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Executive Summary

Findings from the RCN Employment Survey 2017 reveal a picture of a nursing workforce under severe pressure, which has, in many respects, got worse in recent years. Now, more than ever, it is evident that nursing staff feel over-worked, underpaid and often have to grapple with short-staffing, abuse and low morale in their workplace. This is taking a personal toll on a number of staff, with many experiencing poor health and financial struggles. It is also taking a toll on patient care; most staff do not feel able to provide the level of care that they would like and many are either looking to leave their current job or leave the profession altogether.

Key findings are summarised below. Across almost all of these findings, nursing staff working in mental health, nursing homes, and community and district nursing report worse experiences than others, highlighting how pronounced workforce pressures are for frontline staff in particularly overstretched areas of the health and social care system.

1. Nursing staff feel overworked, underpaid and unable to provide the level of care they would like, driving overall dissatisfaction with their role:

- Most (63%) nursing staff feel that they are too busy to provide the level of care they would like and the same percentage feel that they are under too much pressure at work.
- Seventy-one per cent work additional hours at least once a week but only half are paid for these hours.
- Over half (61%) now think that their pay band/grade is inappropriate, significantly up from recent years, with particularly low satisfaction scores in the NHS among nurses in Band 5.
- Dissatisfaction with pay band/grade is closely related to the sense that pay does not match the level of responsibility, the duties or the intensity of the job.

2. Growing work pressures are closely associated with short-staffing and compromised patient care:

- Eight in ten nurses (79%) feel that staffing levels at their place of work are insufficient to meet patient needs.
- Three-quarters (77%) feel that patient care is compromised several times a month or more because of short-staffing.

3. All nursing staff feel financially worse off but financial struggles are most pronounced among lower-paid nurses in the NHS

- The majority of nursing staff (75%) feel financially worse off than they did five years ago. In the NHS, this is more notable in Bands 6 and 7, implying a more widespread effect of the public sector pay cap, which has been in place since 2010.[1]
- Almost three-quarters (74%) of nurses in Bands 1-4 report financial struggle. Over the past year, 33 per cent of staff in Bands 1-4 report struggling to pay utility bills, 22 per cent report missing or defaulting on mortgage or rent payments and 64 per cent report cutting back on food or travel.

4. High levels of sickness, abuse, bullying and harassment characterise many workplaces

- Just under half (49%) of nursing staff say that they have gone to work when unwell at least twice in the past year. Stress and mental health issues account for a significant proportion of health problems.
- Over a quarter of nurses (27%) have experienced physical abuse from patients, service users or relatives in the last 12 months, and 68 per cent have experienced verbal abuse from the same groups.
- One in three nursing staff (31%) say that they have experienced bullying or harassment from colleagues in the last 12 months, with Black African/Caribbean and disabled nursing staff more likely to report this than other staff.

5. Poor morale and developmental opportunities mean that increasing numbers of staff are questioning their career in nursing

- Nursing staff are less likely to recommend nursing as a career than at any point in the last 10 years. Just 41 per cent say they would recommend nursing as a career.
- Over half (54%) of nursing staff feel they do not have opportunities to progress in their current job. Among registered nurses, those who first qualified outside of the UK are almost twice as likely as UK-qualified nurses to express uncertainty about their opportunities to progress, suggesting that ongoing uncertainty[2] about the status of EU nationals, post-Brexit, may be having a negative impact.
- More than a third (37%) of nursing staff are seeking a new job.

[1] Public sector pay was frozen in 2010 and in 2013 was capped at one per cent. In September 2017, the public sector cap was lifted in England and Wales for police officers and prison officers but remains in place for other public sector workers, including nurses. In the Autumn Budget 2017, the Government pledged a pay rise for nursing staff but this was said to be dependent on the outcome of ongoing talks with the sector regarding pay reform.

[2] At the time of writing.

1 Introduction

There are seven years till I can take early retirement at 55, then I will leave nursing and get a little job working in a supermarket. The pay, terms and conditions of working 12 hour shifts eventually wear you down and demoralise you. This is not what I came into nursing for. I really feel for the patients, but feel I have nothing else to give. We have two generations of nurses in our family, but I am so glad my daughter has not followed in my profession.

Band 5 staff nurse, North West England.

The profile of the nursing workforce has changed enormously in the last 30 years, both in demographic and employment terms. This has brought about unprecedented challenges for the health and social care system which workforce planners have failed to adequately address, and which have now brought the nursing workforce to something of a crisis. The workforce is ageing, with one in three nurses are due to retire in the next ten years, and this poses a huge replacement challenge not just in terms of numbers but also in terms of experience.[3] Retention continues to be an issue, with more nurses now leaving the Nursing and Midwifery Council (NMC) register than joining. Stress, burnout and a lack of 'sufficient incentive and opportunity'[4], such as the restraint on nurses pay which has been in place since 2010, partly explain why retention continues to be a challenge. There also continues to be a lack of long-term workforce planning which has resulted in nursing shortages and increasing pressure on frontline staff.

