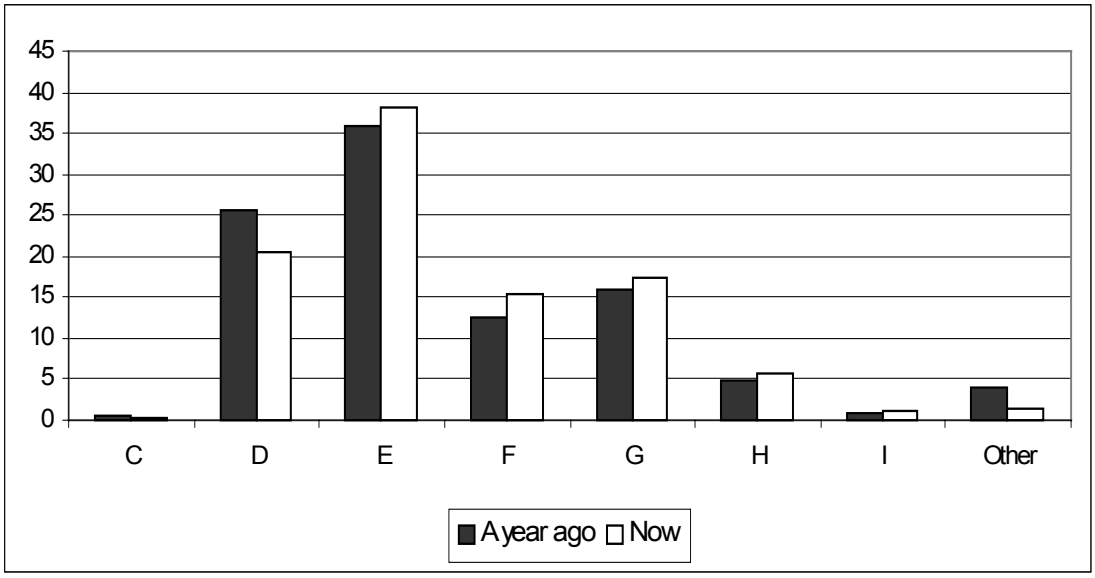
A third of NHS nurses currently on F grade (34%) had increased their grade over the previous year. One in four H grade nurses had also gained a grade increase in the same period. Nurses in the first ten years of their careers are more likely to have achieved an increase in grade in the previous 12 months: 26% compared to 16% of those 10-20 years into their careers and 12% of nurses more than 20 years into their careers.

Of respondents with degrees 26% had gained a promotion compared to 15% of those with no nursing degree or diploma qualifications. This is partly age-related, but not entirely. There are no differences by gender or ethnicity in likelihood of respondents gaining a grade increase.

Finally, nurses in London are much more likely to have gained increases in their grade in the preceding year (29% compared to 19% overall).

[25] Note that this is the grade change for individuals in the last 12 months, not the difference between last year's survey and this

Figure 5.2 Grade now and one year ago – percentages (NHS-only)

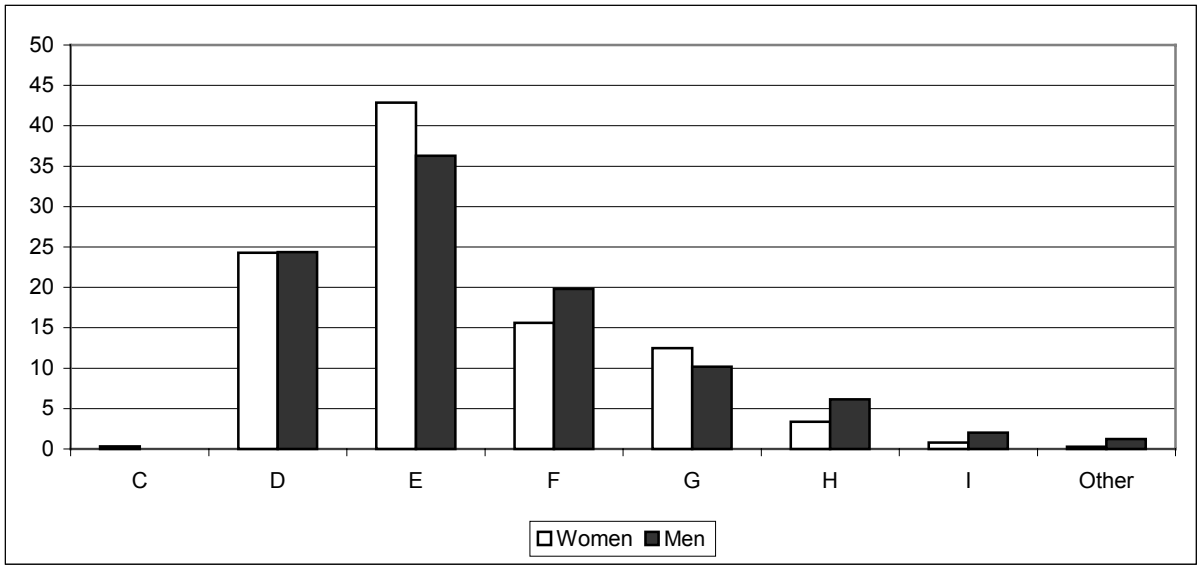


Source: Employment Research/RCN 2002

5.4 Gender respresentation in senior positions

Contrasting the grade profile by gender for NHS hospital nurses (figure 5.3) we find that men are as likely as women to be on D grade posts, but that there are higher proportions of men in F, H, and I posts. On the other hand, disproportionately more women are on E grade or G grade posts. Of male nurses in NHS hospitals 23% are ward managers, compared to 20% of women (see figure 5.4).

Figure 5.3 Grade by gender – percentages (NHS hospitals only)



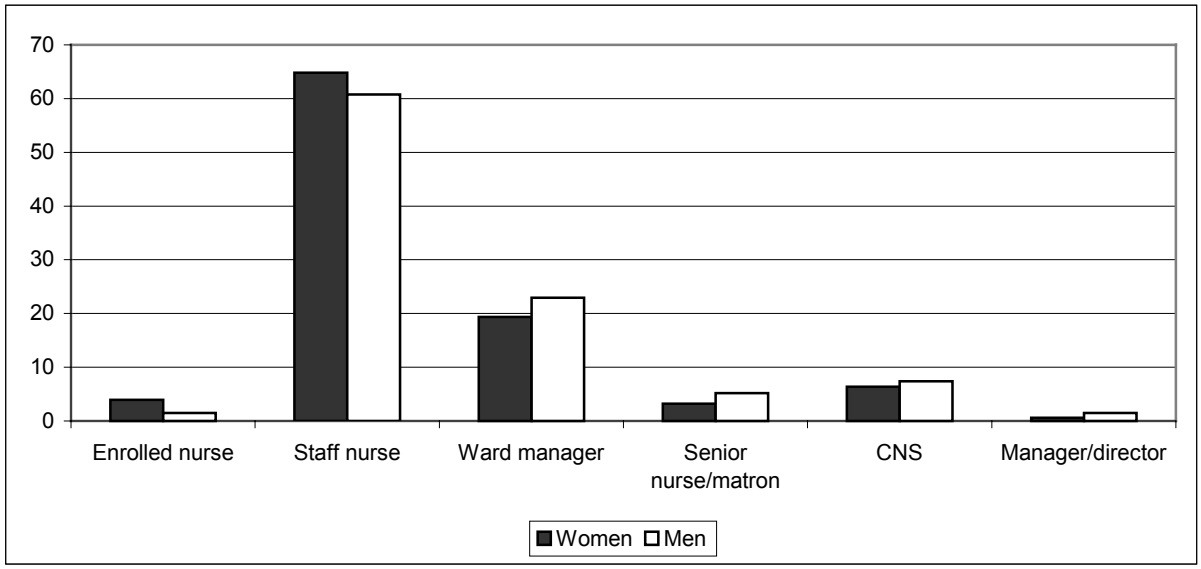
Source: Employment Research/RCN 2002

One reason that there is a higher proportion of women on G grades but not in ward manager posts, is that in the more senior jobs (senior nurse, CNS, manager) women are less likely to be paid on higher grades. So for example, of CNS nurses in NHS hospitals (139 cases), 31% of women are H grades or higher, while 50% of men are grade H and above. Women are apparently being paid on lower grades than men are for doing the same jobs.

A larger proportion of women work as staff nurses (70% relative to 62% of men), while the proportion of men exceeds women in all the higher level posts (see figure 5.4). Two-thirds (66%) of female staff nurses are E or above, compared with 61% of male staff nurses.

In summary, women are more likely than men to be in staff nurse posts or sister posts, and less likely to be in posts above this. Where they do reach the more senior posts, women are apparently graded lower than men in the same job function. Career progress of men and women is looked at in greater detail in section 5.5, where time taken to reach current grade is explored.

Figure 5.4 Job title by gender – percentages (NHS hospitals only)



Source: Employment Research/RCN 2002

5.5 Length of career and career breaks

The above analysis confirms that there are clear differences in the seniority that men and women have achieved in NHS nursing. However, other variables influence career that need to be taken into account.

Length of career is the most obvious factor influencing career progress. In theory, the longer a person has been in nursing the greater their opportunities to access a senior position and higher grade. The crudest measure of career length is the time since qualification. However, many nurses, women in particular, will have taken some time out of their careers, and this time needs to be taken into account to look more fully at career progression.

Prevalence and length of career breaks

The questionnaire asked respondents about breaks in their nursing careers. Nearly two-thirds of all respondents (64%) had taken some kind of break (66% of women and 28% of men). Of these approximately 80% had taken a break specifically to have or raise children. Among those who had taken a break, the average number of breaks taken was 2.5 for women and 1.8 for men. There was little difference by ethnicity for UK-qualified nurses.

Not surprisingly, given that the main reason most nurses have taken a break is to have or raise children, taking a career break varies by age. One in five (19%) 20 to 24-year-olds have taken a break compared to 39% of 25 to 29-year-olds, 64% of the 30 to 34 age group, and 75% of the 35 to 39 age band. At this age the Percentage levels out, suggesting that approximately three-quarters of all nurses will have had a career break by the time they reach their 40s. The average total length of break is 3.4 years for women and 2.2 years for men.

A full breakdown of the nature of career breaks is provided in table 5.4. The data shows:

on average nurses who take time out to have children take a year of maternity leave. In addition, at least one in five take a longer break to look after their children, which averages approximately five years

6% of all UK-qualified nurses have worked abroad as a nurse for an average of 2.5 years

approximately one in eight respondents have taken a career break due to illness at some time in their career (and in a third of cases more than once) for an average of seven months in total

8% of respondents had taken time out for education/training related to nursing (for an average of one year and four months).

To develop a further understanding of what career breaks entail, respondents were asked for more details of the last career break they had taken. The most common reason for the last break taken was to have or raise children, and two-thirds (63%) of all breaks were for these reasons (maternity leave has been merged with breaks to look after children).

The survey also asked where respondents were working before and after their last break. The results show that while the majority (65%) had returned to the same employer after their last break, 35% had gone to a different employer. Four-fifths (81%) of those returning to the same employer were returning to the same job.

While only a third changed employer, there is nonetheless a marked level of movement between the sectors following breaks. NHS nurses were more likely to have remained in the same sector after their break (84% compared to, for example, 68% of independent sector nurses taking a career break). However, more than twice as many people moved from the NHS to the independent sector as moved in the opposite direction. Indeed, the net flows between the sectors show the NHS to have lost nurses to all the other sectors (GP practice, agency/bank and independent sectors) following career breaks.

Table 5.4 Career breaks – percentage of cases

	% of all respondents	% of all breaks	Total time out of career on this break (mean)
Maternity leave[26]	52	46	1yr
Career break to have/raise children	21	17	5yrs 3mths
Care for other dependent	2	2	1yr 4mths
Work abroad as a nurse	6	5	2yrs 6mths
Travel/moved abroad (not as a nurse)	5	3	1yr 8mths
Work in a UK-based non-nursing job	6	4	3yrs
Unemployed/seeking work in UK	3	2	6mths
Training/education in UK (nursing)	8	6	1yr 4mths
Training/education (non-nursing)	2	2	2yrs 3mths
Illness	12	11	7mths
Other	2	1	1yr 6mths
All/total length	65%	100%	3yrs 5mths

Source: Employment Research/RCN 2002

The majority of nurses (55%) reported that the support/reception they were given by their employer when they returned from their last break was good or very good. A further 30% described it as adequate and 15% indicated it to be poor or very poor. Nurses returning to a different employer than the one they left were less likely to consider the support good or very good – 49% compared to 57% of those who returned to the same employment category.

Those returning to bank or agency work were more likely to be negative about the support received. One in four (24%) described it as poor or very poor compared to 8% of those returning to GP practice jobs.

Grade after career break

In September 1991 the Department of Health, on behalf of the NHS, was the first government department to become a campaign member of Opportunity 2000. This was a business-led campaign to increase the quality and quantity of women's participation in the workforce. All members set goals to increase employment opportunities for women by the year 2000. The NHS Executive set eight specific goals for the NHS to achieve by the end of 1994. Goal 7 of Opportunity 200027 was to:

"Ensure that following maternity leave or a career break, all women (including those returning to nursing part-time or as a job-share) are able to return at a grade commensurate with their leaving grade and to work of similar status."

The 2002 survey data shows that one in five (21%) of respondents reported that they had returned from their last career break to a lower grade post. The majority (69%) returned to the same grade. In 9% of cases nurses returned to a higher grade post.

[26] Data on the split between maternity leave and breaks to have/raise children is not entirely reliable as it is apparent that some respondents confused the two

[27] *Women in the NHS. An implementation guide to Opportunity 2000* (1992). London: DH/ NHS Management Executive

Looking specifically at nurses who returned to the same employer, in aggregate 11% returned to a lower grade although this varies by employment sector (10% in the NHS, 12% in independent sector). A survey of RCN members in 198928 found that across all respondents 11% of NHS nurses had returned to a lower graded position after a break – only 1% higher than the 2002 figure. Thus there seems to have been only marginal improvement towards the goal set over ten years ago.

The likelihood of returning to a lower grade appears to relate to how long ago the break was taken. Of NHS nurses who returned from their break in the last five years, 6% returned to a lower grade. Among those who returned five to ten years ago 10% returned to a lower grade, and of all those who returned from their last break before 1992 18% returned to a lower grade. These findings point to an improvement over the last ten years and are perhaps a reflection of changes in expectations and in the labour market.

Encouraging nurses back after a career break

Respondents were provided with an open section in which they could make suggestions as to how employers might make it easier, or more attractive, for nurses to return from a career break. Table 5.5 shows the aggregate findings.

The main change that nurses feel employers could make is to improve the working hours offered. More than half (54%) of all respondents cited this in answering the question. A quarter referred to improving the childcare assistance available.

Table 5.5 Factors that would make returning to nursing easier after a break

	Percentage of cases
Family-friendly/working hours	54
Childcare assistance	24
Break in more gently	19
Back-to-nursing course	16
Better pay/grading	15
Improved attitude of manager/employer	12
Mentoring/preceptors	11
Induction programme/orientation	10
Appreciate skills/experience gained in break	7
Confidence-building	6
Support in clinical areas	6
Better staffing/resources/skill mix	6
Training (ongoing)/access to study days	6
Better access to education/updates	5
Better prospects/opportunity to progress	5
Individual development plan	4
Better terms and conditions/type of contract	3
Information	2
Involve staff while on break	2
Incentives	1
Access to well-organised bank work	<1
Weighted cases (responses)	*1,875 (3,979)*

Source: Employment Research/RCN 2002

[28] Seccombe I, Ball J and Patch A (1993) *The price of commitment: nurses' pay, careers and prospect 1993* IES Report No. 251. London: RCN/IES

Another theme emerging from the response to this question was that many nurses felt that they returned in at the deep end with a sink or swim approach from their managers or employers. Respondents suggested that being given opportunities to re-enter work more gradually (cited by 19%) with active mentorship (11%) to build confidence (6%) within a supportive clinical environment (6%) would make returning after a break easier.

5.6 Making progress

Goal eight of the Department of Health's *Opportunity 2000* set in 1991 was to:

"Monitor the time taken to reach management posts to ensure that men and women have equal access to these positions."

The 2002 survey enables us to test this. Data was collected on how long respondents had been in their current grade. Subtracting this period from the total length of their nursing career gives the time taken (including or excluding breaks) to reach their current grade. The average time taken by men and women to reach each of the grades F to I is shown in table 5.6. The analysis excludes nurses who first qualified outside the UK. The results show that on average men progress up the career ladder more quickly than women, even when career breaks are taken out of the equation. For example, even when career breaks are excluded from the analysis, it takes women on average 3.5 years longer to reach F grade compared to men.

Table 5.6 Mean years to reach current grade by gender (UK-only)

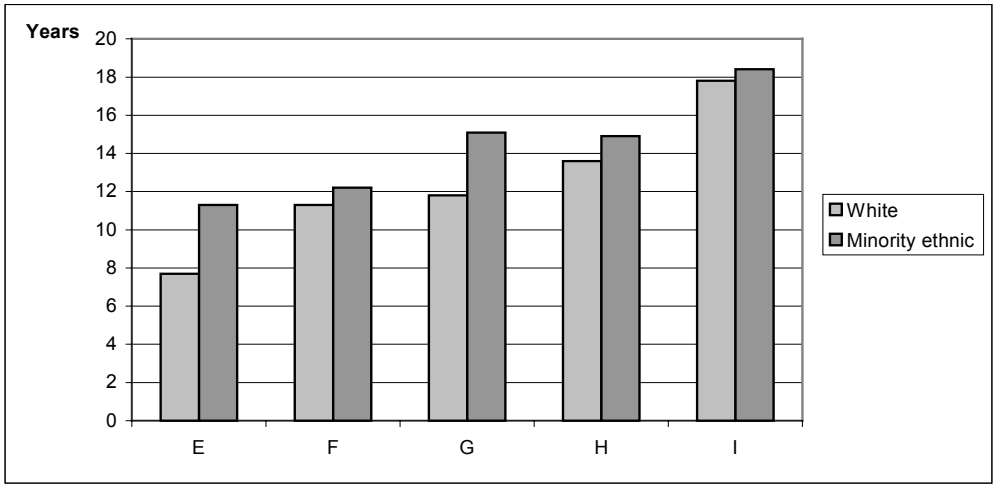
	Men		Women	
	excluding breaks	**including breaks**	**excluding breaks**	**including breaks**
E	7.3	7.8	9.2	11.0
F	8.7	9.1	12.2	14.4
G	10.6	11.1	12.5	14.6
H	13.2	14.0	14.6	16.4
I	14.5	14.6	17.7	18.4

Source: Employment Research/RCN 2002

A similar analysis examined differences between ethnic groups. The results for NHS hospital nurses who first qualified in the UK (figure 5.5) shows that on average, white nurses had reached their current grades more quickly than minority ethnic nurses. For example, white nurses had taken an average of 11.8 years (excluding breaks) to reach their current G grade post, while the average for minority ethnic nurses was 15.1 years – more than three years longer. This difference exists despite the fact minority ethnic nurses are more likely to work full-time. Focusing the analysis on full-time staff alone suggests the differences are even greater, although the numbers are too small to test reliably.

Analyses exploring the ethnic make-up of different grades of staff and of different jobs found no apparent difference in the seniority of white and minority ethnic nurses when looking at job titles. However, mirroring the findings in relation to gender, differences become more apparent when grade-relative-to-job-title is explored. In NHS hospitals of the UK-qualified nurses, 33% of minority ethnic ward sisters are G grades or above, compared with 46% of white ward managers.

Figure 5.5 Average time (minus breaks) to reach current grade by ethnicity (UK-qualified, NHS hospital only)



Source: Employment Research/RCN 2002

Applying for and achieving higher grade jobs

More than one in four (28%) respondents had applied for a post of a higher grade in the last 12 months. Of these about one half (53%) had been successful. Gender and whether the nurses are working full-time emerge as the two main factors that relate to success of job applications. Interestingly, although women are less likely to have applied for jobs of a higher grade (27% compared with 35% of men), they are more likely to have been successful than men (54% compared with 42%).

Fewer part-time nurses have applied for a higher grade post (20% compared to 33%), and of those that have applied a lower proportion are successful than full-time staff (48% compared with 56%).

Overall, ethnicity appears to make little difference to whether or not a nurse had applied for a job of a higher grade in the previous 12 months. In the UK-qualified nursing workforce there is also little or no difference in the success rate of white and minority ethnic nurses (54% of white UK-qualified, 53% of minority ethnic UK-qualified nurses).

Those who qualified outside of the UK, however, are less likely to have been successful whether white (48%) or from minority ethnic origins (40%). Looking specifically at the NHS and those applying for higher grades, again there is little difference by ethnicity on any of the grades looked at, although minority ethnic nurses who were graded D seem slightly more likely to have been successful in their job applications than white nurses.

It might be thought that the apparent lack of difference by ethnicity is because more minority ethnic nurses work full-time and are men. But even when only full-time NHS hospital nurses (again qualified in the UK) are examined, there is no significant difference between white and minority ethnic nurses in applying for and getting jobs of a higher grade.

There appear to be no discernible differences in either the job application behaviour or success rates of white and minority ethnic nurses. This finding may appear contradictory in the face of two of the possible theories put forward to explain the career progression differences found between white and minority ethnic nurses (see the PSI study section 5.1). However, this data reports on nurses' experiences in the last 12 months, not the entire duration of their careers.

A third possible explanation for differential career progression that minority ethnic nurses may be less career motivated is not borne out by this survey. Minority ethnic nurses display stronger career motivation, with 25% agreeing strongly that they are "*interested in career progression"* compared to 16% of (UK-qualified) white nurses.

Differences in the grades reached and rate of career progression will clearly relate to experiences during the whole course of a career, not just the last 12 months. And it may also be that recent attention to institutionalised discrimination has reduced the disadvantage experienced by minority ethnic nurses in the last year or so, as witnessed by similar success rates in job applications.

Predicting grade

Multivariate analysis explored the extent to which different factors contribute to individuals' current grade. Eight key variables were entered into a series of stepwise linear regression models to see the contribution each make in predicting grade: age; gender; ethnicity; time in nursing (excluding breaks); career breaks; full-time or part-time; field of practice; and highest nursing qualification.

Table 5.7 shows the relative importance of each of the factors. As might be expected, length of active career (that is the time spent in nursing excluding career breaks) is a key predictor of grade.

Table 5.7 Predciting current grade – order of importance in prediciton

	Grade	F and above	G and above
Time in nursing	1	2	2
Highest nursing qualification	2	4	3
Field of practice	3	1	1
Full-time or part-time	4	3	4
Ethnicity	5	6	6
Had career break or not	6	5	5
Age	-	-	-
Gender	7	7	7

Source: Employment Research/RCN 2002

Field of practice is a key factor. This is perhaps not surprising, given that some of the response categories such as *several specialties/across organisation* and *education and research* are more likely to include higher-grade posts. If the analysis is repeated to look at the chances of reaching F or above for NHS ward staff only, the importance of field of practice falls to sixth place. Highest nursing qualification also emerges as a predictor of grade. Mode of working (that is full or part-time) also consistently emerges as a predictor of grade.

Findings earlier in the chapter regarding career differences by ethnicity have presented a mixed picture. There is no clear difference in the grade profile of white and minority ethnic nurses, and both groups are as likely to have applied for and achieved higher grade posts in the preceding 12 months. Yet minority ethnic nurses' careers have progressed more slowly, taking longer to reach the higher grades. The multivariate analysis allows us to take into account factors such as length of service, full-time or part-time, taking career breaks, and to see if demographic factors such as ethnicity play any part in determining grade.

The results show that ethnicity is indeed a factor affecting the chances of reaching higher grades, and appears to be more important than gender in all three of the regression models summarised in table 5.7. It ranked sixth as a predictor of current grade and fifth as a predictor of reaching senior grades (F and above, G and above).

5.7 Views of careers and progression

Two related issues are addressed in this section.