To this picture, this report adds important evidence on the impact of these pressures on nursing staff and patient care. It points to a nursing workforce under increasing and unrelenting pressure, often working against the odds to put patient care first. Our findings reveal that most nursing staff (71%) work additional hours at least once a week, but only half of those are paid for those hours. Related to this, 63 per cent of nursing staff feel that they are too busy to provide the level of care that they would like, while a staggering 79 per cent feel that staffing levels are insufficient to meet patient needs. Work pressures often spill over into home life, with just 34 per cent of nursing staff satisfied with their work-life balance and many stressing the 'all consuming' nature of the role in their responses.

[3] Marangozov R, Williams M and Buchan J (2016), *The Labour Market for Nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS,* Institute for Employment Studies. Available at: http://www.employment-studies.co.uk/resource/labour-market-nurses-uk-and-its-relationship-demand-and-supply-international-nurses-nhs

[4] MAC (2016), 'Migration advisory committee recommends limited retention of nurses on shortage occupation list', news release, Migration Advisory Committee. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510626/MAC_press_release_on_nurses_report.pdf

Unprecedented pressures at work are compounded by the ongoing restraint on nurses' pay. Sixty-one per cent of respondents from the NHS, wider public and independent sector now think their pay band is inappropriate, largely driven by a sense that it no longer matches the responsibilities or intensity of the role. The pay restraint, which has been in place since 2010, is also resulting in widespread financial struggles among lower-paid nurses in the NHS: 74 per cent of nurses in Bands 1-4 and 67 per cent of nurses in Band 5 say that they have experienced financial struggle in the past year. These struggles are particularly pronounced among the lowest paid nurses; among nurses in Bands 1-4, 33 per cent report struggling to pay utility bills, 22 per cent report missing or defaulting on mortgage or rent payments and 64 per cent report cutting back on food or travel over the past year.

Growing work pressures for nursing staff feature against a backdrop of abuse, bullying and harassment in the workplace. Sixty-eight per cent have experienced verbal abuse from patients, service users or relatives in the last 12 months, while over one-third of staff say that they have experienced bullying or harassment from colleagues in the last 12 months. Black African/Caribbean and disabled nursing staff are more likely to report bullying or harassment from colleagues than other staff, but in all cases, much of the abuse goes unreported because nursing staff do not think it is serious enough or because they do not think anything will be done about it.

Growing workplace pressures are resulting in high levels of reported sickness, stress and burnout among staff, with 49 per cent of nursing staff saying that they have gone to work while unwell at least twice over the past year. They are also resulting in low levels of morale and motivation, with nursing staff now less likely to recommend nursing as a career than at any point in the last 10 years and 37 per cent reporting that they are looking for a new job.

Across almost all of these findings, nursing staff working in mental health, nursing homes, and community and district nursing report worse experiences than others, highlighting how particular staff are being stretched to their limit, as demand outstrips current capacity.

Challenges over funding and ever-increasing demand for healthcare services are well-publicised, but beyond the headlines, it is the voices from the frontline that articulate how these pressures are affecting nursing staff and the people they care for. This report does more than simply set out the findings of the RCN Employment Survey 2017; it also reveals the personal and financial costs of a career in modern-day nursing. These are costs which many nursing staff judge to be too high, not just in terms of inadequate pay, increasing workload pressures, and declining levels of their own health, but also in terms of compromised levels of patient care – the very thing that motivated them to take up a career in nursing in the first place.

Nursing staff who 'have nothing left to give' are unable to provide the level of care they would like, and the level of care that patients deserve. Both nurses and patients deserve a workforce that is appropriately staffed, qualified and sufficiently motivated to pursue careers in nursing. For these reasons alone, policymakers and workforce planners will need to proactively address the issues raised by this survey.

2 About this report

This report presents the findings of the Royal College of Nursing (RCN) Employment Survey 2017. The survey was carried out by the Institute for Employment Studies (IES) and Employment Research Ltd (ERL) on behalf of the RCN.

The nursing workforce in 2017 is under a number of pressures, both from the demand side but also the supply side. A brief summary of these issues is provided in Appendix A.

The survey was conducted online and achieved 7,720 usable responses. The respondent profile was sufficiently similar to the RCN membership that it can be said to be representative of the membership as a whole. A full profile of respondents is provided in Appendix B.

Survey questions were structured around five key areas, which also serve as a structure for this report:

- Chapter 3: Staffing Levels and Workload
- Chapter 4: Abuse, Harassment and Bullying
- Chapter 5: Pay and Grading
- Chapter 6: Income and Additional Work/Hours
- Chapter 7: Career Satisfaction, Development and Progression.

More details about the survey methods are detailed in Appendix C and D.