First, issues connected with the degree of **career control** nurses perceive they have over the way in which their careers develop and progress are taken together. The issue statements included as career control are:

- I do know where my career in nursing is going
- I can determine the way career develops
- I know what I want to do in the future in my career
- there is open dialogue about my career with my manager.

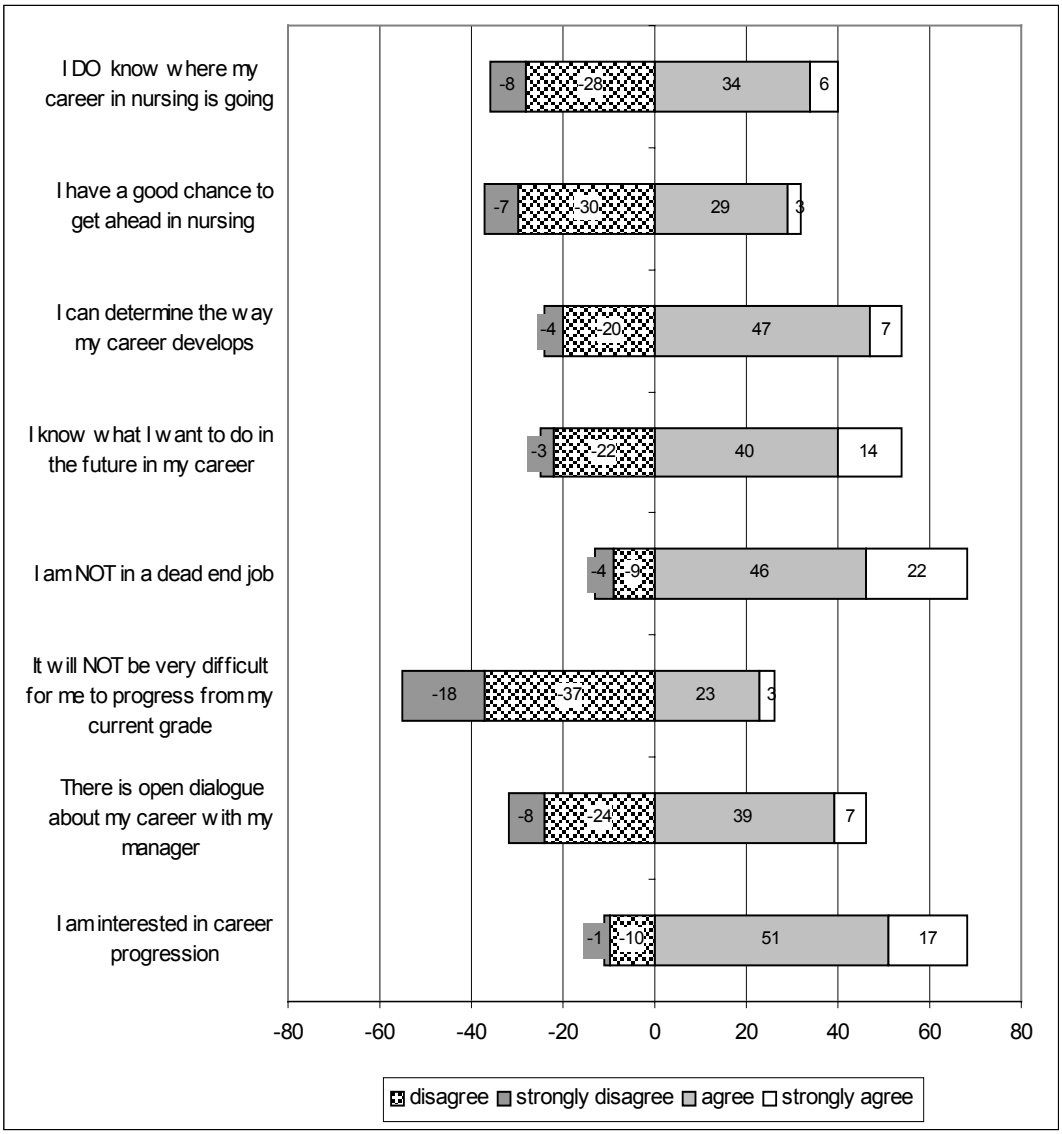
Second, issue statements connected with the **progression opportunities** nurses feel are open to them are explored. These are:

- I have a good chance to get ahead in nursing
- I am not in a dead-end job
- it will not be very difficult for me to progress from my current grade.

Scales were derived by summing up the scores on each of the issue statements. The wording of the statements has been changed (and scores reversed) so that each one is positively framed, and high scores indicate greatest satisfaction. Results for each scale are presented in the figure below. In the main, nurses on higher grades and at later stages in their careers are more positive about career-related issues than other nurses. However, there are a number of interesting differences in responses.

First looking at nurses' control over the way their career develops, it has been shown above (Chapter 3) that part-time nurses feel less able to influence their careers, and indeed appear less concerned with career progression than full-time nurses. Also, nurses who do not feel appropriately graded, presumably as they are frustrated in their current grade, feel less able to determine the way their career develops. While nurses on grades H and I, particularly those with higher degrees, feel by comparison that they have considerable control over their careers.

Figure 5.6 Views of career control and opportunity to progress (NHS-only)



Source: Employment Research/RCN 2002

A similar picture emerges in relation to nurses' perceptions of the opportunities open to progress their careers. Again, those who feel inappropriately graded are less positive. A sense of nurses feeling trapped in their grade emerges throughout the analysis when comparing nurses in this way. As nearly a half of all nurses feel inappropriately graded, this colours perceptions of a range of issues relating to nursing employment.

There is no difference in attitudes by gender or ethnicity on these scales.

As might be expected nurses whose grade has increased in the 12 months prior to the survey have a more positive attitude to their opportunities to progress their careers.

5.8 Key points

The key points related to job change made in this chapter are:

- 25% of respondents had changed jobs in the preceding 12 months, half of whom also changed employer. In 1997 21% had changed jobs, and in 2000 23%
- a larger proportion of men than women changed jobs (31% compared with 25%)
- 85% of those who changed employer who had been in the NHS continued to work for the NHS
- of those who left the NHS, half (52%) gave workload and stress as reasons for changing jobs
- in the NHS more than half (58%) of all those who changed employer said they did so to get better working hours or to accommodate domestic circumstances
- minority ethnic nurses are more likely to change jobs because of negative factors. 14% said they changed jobs due to bullying or harassment.

The key points related to career progression made in this chapter are:

- men are more likely to be in senior posts, and to have progressed more speedily up the career ladder than women (even accounting for time out in breaks)
- 64% of women and 28% of men had taken some form of break in their careers
- the majority of respondents (65%) returned to the same employer after their last break, but in 11% of cases they returned to a lower grade
- access to suitable working hours was the most frequent suggestion for making the return after a break easier or more attractive (suggested by 54%)
- white nurses had progressed to their current grades more quickly than minority ethnic nurses, but there is no difference in the proportions applying for or getting higher grade posts in the last 12 months
- men are more likely to apply, but women are more likely to get higher grade jobs
- in conjunction with length of career (excluding breaks), nursing qualification, field of practice and mode of work all emerged as factors related to achieving higher grades. Whether or not respondents had taken career breaks and respondents' ethnicity are also factors
- part-time nurses were less positive about the control they have over their careers and opportunities to progress.

6. Valuing and safeguarding nurses

6.1 Introduction

In the 2001 RCN membership survey report a sense of being valued, and all that entails, was considered the most important attribute of nurses' working lives. Yet many nurses reported that their experience of feeling valued did not match the importance they attached to it. It was clear from the responses that what contributes to a sense of feeling valued was complex. Pay, grading, fair and equal treatment, respect for staff preferences, the ability to balance home and work lives, and manageable workloads all contributed.

A previous RCN survey[29] exploring wellbeing at work found that nurses' job satisfaction and psychological wellbeing are both strongly correlated with the extent to which they feel they are valued by their employer, and safeguarded from unfair treatment, bullying or harassment. Indeed, whether or not an individual had been bullied in the preceding 12 months was the best predictor of nurses' psychological health.

"Where nurses feel employers do not take bullying or harassment seriously, these problems contribute strongly to a sense that they are not valued by their employers- and that in turn again damages psychological wellbeing and job satisfaction." (p9)

This chapter examines the concept of value in more depth and explores the extent to which nurses in different situations feel valued, and who they feel valued by. The chapter then looks at the other end of the spectrum through an examination of nurses' experience of bullying, harassment and assault, and at employers' responses. Finally the relationships between feeling valued and bullying and harassment are described.

6.2 Responses to '*I feel my work is valued*'

An attitude statement introduced in 2002 asked nurses to consider the extent to which they agreed with the general statement: *I feel my work is valued.* Overall, 56% agreed and 26% disagreed, with 18% neither in agreement or disagreement. While half feel their work is valued, the remainder are either unsure or feel their work is not valued.

Table 6.1 summarises the main findings for different groups of nurses:

- NHS nurses are slightly less likely to feel their work is valued (52%)
- staff nurses are more likely to feel their work is not valued as do, to a lesser extent, ward managers
- there is little difference between respondents in terms of their ethnicity
- the clearest relationship is with age – the proportion feeling their work is valued increases steadily as age increases

[29] *Working well: a call to employers. Summary of the RCN working well survey into the wellbeing and working lives of nurses* (2002). London: RCN

- nurses who feel that they are not on a grade commensurate with their role and responsibilities are most likely to feel their work is not valued - 33% compared to 19% of those who feel appropriately graded

- shift pattern and job title accounted for most of the variation in nurses' views. Night staff are particularly likely to feel that their contribution is not valued.

Table 6.1 *'I feel my work is valued'* – percentages agreeing

	Agree	*Weighted cases*		Agree	*Weighted cases*
London	62	*336*	Staff nurse	50	*1,926*
Rest of England	57	*2,787*	Ward managers	52	*600*
Wales	53	*216*	CNS	68	*327*
Scotland	50	*366*	Senior nurse	67	*197*
Northern Ireland	49	*139*	District nurse	59	*180*
NHS hospitals	50	*2,131*	D grade	50	*736*
NHS community	59	*506*	E	50	*1,348*
GP practice	79	*284*	F	58	*621*
Independent hospital	62	*96*	G	61	*718*
Independent nursing home	65	*211*	H	71	*219*
Bank/agency	52	*137*	I	71	*41*
Hospice/charity	71	*150*	Men	48	*241*
HA/NHS Executive	52	*87*	Women	57	*3,770*
All	**56**	***4,020***	**All**	**56**	***4,020***

Source: Employment Research/RCN 2002

6.3 Who values nurses' work?

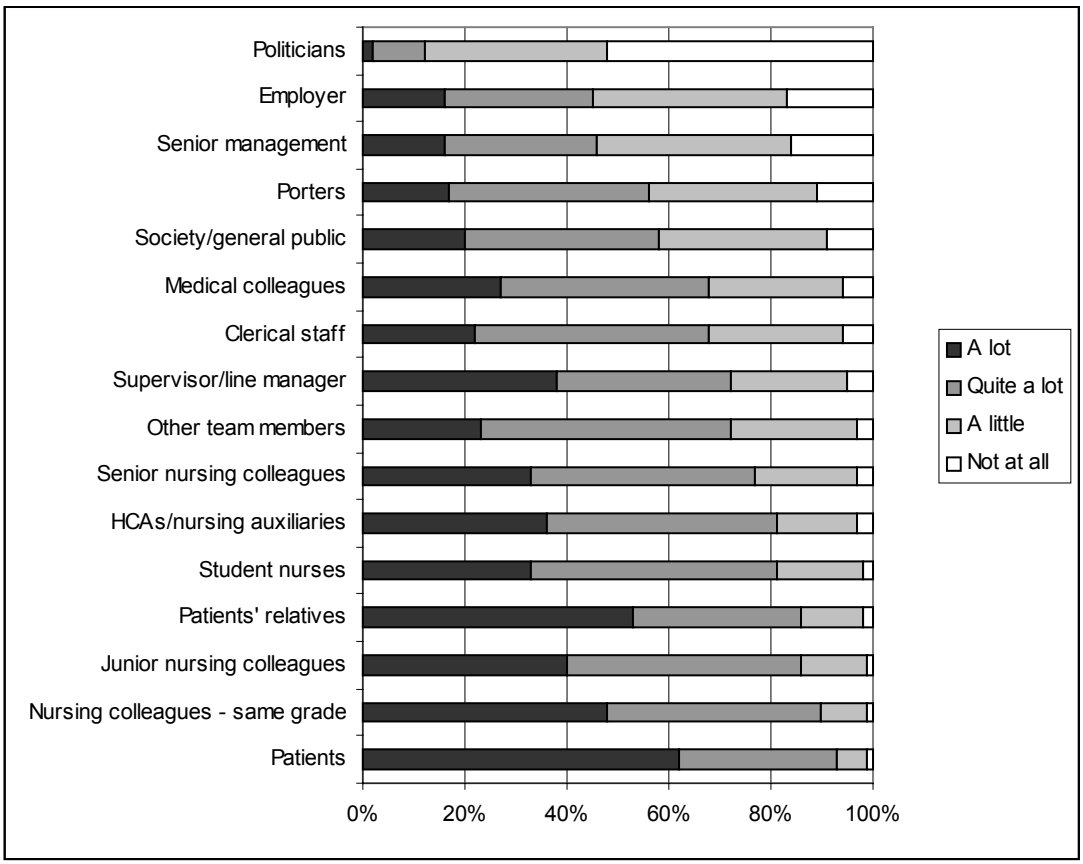
Respondents were questioned about the extent to which they feel their work is valued by different groups of people, including work colleagues, patients, society and politicians. The results are presented in figure 6.2.

Most respondents (more than 75%) feel their work is valued either *quite a lot* or *a lot* by their colleagues. Nearly three-quarters of respondents perceive that their line manager/supervisor values their work *a lot* or *quite a lot* and a similar response is reported for medical colleagues (68%).

Perhaps most importantly, nurses are most likely to feel that patients value their work. More than 90% say their work is valued *a lot* or *quite a lot* by the people they care for. A similarly high proportion (86%) feel valued by patients' relatives.

However, nearly 40% say that their employer only values their work *a little* and 17% say that the employer doesn't value their work at all. A third of nurses feel that society and the general public only values their work *a little* and one in ten say the general public does not value them at all. More than a half of all respondents (52%) say that politicians do not value their work at all.

Figure 6.2 Extent to which different groups value nurses – percentages (all respondents)



Source: Employment Research/RCN 2002

In order to examine which categories of people are most significant in engendering a sense of feeling valued in nurses, a regression analysis looked across all these items and explored the relationship with the general statement: *I feel my work is valued*. Being valued by their employer is the variable explaining most of the variation in nurses' views that their work is valued. Being valued by the employer is also the variable most closely correlated with overall sense of being valued. Being valued by the line manager and senior management is the next most strongly correlated item.

Employers valuing nurses

Clearly employers are key to nurses sense of feeling valued. Further examination demonstrates that there is significant variation in the degree to which employers in different health sectors are perceived to value their nursing workforce (table 6.2). Two-thirds of nurses in NHS hospitals report that they feel valued *only a little or less* by their employer. This compares with a half of nurses in independent hospitals and 41% of those employed in independent nursing homes. Half of all practice nurses feel their employers value them a lot.

Table 6.2 Feeling valued by employers by type of employer – percentages

	Not at all	A little	Quite a lot	A lot	*Weighted cases*
NHS hospital	21	45	25	9	*2,082*
NHS community	18	41	30	11	*483*
GP practice	1	12	36	50	*291*
Independent hospital	12	39	31	19	*101*
Independent nursing home	10	31	32	27	*205*
Bank/agency	18	31	25	27	*124*
Hospice/charity	7	23	41	29	*146*
All	**17**	**38**	**29**	**17**	***3,909***

Source: Employment Research/RCN 2002

Staff nurses in some specialities in the NHS are more likely to feel that their employer does not value their work very much (that is *a little* or *not at all*) – 71% working in mental health, 73% in adult critical care.

Nurses who feel they are inappropriately graded are most negative about the extent to which their employer values their work – and this variable explains most variation in perceptions of employers' value of nurses work. One in four nurses who feel their grade is inappropriate (24%) say their employer does not value their work at all, and a further 47% say they are only valued *a little* by their employer.

Ethnicity and feeling valued

Although there is little difference between UK-qualified minority ethnic and white nurses in the degree to which they feel their work is valued in general, the extent to which they feel valued by different groups does vary.

Minority ethnic NHS nurses are more likely to be more positive about the extent to which their employer values their work than white NHS nurses (see figure 6.3).

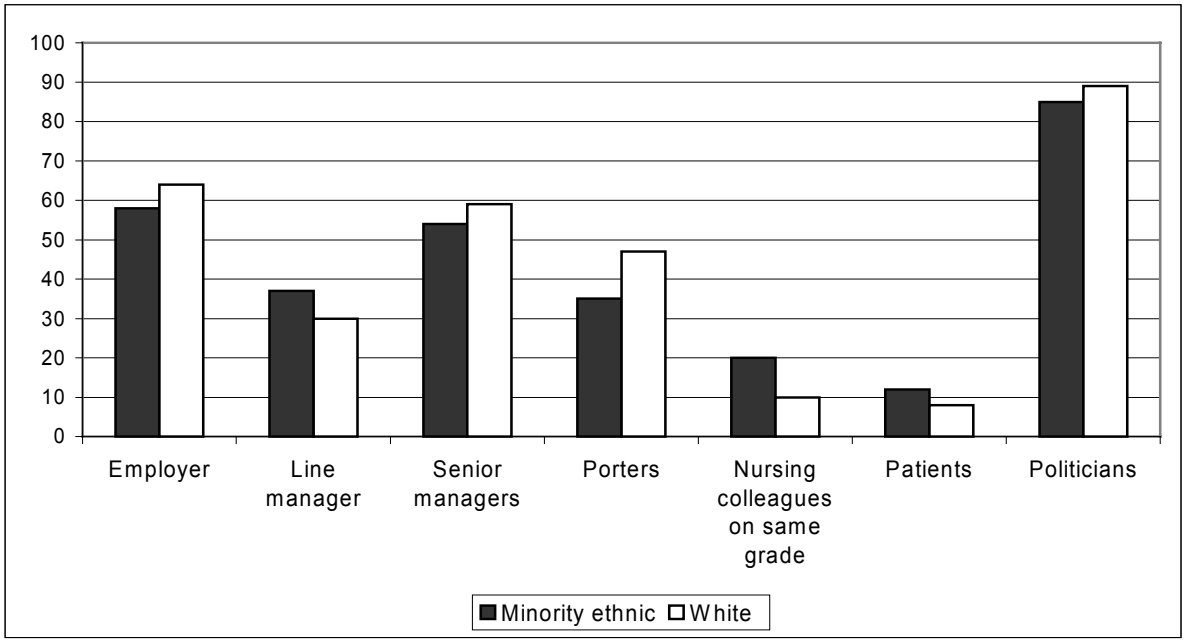
However, minority ethnic nurses are less likely to report that their contribution is valued by nursing colleagues of the same grade, or by their supervisors. One in five minority ethnic nurses say that their nursing colleagues only value them *a little* or *not at all*, compared to one in ten white nurses.

Taking these findings together suggests that minority ethnic nurses perceive that the people they have to work most closely with (nursing colleagues and patients), value them less than the equivalent perceptions of white nurses. Conversely, they seem more positive than white nurses about the views of employers, senior management and staff with whom they have less contact.

It may be that some of this variation can be explained by incidences of bullying and harassment (see section 6.3). Minority ethnic nurses are more likely to report having been bullied or harassed in the previous 12 months (28% compared to 16% of white nurses). Previous RCN research[30] found that in most cases where nurses had reported being bullied and harassed it was an immediate supervisor or a colleague who had been the perpetrator.

[30] Ball J et al (2002) *Working well?* London: RCN

Figure 6.3 Work is valued *a little/not at all* percentages by ethnic origin – NHS-only



Source: Employment Research/RCN 2002

Gender issues

Although men are less likely to feel their work is valued overall, the only areas where there appear to be significant differences between men and women are in the degree to which they feel their work is valued by colleagues of the same grade, and by patients. A lower proportion of men report that they feel their colleagues value them a lot compared to women (37% of men compared to 48% of women). Relatively few male nurses perceive patients to value their work a lot.

Other factors influencing nurse views

There are a number of inter-related factors that seem to have a bearing on the extent to which nurses feel different groups of individuals value their work. They are:

- nurses on higher grades are more likely to feel their work is valued by clerical staff, medical colleagues, management, their employer and supervisor/manager, but less likely to feel their work is valued by HCAs, junior nursing staff and students
- full-time staff are more positive about the extent to which their work is valued, particularly in relation to managers, senior nursing staff, medical colleagues and other members of multidisciplinary teams. Part-time staff are more likely than full-time colleagues to feel their work is valued by society and the general public
- more nurses working shift patterns, particularly nights-only, feel they are not valued compared to those working other patterns. Nurses working nights-only are much more likely to feel their work is not valued much by senior nursing colleagues, management, their employer, other members of the team and clerical staff.

6.4 Bullying, harassment and assault

The survey collected some basic data on bullying, harassment and assault at work, and satisfaction with the way in which employers deal with these incidents. A definition of bullying and harassment was not provided in the questionnaire. The results are based on nurses' own interpretations of the phrase.

Bullying at work

Qualitative research by the King's Fund reported a discriminatory culture in the NHS, and quoted one senior interviewee as saying: *"Unfortunately, bullying, hectoring and harassment, is almost institutionalised in some of the professions. And the NHS hasn't really got to grips with a lot of that."* (p41)[31]

In the 2002 RCN membership survey more than one-third (37%) of all respondents reported that they had been bullied or harassed at work at some time. One in six nurses (17%) had been bullied or harassed specifically by a member of staff in the last 12 months. This is the same figure as found in the *Working well*[32] survey conducted in the summer of 2000. Almost three-quarters (73%) of those who had been bullied or harassed in the last 12 months were dissatisfied with the way in which their employer had handled the situation.

A larger proportion had been bullied or harassed in the last year in the independent sector (20%), but fewer in GP practices (13%) or in universities (14%). In the NHS the following reported having been bullied or harassed in the last 12 months:

- 20% of men and 16% of women
- 19% of nurses aged 40 or over, 15% of those under 40
- 31% of Afro Caribbean nurses, 33% mixed, 26% Asian, 25% other White, compared with 15% of British White nurses
- 16% of white UK-qualified nurses, 25% of minority ethnic UK-qualified, 19% white non-UK-qualified, 34% minority ethnic first qualifying outside of the UK
- 30% of those with a disability, 16% without
- 19% of those working internal rotation, 8% of those on permanent nights, 15% of respondents working office hours
- 20% of full-time staff, 12% part-time staff.

Harassment/assault by patients or clients

Approximately one in three nurses, across all sectors, experienced some form of harassment or assault by patients or clients in the 12 months prior to the survey. Again this is almost identical to the figures reported in the earlier *Working well* survey. Similar differences to the experiences of bullying by colleagues are also apparent by sector, with nurses working in NHS hospital settings (43%) and independent nursing homes (43%) being most likely to be harassed or assaulted at work by patients/clients.

[31] Meadows S et al (2000) *The last straw: explaining the NHS nursing shortage.* London: King's Fund
[32] Ball J et al (2002) *Working well? Results from the RCN working well survey*. London: RCN

Summarising differences in the NHS:

- more than a half of all nurses working in mental health (55%) and learning disabilities (50%), and 45% of those in adult general nursing have been harassed or assaulted by patients in the 12 month period prior to the survey
- nurses working nights (47%) or three-shift rotation (48%) are more exposed to harassment than others
- more than half of men (53%) have been harassed or assaulted by patients in the 12 month period prior to the survey compared to 38% of women. This in turn is related to a concentration of male nurses in fields where harassment is more prevalent
- in contrast to the experience of bullying and harassment by colleagues at work a lower proportion of UK-qualified minority ethnic nurses (34%) have been harassed or assaulted by patients or clients than white nurses (40%)
- when and where nurses work (for example, at night, in mental health or leaning disabilities) are the factors that are most strongly correlated with incidence of harassment and assault by patients.

Despite minority ethnic nurses being more likely to work in mental health and learning disabilities than white nurses, they are less likely to report having been assaulted/harassed by patients in the previous 12 months.

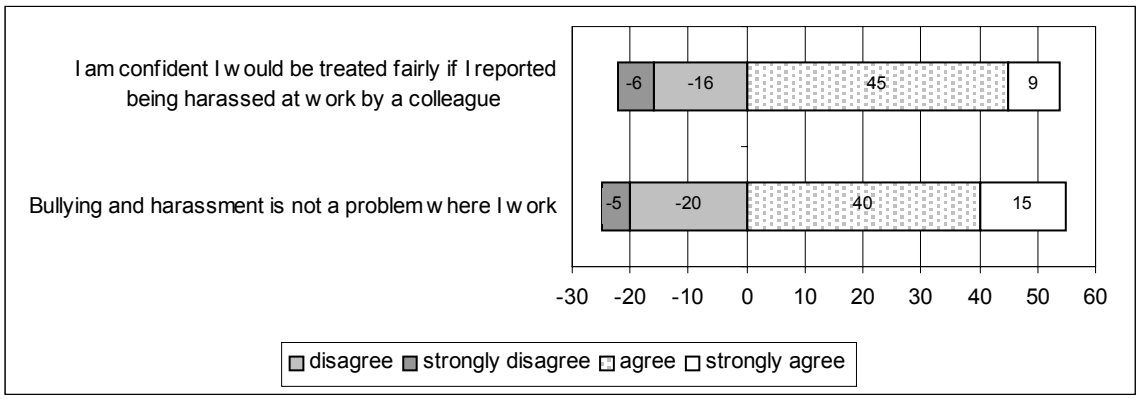
More than half (56%) of nurses are satisfied with the way in which their employer handled the most recent incident of harassment by patients. Bank and agency nurses are less likely to feel satisfied with the way their employer handles incidents of harassment or assault (41%), while respondents in independent nursing homes (67%) and GP practices (75%) are more likely to be satisfied. There is little difference between different groups of nurses in terms of their ethnicity or gender. However, younger nurses are less likely to feel satisfied with the way in which the last incident was handled (52% of under 40s compared to 58% of over 40s).

Views of bullying and harassment

Figure 6.4 shows the proportion of nurses agreeing with statements relating to bullying and harassment. Approximately one in four nurses see bullying and harassment as a problem where they work, and more than a fifth (22%) think they would not be treated fairly if they were to report being harassed by a colleague at work.

Not surprisingly, those respondents who have experienced bullying and harassment are much more likely to feel that it is a problem where they work, and are also less likely to say that they would be treated fairly if they reported an incident.

Figure 6.4 Views of bullying and harassment (NHS-only) – percentages



Source: Employment Research/RCN 2002

6.5 How bullying and valuing relate

Whether or not nurses have experienced bullying and harassment, their confidence in their employers to handle situations fairly are strongly correlated with nurses' sense of their work being valued, both in general and by their employers. For example, looking at NHS nurses only:

- nurses who have been bullied or harassed by a member of staff in the last 12 months are much less likely to feel that their work is valued (40% compared to 55% of those who have not experienced this problem at work). The difference is even wider for those nurses who have been assaulted or harassed by patients or their relatives in the last 12 months (only 41% saying they feel their work is valued compared to 59% of those who have not been harassed or assaulted)

- of those respondents who report strong agreement with the statement *I am confident that I would be treated fairly if I reported being harassed by a colleague*, 70% say they feel their work is valued. This compares with 23% of those who do not feel confident that they would be treated fairly. More specifically, 68% say they feel their work is valued *quite a lot* or *a lot* by their employer (compared to 34% of those who do not).

- 55% of nurses who feel satisfied with the way their employer handled an incident of bullying/harassment by a colleague feel their work is valued, and 44% feel valued by their employer. These figures compare with 40% and 30% of those who are not satisfied with the way the situation was handled by their employer

- where nurses have been assaulted or harassed by patients or clients 55% feel that patients value their work *a lot* compared to 67% of those that have not experienced a problem.

Similar differences between NHS nurses are noticeable when looking at job satisfaction. Nurses who have experienced bullying and harassment by colleagues or harassment by patients/clients are much less likely to feel satisfied in their jobs. Also, where respondents feel valued a lot by their employers 87% are satisfied in their jobs, compared with 38% of nurses who do not feel valued at all by their employers. Of all these variables, feeling that your work is valued, particularly by your employer, is the key factor influencing whether or not nurses feel satisfied in their jobs.

6.6 Key points

Nurses' perceptions that their work is valued (particularly by their employer) and that they are not exposed to bullying and harassment, are both related to overall job satisfaction:

- most (56%) feel in general that their work is valued but there are significant differences between groups of nurses
- men are less likely to feel their work is valued than women, but there is little difference in overall perceptions by ethnicity
- feeling valued by employers contributes most to an overall sense of being valued. Yet 17% of nurses feel that their employer does not value their work at all, and 40% say their work is only valued a little by their employer
- perceptions that employers value nurses work depend on who the employer is. NHS hospital staff are least likely to feel their work is valued, while those in GP practices are most likely to feel valued. Of NHS hospital staff 34% report that their employer values them *a lot* or *quite a lot*, compared to 86% of GP practice nurses
- minority ethnic nurses are more likely to be positive about the extent to which employers value their work, but less positive than white nurses about the extent to which they feel valued by their colleagues or by patients
- being appropriately graded contributes to feeling valued
- nurses who have been bullied or harassed in the preceding 12 months (17% of all respondents) are less likely to feel their work is valued
- minority ethnic nurses are more likely to have been bullied or harassed than white colleagues
- three-quarters of those who had been bulled or harassed by staff were not satisfied with their employers' handling of the situation
- feeling valued is closely correlated with job satisfaction. Of staff who feel their employer values their contribution 87% are satisfied with their jobs, compared with 38% of nurses who do not feel valued at all by their employers.

7. Quality of working life

Throughout this report differences between groups of nurses have been identified. These differences are described in each chapter as the main themes of the employment survey are pursued. They are:

- working hours
- workloads
- pay
- careers.

Views of staff on each theme have also been presented chapter by chapter. In this final chapter, the focus moves from this thematic view of the survey findings, to look at the quality of working lives experienced by different groups of nurses. The section:

- reviews the attitudes of nurses as a group to explore overall levels of morale in 2002 and identify the issues that nurses in general are most and least satisfied with
- summarises the work/life experiences for each of the major groups within nursing and explores differences between groups
- considers a key indicator of morale: whether or not nurses want to stay in nursing and in their current jobs
- examines nurses' views of what could be done to make them feel more valued and so improve their working lives.

7.1 Overview of morale in 2002

The RCN *Employment survey* has included core attitude statements for ten years. In addition, new statements are included in every survey to explore particular themes each year. In the 2002 survey respondents were presented with a total of 41 statements and asked to indicate the extent to which they agreed or disagreed with each of them on a five-point scale.

In subsequent reporting the scores of negatively-framed statements have been reversed and the wording altered so that they are all reported as positives. To make the scale results more intuitive, higher scores indicate greater satisfaction.

Table 7.1 shows the proportion of NHS nurses agreeing with the positively-framed statements. Where statements are marked with an asterisk (*) they have been reworded from a negative statement to convey a positive sense. The statements are ordered according to the degree of change since the 2001 survey. Items at the top of the list are those that have improved, while views on the statements at the bottom of the table are more negative this year than last. Broadly speaking, most nurses are satisfied with their job (61%) and feel enthusiastic about it (73%). However, nurses as a whole remain dissatisfied with their pay and workloads.

Comparing the 2002 and 2001 results shows an increased proportion of NHS nurses reporting that the quality of care provided is good (up from 81% to 88%). In 2001, 31% of nurses in the NHS felt that quality had improved in the last year. This year, the figure has risen to 39%.

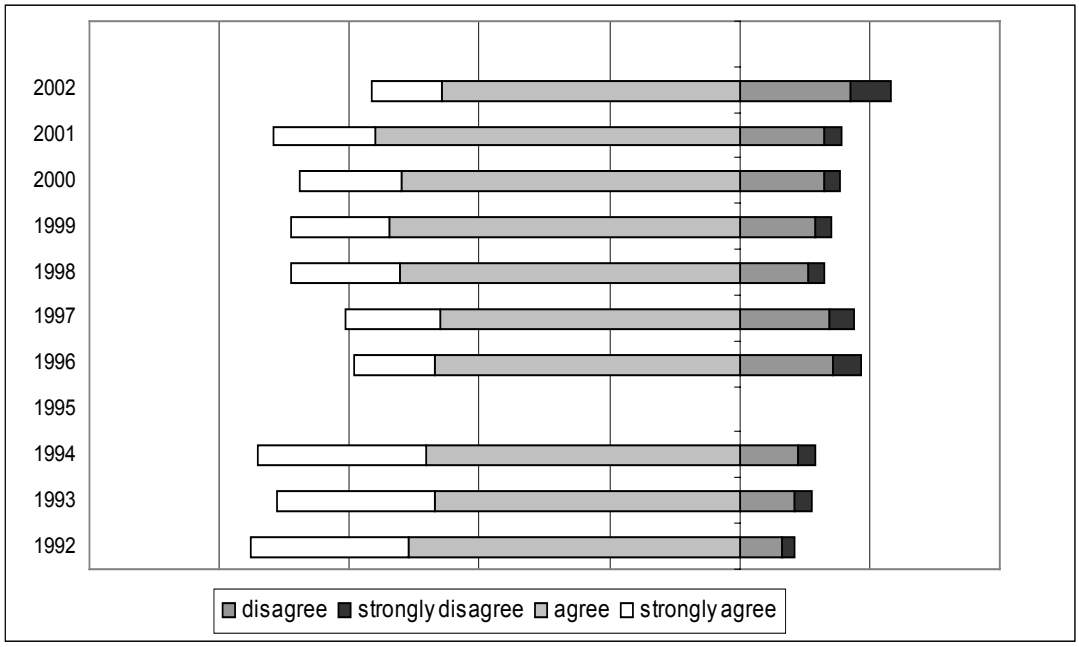
Table 7.1 Percentage agreeing with positive items – NHS 2001 and 2002

Item no		2001	2002
3	I feel my work is valued	n/a	52
12	I have sufficient time to do my job properly	n/a	21
13	I am satisfied with the choice I have over the length of shifts I work	n/a	59
33	Bullying and harassment is not a problem where I work	n/a	56
35	I have good relationships with colleagues	n/a	93
36	I feel able to balance my home and work lives	n/a	61
38	Staff working part-time are treated as well as full-time staff	n/a	68
39	I am satisfied with my input in planning my own off duty/times of work	n/a	64
40	I am confident I would be treated fairly if I reported being harassed at work by a colleague	n/a	54
25	The quality of care where I work has improved in the last year	31	39
22	The quality of care provided where I work is good	81	88
18	Opportunities for nurses to advance their careers have improved	52	58
34*	I am NOT worried that I may be made redundant	72	78
7	Nursing will continue to offer me a secure job for years to come	62	67
19	I am interested in career progression	63	68
20	There is open dialogue about my career with my manager	41	46
1	I would recommend nursing as a career	40	43
23	I feel satisfied with my present job	58	61
37*	It will NOT be very difficult for me to progress from my current grade	24	27
10	I have a good chance to get ahead in nursing	29	31
14*	Nurses are paid WELL in relation to other professional groups	4	6
32	I would find it easy to get another job using my skills	45	47
41*	I am NOT in a dead-end job	66	68
8*	I am NOT under too much pressure at work	16	17
11*	I am ABLE to take time off for training	50	50
17	My employer provides me with the opportunities to keep up with new developments related to my job	59	59
24	I'm proud to work in this organisation	47	47
26*	NOT too much of my time is spent in non-nursing duties	24	24
4*	My workload is NOT too heavy	15	14
30*	I could NOT be paid more for less effort if I left nursing	11	10
31	Nurse staffing levels have got better in the last year	14	13
5	I know what I want to do in the future in my career	56	54
6	I can determine the way my career develops	56	54
15	I would not want to work outside nursing	42	40
21*	Career prospects in nursing are NOT becoming less attractive	24	22
27	I would NOT leave nursing if I could	48	46
9	Considering the work I do I am paid well	15	12
2	Most days I am enthusiastic about my job	77	73
16*	I DO know where my career in nursing is going	44	40
28	There are sufficient staff to provide a good standard of care	24	20
29	I think nursing is a rewarding career	72	56
	* denotes reworded and reversed statement		

Source: Employment Research/RCN 2002

The numbers responding positively to statements on job security, progression and opportunities in nursing have increased. However, one area where there has been a significant change is in the proportion of nurses who feel that nursing is a rewarding career. This is down from 72% last year to 56% in 2002. To explore this dramatic change in more detail the results for this statement each year since 1992 are shown in Figure 7.1. Between 1998 and 2001, the responses to this item were broadly similar. The last time respondents were noticeably less positive about the extent to which they see nursing as a rewarding career was in 1996/97 during the period of discontent surrounding the 'local pay experiment'. It is difficult to understand why in 2002 views have swung so sharply towards the negative end. One possible explanation may be heightened expectations associated with NHS pay modernisation, which have not yet been met.

Figure 7.1 Percentage agreeing with positive framed items from 1996-2002 (NHS-only)



Source: Employment Research/RCN 2002

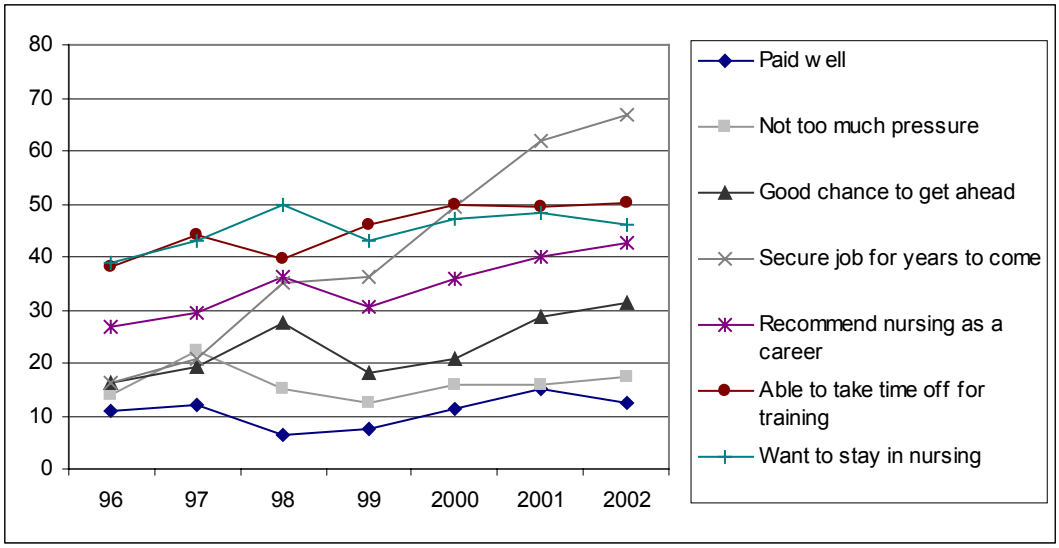
Workload and pay continue to be the themes with which respondents are most negative. More than half (56%) feel they are under too much pressure at work, and more than two-thirds of respondents feel that there are insufficient staff to provide a good standard of care.

When asked whether staffing levels had improved in the last year, only 12% felt that they had, with 68% reporting that they had not.

Very few NHS nurses surveyed – just one in ten – feel that they are paid well in relation to the work they undertake, and even fewer (6%) consider that nurses are well paid relative to other professional groups.

Figure 7.2 presents the findings for NHS nurses from 1996 to 2002 for a selection of statements that illustrate the main themes.

Figure 7.2 Percentage agreeing with positive framed items from 1996-2002 (NHS-only)



Source: Employment Research/RCN 2002

Views concerning career prospects, job security and recommending nursing as a career have become more positive since 1999. Desire to stay in nursing has changed little over the last four years. Reports of not feeling under pressure have also changed little, although satisfaction with pay has fallen slightly since last year.

7.2 Differences between nurses

The preceding sections demonstrate that in general nurses are reasonably positive about their working lives but that many feel that their workloads are too great and pay is inadequate for the work undertaken. But how do the views of nurses vary? For example, on which issues do male and female views differ? The aim of this section is to highlight the issues of particular concern to different groups in the nursing workforce, and to recap on the survey and findings that help to explain these differences.

For each group of nurses a figure highlights the key differences (both in size and significance) in attitude between two groups (white and minority ethnic nurses, men and women and so on) in their attitudes to different aspects of nursing, their careers and working lives.

Gender

Men are more likely than women to:

- qualify as nurses late in life
- work full-time
- work in mental health and learning disabilities
- be in senior positions
- be on higher grades with senior positions
- progress quickly through the grades
- to have applied for a higher-grade post

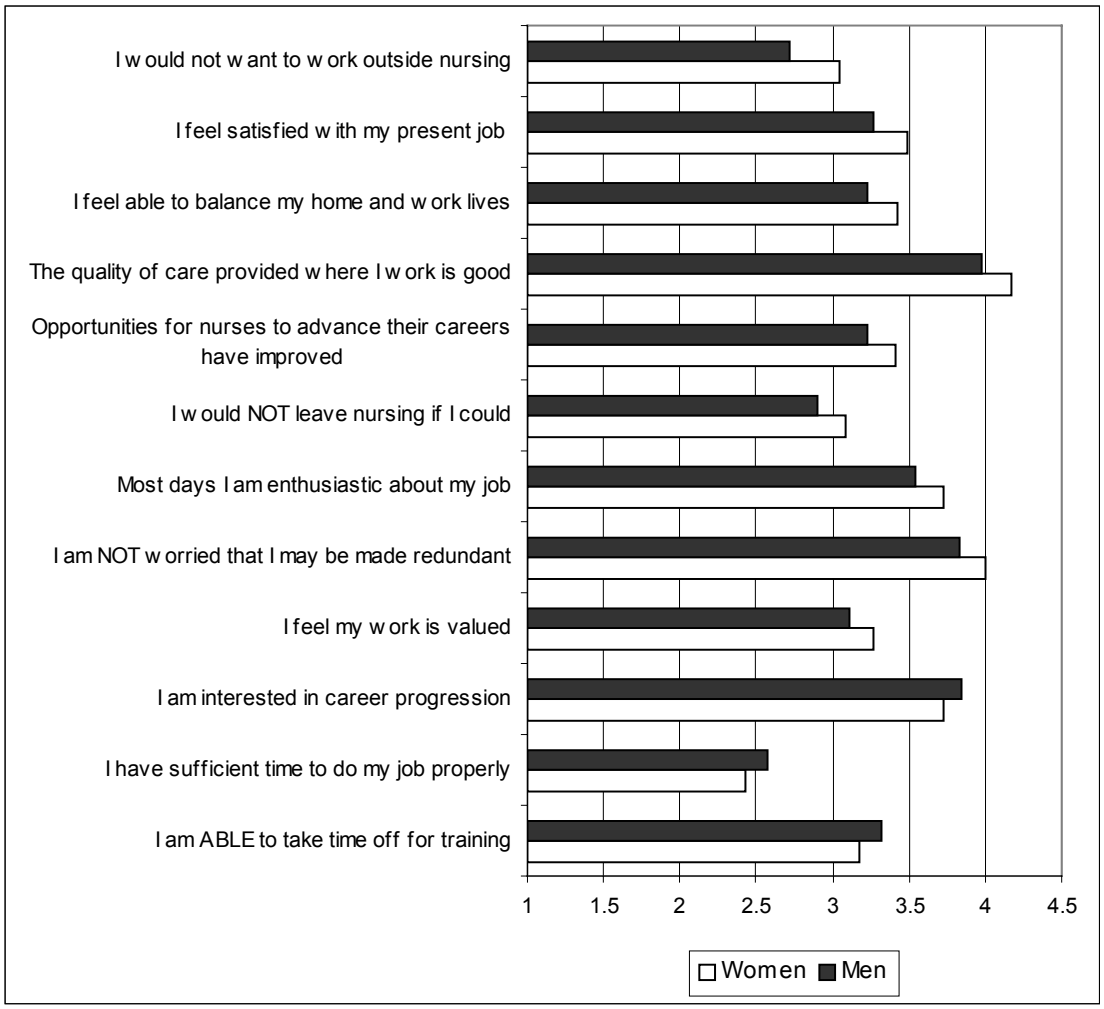
- be paid for the overtime they work
- have an additional job
- to have changed jobs in the preceding 12 months.

While women are more likely than men to:

- work in the community
- work part-time
- have had a career break
- be successful in their applications for higher grade jobs
- feel their work is valued.

Figure 7.3 shows where the views of male and female nurses differ most. In general, men tend to be more dissatisfied than women are. Hence, the number of issues against which men show a more positive response is only three out of the 12 shown in the figure, where views differ most. Across all attitude statements men display more negative responses in 28 of the 41 items.

Figure 7.3 Differences between men and women – mean scores



Source: Employment Research/RCN 2002

Where men are slightly more positive than women is in their attitudes to career progression, the amount of time they have to do their job properly, and in being able to take time off for training. However, the differences here are not statistically significant.

Lower proportions of men say that they are satisfied with their job (55% compared to 65% of women). Fewer feel the quality of care where they work is good (82% compared to 90% of women) or feel valued and enthusiastic about their work (65% say they feel enthusiastic in their work compared to 77% of women). Men are also more likely to be concerned about redundancy and fewer agree that opportunities for nurses to advance their careers have improved.

Although women appear more able than men to balance their home and work lives, this is because they are more likely to work part-time. There is little difference between men and women when working hours are controlled for.

Age

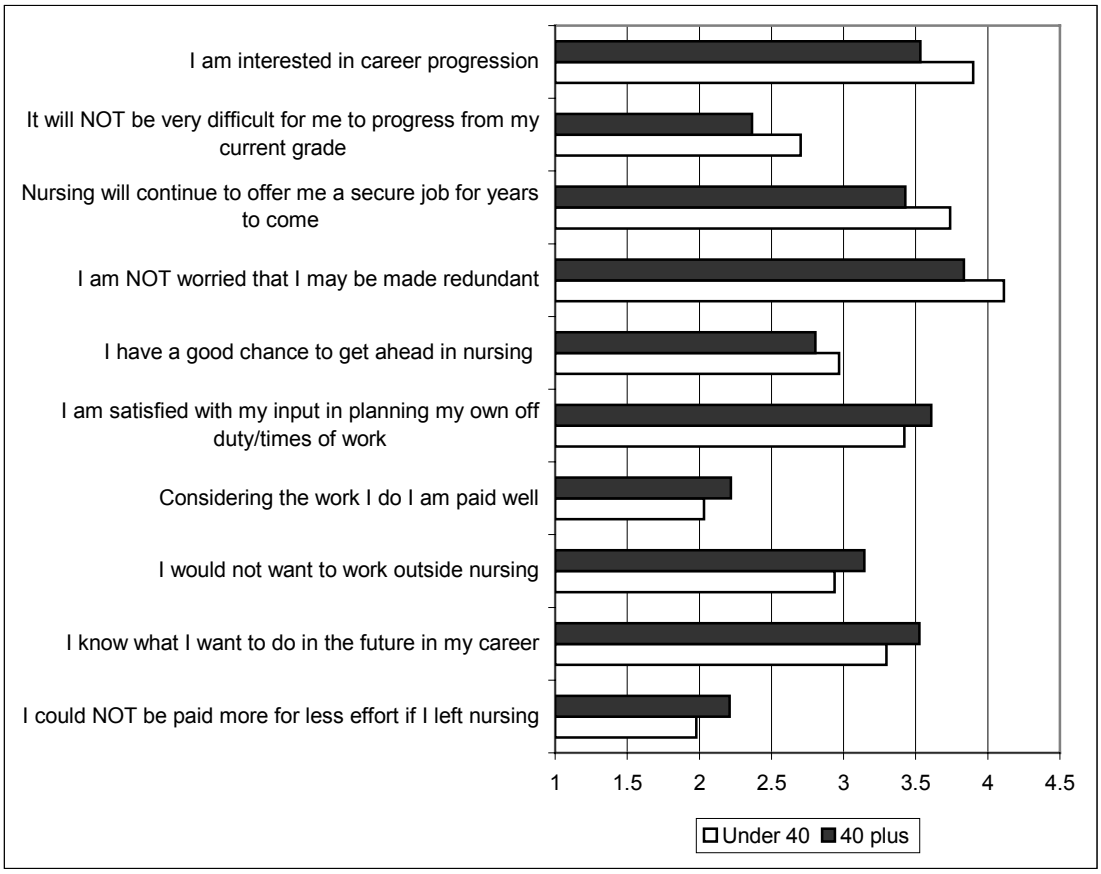
Nurses display very different career and biographical profiles by age. More older nurses are employed in senior posts than is the case among younger nurses, more have children living at home and work part-time, while more of the younger nurses work in NHS hospitals in acute fields. They are also more likely to feel that their grade is inappropriate given their role and responsibilities.

These differences influence their responses. On 20 of the 41 attitude statements there are significant differences in the views of older nurses (categorised as those aged 40-plus) and younger nurses (under 40). In general, where there is an age-related difference in views, younger nurses are less likely to be satisfied.

In summary, nurses aged over 40 are:

- less interested in career progression (56% report that they are interested compared to 77% of the under-40 age group). They are also more certain of what they want to do in their future career and feel that opportunities to progress their careers are more limited (18% agree that it will be easy to progress from their current grade compared to 30% of those aged under 40)
- more concerned about the possibilities of redundancy and that nursing may not offer a secure job for years to come
- marginally less concerned with their pay. Of older nurses 19% report that considering the work they do they feel well paid compared to 12% of younger nurses
- more satisfied with the level of input they have in planning their off duty/times of work
- more likely than their younger colleagues to say they would do not want to work outside nursing even if they could (45% compared to 35% of those aged under 40).

Figure 7.4 Differences by age in attitudes – mean scores



Source: Employment Research/RCN 2002

Ethnicity

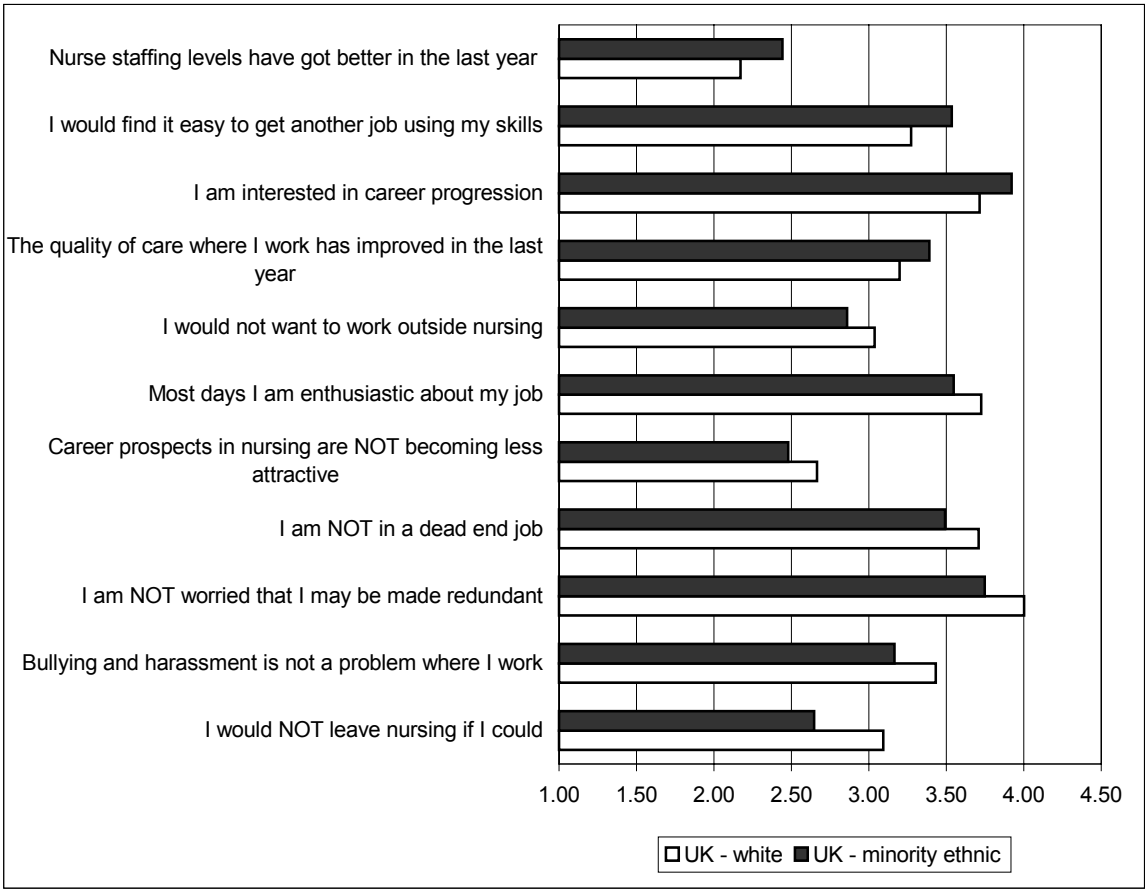
Nurses from minority ethnic origins are more likely than white nurse to:

- work full-time, and to work three shift internal rotation
- live in London
- be in a breadwinner role
- have children
- work longer hours
- have additional jobs
- feel their grade is inappropriate relative to their role and responsibility
- have been bullied and harassed at work
- have changed jobs due to negative pressures.

No significant differences were found in the grades or rate of job applications by ethnicity, although on average the career progress of minority ethnic nurses was slower than that for white nurses.

When considering nurses who first qualified in the UK, white nurses are more positive on 22 statements, and minority ethnic nurses are more positive on 19. The difference is statistically significant on only eight statements. The items on which biggest differences were found are shown in figure 7.5.

Figure 7.5 Differences by ethnicity UK qualified only – mean scores



Source: Employment Research/RCN 2002

Minority ethnic nurses were more likely to respond positively about being able to find another job using skills (59% agreeing compared to 49% of white nurses), the quality of care having improved, and interest in career progression.

However, bullying and harassment is reported as being more of a problem among minority ethnic nurses (27% agreeing there is a problem compared to 22% of white nurses). Minority ethnic nurses are also more likely to be report negatively about possibilities of redundancy (67% say they are not worried about redundancy compared to 77% of white nurses).

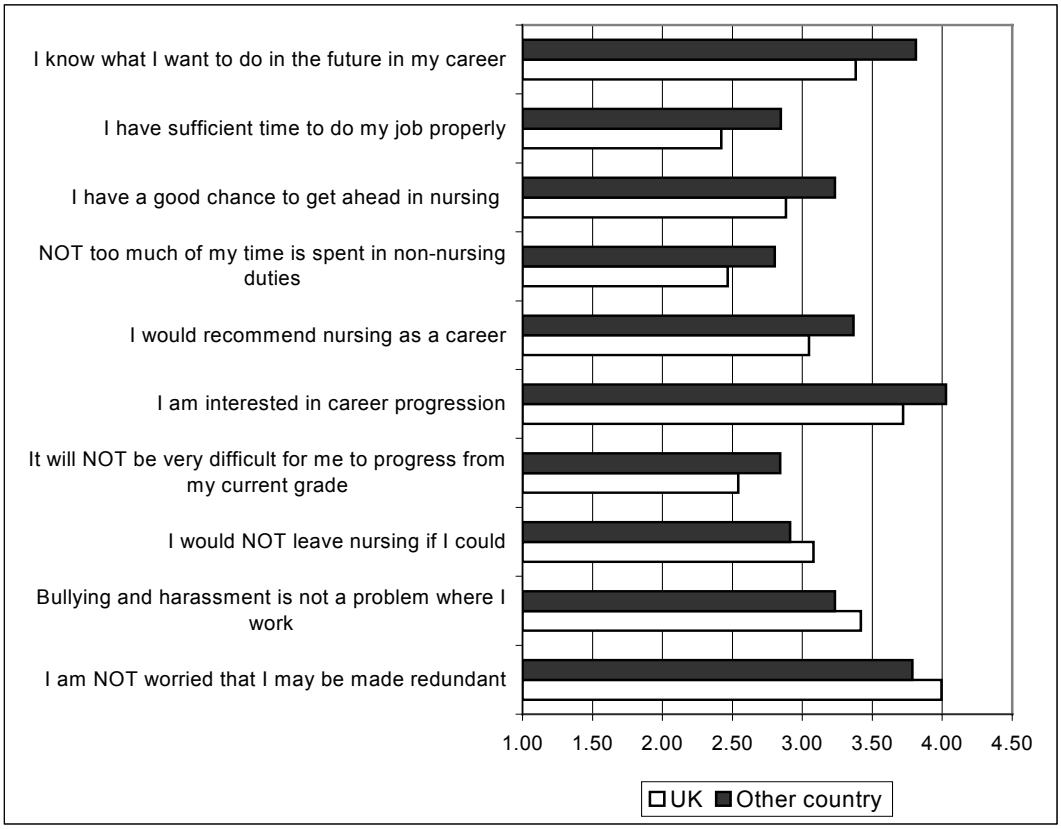
Finally, 46% of minority ethnic nurses would leave nursing if they could, compared to 33% of white nurses.

Nurses who first qualified outside the UK

This year we have devoted more attention to non-UK-qualified nurses as they form a distinct group that crosses ethnic origin. Chapter 2 showed that nurses who first qualified outside the UK were varied, including a proportion, the size of which we are unable to quantify, who are recent internationally recruited nurses.

Looking across all nurses who qualified overseas, and comparing their attitudes to nursing with UK-qualified nurses, some interesting differences emerge. On 12 statements the differences in views between UK and non-UK-qualified nurses are significant. Across all the statements, UK-qualified nurses are more positive on 14 and overseas-qualified nurses are more positive on 25 items.

Figure 7.6 Differences by where qualified UK/Overseas – mean scores



Source: Employment Research/RCN 2002

Overseas-qualified nurses are in the main more positive about their working lives and nursing more generally. Where they seem more negative is in concerns about being made redundant, bullying and harassment at work (27% saying it is a problem where they work compared to 22% of UK-qualified) and that they are more likely to leave nursing if they could – this despite displaying more positive responses elsewhere.

It is noticeable that nurses who qualified outside the UK are more positive about career-related issues. Figure 7.6 highlights some key differences. For example, 70% say they know what they want to do in their future career compared to 56% of UK-qualified nurses. Also 47% agree they have a good chance to get ahead in nursing compared to 31% of UK-qualified nurses. Nearly 60% say they would recommend nursing as a career compared to 45% of UK-qualified nurses.

7.3 Intentions to leave

The preceding sections have looked at the attitudes of nurses and how these vary between groups. We now turn attention to look at what could be regarded as a key indicator of morale – whether or not nurses want to stay in nursing or their current jobs, and whether they would leave nursing if they could.

Plan to leave nursing/current employer

The questionnaire asked two separate questions on intentions to leave nursing, and intention to leave current job. Respondents were asked to indicate whether they intended to stay in nursing for more than five years, or leave nursing, or their employer, in the next six months, two years, or two to five years, This is a standard question that has been asked for many years. The 2002 survey shows that there is little or no change in the aggregate proportion of nurses intending to leave nursing in the next two years – 12% for all nurses and 11% for NHS nurses.

However, the 2001 survey reported that more nurses aged under 40 intended to leave nursing within five years than was the case among nurses aged 40 to 50. This year a significantly higher proportion of nurses aged under 40 indicated that they intend to leave nursing within five years – up from 37% to 46%.

The most important factor that can predict whether a nurse plans to stay in or leave nursing for two years or more is whether they feel their work is valued. Eight per cent who feel their work is valued are planning to leave in the next two years, compared with 19% of those who do not feel their work is valued.

Other variables that appear to play some part in predicting whether or not a nurse will be planning to leave nursing are, in order:

- age
- geographical location
- workload
- bullying
- shift pattern
- employment setting.

Ethnicity, gender, mode of working and appropriateness of grade do not emerge as predictive factors.

These findings suggest that commitment to staying in nursing is consistent between different groups of nurse. Women, minority ethnic and part-time nurses are as likely to be planning to stay in nursing as white, full-time, male nurses are.

Being able to achieve a work/life balance and get suitable working hours is also correlated with plans to stay in or leave nursing. Nurses who do not feel they can achieve a balance between home and work are twice as likely to be planning to leave nursing in the next two years (18% compared to 10% of those who agree that they have a home/work balance).

The differences between nurses who feel their work is valued and those who do not are even greater when we look at intention to stay with the current employer. More than three-quarters (77%) of those who plan to stay with their current employer feel their work is valued compared with 22% of those planning to leave in the next two years. Working hours and appropriate grading emerge as major factors here.

Responses to *I would leave nursing if I could*

A separate question from that above asked the extent to which nurses agreed or disagreed with the simple statement *I would leave nursing if I could*. The difference in the phrasing of this question, and the career plan question above, enables exploration of differing levels of frustration with nurses' working lives. Whether or not nurses are planning to leave nursing will depend on many issues. Plans to have a family, to retire, the need for the income nursing provides and dissatisfaction with nursing work will all play a part in the overall career plans of individuals. This question puts these practicalities to one side, and gets at the heart of whether or not a nurse would really rather not be in nursing.

A third (34%) of all respondents agreed that they would leave nursing if they could. This varied by setting – 36% in the NHS and 35% in independent hospitals, compared with 40% of bank and agency nurses, and just 19% of GP practice nurses.

Reports of wanting to leave nursing (as opposed to actively planning to) are also strongly correlated with how valued the individual feels their work is. Only a third (34%) of those who agree that they would leave nursing if they could feel that their work is valued, while 68% of those who do not wish to leave feel their work is valued.

Further analysis was undertaken to see which variables could predict whether nurses want to leave nursing. There are some interesting similarities and differences in the results relating to the attitude statement concerned with the *desire* to leave and that concerned with *plans* to leave.

In common with the previous analysis, whether or not respondents feel their work is valued is the highest-ranking factor relating to their desire to leave nursing. However, thereafter the results differ. The next most important factor concerned with desire to leave is working hours. This is followed by appropriateness of grade, workload, whether bullied or harassed in the last 12 months, and ethnicity.

Some key differences in the proportion indicating they would leave nursing if they could are:

- 20% of those who felt their work is valued would leave is they could compared with 61% of those who do not
- 26% of those who felt there are sufficient staff compared with 39% who did not
- 49% of those who had been bullied compared with 31% of those who had not
- 26% of those who considered their grade appropriate compared with 42% who did not
- 33% white of white nurses compared with 45% of Afro Caribbean nurses.

Variables discussed in connection with career intentions were entered into a series of stepwise regression models to look at which were most important in predicting respondents' plans to stay in nursing, plans to stay with current employer and desire to leave nursing, if they could. The results are summarised in table 7.2 below that shows the relative ranking of each factor.

Table 7.2 Predictors of career plans/wishes (rank positions)

	Plan to stay/leave nursing in 2 years	Plan to leave current employer in 2 years	Would leave nursing if could
Feel work is valued	2	1	1
Age (years)	1	5	-
Dependant children	3	2	-
Satisfaction with working hours	4	3	2
Part-time/full-time only	5	9	-
Views of workload (scale)	6	-	4
London/rest UK	7	4	-
Gender	-	-	-
Composite employer Variable	-	-	-
Current grade appropriate	-	8	3
Been bullied/harassed by staff in last 12 months	-	-	5
Shift pattern	-	7	7
Views of bullying scale	-	6	-
Ethnic groups	-	10	6

Source:Employment Research/RCN 2002

Feeling valued is an important factor in all three models. That is, feeling valued is a predictor of planing to stay in or leave nursing, of planing to stay in or leave current job, and of wanting to leave. The fact that whether or not a respondent has children features in their career plans is not surprising because for many it will be the reason they are *planning* to leave. On the other hand, family status is not a factor influencing likelihood of *wanting* to leave. Instead, satisfaction with working hours and opportunity to balance home/work lives ranks second after feeling that work is valued in predicting whether a nurse says they would leave if they could.

7.4 Valuing nurses, valuing nursing

The 2002 survey has examined the theme of valuing nurses and found that nurses' perceptions that their work is valued is of central importance – both in general and more specifically by their employers. Nurses who feel their work is valued are more likely to be satisfied with their jobs and to want to stay with their current employer and in nursing. And yet nurses' experience of being treated fairly and valued equally, in terms of career opportunities, pay and grading, and working hours, is not consistent.

There are clear differences in the experiences of different groups of nurses, which impacts on their views of the extent to which they feel valued. This suggests that there is scope to influence the extent to which nurses feel valued. Why do some nurses feel more valued than others, and what is it that these employers are doing right?

The survey tackled this issue directly by asking respondents what could be done to make them feel more valued at work. The aggregate figures are presented in table 7.3. Up to five responses were coded for each individual - the number of responses thus exceeds the number of cases.

Table 7.3 What would make you feel more valued at work? Percentage of cases

Category	Example of responses	% cases
Pay	Improve salary	42
Appreciation/awareness of nurses' contribution	Saying thank you, positive feedback	32
Better management/supervision	More supportive management, better supervision of newly-qualified nurses Less competitive management	29
Staffing – more staff/nurses (RNs)	Better staffing levels Better skill mix Better staff to patient ratios	19
Respect	From management, patients/public	18
Communication	Such as team meetings	11
Prospects	Promotion/progress opportunities Better career development	10
Study opportunities	Access to training	9
Better terms and conditions	Same contracts for different groups of staff, annual leave	7
Staff facilities/physical environment	For example, canteen, parking, changing rooms, coffee rooms	7
Status/power of nursing	Not running nursing down/bad press	7
Working hours	Flexible work Self-scheduling Opportunity to work part-time Better planned hours Not made to work internal rotation	6
Resources/funding	More equipment available	6
Working relationships	Attitude of other staff	6
Decision making/involvement		5
Appraisals/IPR/personal review	Personal development plans	5
Ensure quality of care	Patient contact, continuity of care, support of relatives	5
Nursing autonomy/free to do proper nursing	Utilise knowledge and skills fully Not doing non-nursing things	4
Protection from violence/blame	Better security, less exposure to violence	4
Other	Nurses Charter, more stability in NHS, RCN/union support, perks/ freebies	4
Clerical support/less paperwork	Less bureaucracy/red tape	3
Work/home life balance	Help with childcare	2
Weighted cases		*2,598*
Number responses		*6,018*

Source: Employment Research/RCN 2002

Nurses see increased pay as the single most important change that can be made to make them feel more valued. More than four out of ten nurses (42%) wrote that improved pay would make them feel more valued at work. A further 10% would like to see better prospects for nurses, and 7% would also like to see better terms and conditions of employment.

A third of nurses wanted to see more appreciation of their roles, commitment and quality of work. Messages here included more and better feedback and communication, sometimes as simple as saying *thank you* from time-to-time. On a similar theme, 18% would like to see more respect both internally in their organisations and from patients and the general public.

Nearly 30% of respondents highlighted better management and supervision and a further 11% mentioned better communication. Five per cent also cited more/better appraisals and reviews/personal development plans as measures that would contribute to a sense of feeling valued.

The main themes that emerge tie in with the messages from the attitude statements presented earlier in this chapter. There are strong views on pay, workload and being appreciated. Thus, perhaps unsurprising given the lack of satisfaction with workloads, one in five respondents report that an important way to help nurses feel more valued is to improve staffing levels where they work. Others point to quality of care, saying that ensuring that the resources required to allow a high standard of care is maintained would result in them feeling more valued as nurses.

Six per cent want to see changes to their working hours. A further 2% report that improved home/work balance, for example through more suitable childcare support, would be the change they would like to see to make them feel more valued at work.

Views of men and women differed on some of these issues. Men were more likely to refer to pay (56% compared with 48% of women), while women were more likely to cite understanding/appreciation of nursing roles and working hours.

Echoing the findings elsewhere in the report, larger proportions of minority ethnic nurses reported that better career prospects would make them feel valued (16% relative to 10% of white nurses). Nine per cent of minority ethnic nurses referred to improving working relationships and attitudes of other staff (9%, compared with 6% of white nurses).

Finally, table 7.4 shows the differences by employer setting in the proportions citing different changes that would make them feel more valued. The categories have been compressed for this analysis, for example terms and conditions are combined with pay. While pay/terms and conditions is the most frequently cited improvement that nurses feel would make them feel more valued at work across all the employer groups, a particularly large proportion (64%) of nurses working in hospices cite pay. In all the settings, except for NHS community, appreciation and awareness of the contribution of nurses' roles is the second ranked item. Improvements in the way in which staff are managed ranked second for community nurses, where 37% referred to some aspect of management/appraisal or review, compared to just 18% of GP practice nurses.

The issue that GP practice nurses were more likely to raise was the level of nursing autonomy they have, wishing to be more involved in decisions and to have greater freedom to get on with proper nursing (this ranked fifth for practice nurses, compared with tenth for NHS hospital nurses). In independent hospitals autonomy and involvement in decision-making comes higher up the list of priorities in fourth position.

Table 7.4 Most important factors in plans/views re nursing and current employer

	NHS hosp	NHS comm	GP	Ind hosp	Nursing home	Hospice	Bank/ agency
Pay, terms and conditions	50	48	52	56	46	64	41
Appreciation of nurses roles'	34	29	29	27	36	31	29
Management/appraisals/ supervision	32	37	18	22	20	24	23
Respect/status/power of nursing	27	20	18	12	17	17	29
Staffing/resources/ funding	27	17	12	14	23	29	14
Communication	11	12	13	10	10	14	16
Prospects	10	14	8	6	10	13	9
Autonomy/involvement in decisions	8	9	14	15	12	5	9
Study opportunities	10	7	4	13	6	15	10
Working hours and work/life balance	9	6	7	11	4	10	9
Staff facilities/environment	7	6	5	8	6	0	3
Protection from violence/blame	5	3	2	5	1	2	8
Clerical support/less paperwork	2	5	1	0	6	2	2
Number of cases	1,454	336	151	66	130	88	82

Source: Employment Research/RCN 2002

7.5 Key points

This chapter has summarised the variation in the experiences of different groups of nurses and revealed how this variation impacts on the views of subgroups in the nursing population. The survey findings on career intentions and desire to leave nursing were described before looking at how nurses feel their work may be more highly valued. The main points are:

- overall, men are less satisfied than women
- views of minority ethnic nurses and white nurses differ, although the direction of the difference depends on the issue (on half the items minority ethnic nurses were more positive, on the other half they were less positive). Minority ethnic nurses are more dissatisfied with bullying and harassment, job security and opportunities to progress
- these differences aside, there is general consensus about the aspects of their working lives that nurses are most and least satisfied with
- workload and pay are the issues the majority of respondents are dissatisfied with regardless of their background, while quality of care, relationships with colleagues and enthusiasm for the job are viewed positively across the board
- just 7% of NHS nurses feel they are paid well in relation to other professional groups. Pay is the most frequently cited improvement that nurses indicate would make them feel more valued

- one in ten nurses plan to leave nursing in the next two years and 34% (36% in the NHS) would leave nursing if they could
- desire to leave nursing is related to many factors, in particular perceptions that work is valued. Just 34% of those who would leave nursing if they could feel their work is valued compared with 68% of those who do not want to leave nursing
- apart from improved pay levels (cited by 42%), nurses would like to see improvements to the way they are managed to help them feel more valued (29%). A third (32%) referred to a desire for greater appreciation of nurses' roles and respect for the work they do, particularly from employers. One in five nurses refer to improved staffing.

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