Over the years, some survey questions have remained consistent; others have not. Where questions can be compared across recent years' surveys (2015 and 2011), we have presented this analysis. In a few cases – for example, views about nursing as a career – we can draw comparisons from the 2007 survey to give a longer-term perspective on trends. In other cases – for example the new questions in 2017 around bullying, harassment and abuse – there are no comparisons because these questions were not asked before. This means that, inevitably, there is a lack of consistency in the presentation of the comparative data across years; this cannot be helped and is an issue which extends beyond the scope of the 2017 Employment Survey. However, the research team felt it more important to include comparisons across the years where data allowed, even if inconsistent, rather than exclude them because they lend more perspective to the survey findings than stand-alone results.

Throughout the report, we use the term 'nursing staff' to refer to the variety of different nursing roles that are represented among the respondents and the RCN membership, more generally. Where the findings relate to registered nurses only (for example, on pay bands in the NHS), we use the term 'nurses'.

3 Staffing Levels and Workload

This chapter presents the survey data on staffing levels and workload with regard to the nursing workforce. Overall, the picture is one of a workforce under severe pressure, which has got worse over recent years. Most nurses feel that they are under too much pressure with 90 per cent saying that they work through their breaks most of the time and 63 per cent saying that they are too busy to provide the level of care they would like. Seventy-nine per cent of nursing staff feel that staffing levels at their place of work are insufficient to meet patient needs and 77 per cent feel that patient care is compromised several times a month due to short-staffing. The combination of work pressures and insufficient staffing mean that one-third of nursing staff do not feel well equipped to do their job and that satisfaction with working hours, length of shifts and work-life balance has dropped in recent years. 'Presenteeism' is also occurring more often than in previous years, with stress and mental health issues accounting for a significant proportion of health problems. This is particularly notable among those who work additional hours, those who report financial struggles, and those from Black African/Caribbean ethnic backgrounds, highlighting how some nursing staff are burdened with multiple and mutually reinforcing pressures.

Summary of key findings:

- The majority of nursing staff (63%) feel that they are under too much pressure at work. The same percentage say that they are too busy to provide the level of care that they would like to.
- Satisfaction with working hours, length of shifts and work-life balance has dropped since 2011; just 52 per cent report feeling happy with their working hours.
- There is a strong association between sufficient staffing levels and the ability to provide adequate patient care; 79 per cent say that staffing levels at their place of work are insufficient to meet patient needs.
- Just 34 per cent feel satisfied with their work-life balance compared to 49 per cent in 2011.
- 'Presenteeism' is occurring more often than in previous years, with stress and mental health issues accounting for a significant proportion of health problems. Just under half (49%) of nursing staff say that they have gone to work when unwell at least twice in the past year.

3.1 Working hours

Working patterns in this chapter are described in the following terms:

- whether working hours are full-time, part-time, or occasional or varied

- whether work hours are fixed times or shift-based
- any experience of missing or working through scheduled breaks.

For analysis of any hours worked in addition to contracted hours, please see Chapter 6, Income, Additional Work/Hours and Financial Wellbeing.

Most nursing staff (70%) work full-time in their main job; a little over a quarter (27%) work part-time; and three per cent work occasional or varied hours (Table 3.1). The continued ageing of the workforce means that one might expect to see fewer nursing staff working full-time and more staff working part-time. However, the proportions of nursing staff working full-time and part-time has not changed substantially in recent years and wider evidence also shows no clear trends in part-time working in the nursing workforce.[5] One reason why part-time working may not have increased is because of increasing financial struggles among lower-paid nurses (see Chapter 6) and/or greater work pressures.

There have been few changes to patterns of full-time and part-time nursing staff compared to previous surveys.

Table 3.1: Main working hours

	%
Full time	70.0
Part time	27.0
Occasional/various hours	2.9
Base N =100%	7,589

Source: IES/ERL/RCN, 2017

Most nursing staff (77%) working in NHS hospital wards or NHS hospital units work full-time, whereas nursing staff in GP practices or in a hospice, charity or voluntary setting are most likely to work part-time (54 per cent and 44 per cent respectively). Unsurprisingly, nursing staff in an agency or bank work setting are most likely to work occasional or varied hours (31%). A higher proportion of BAME nursing staff than White nursing staff work full-time (79 per cent compared with 69%) – a finding that has changed little in the past 10 years and one which is in line with previous surveys. This is likely to reflect a number of possible factors, including greater financial need among some black and minority ethnic groups, potentially caused by fewer opportunities for development and career progression for BAME nursing staff[6], or other forms of disadvantage which characterise BAME communities more generally (such as greater dependence on single

[5] RCN (2016), *Unheeded Warnings: Healthcare in Crisis. The UK Nursing Labour Market Review 2016,* Royal College of Nursing. The latest RCN Review of the labour market shows that levels of part-time working fell from 2006 to 2013, from 36 per cent to 30 per cent, but then returned to 36 per cent in 2017 – RCN (2017 forthcoming), *UK Nursing Labour Market Review,* Royal College of Nursing.

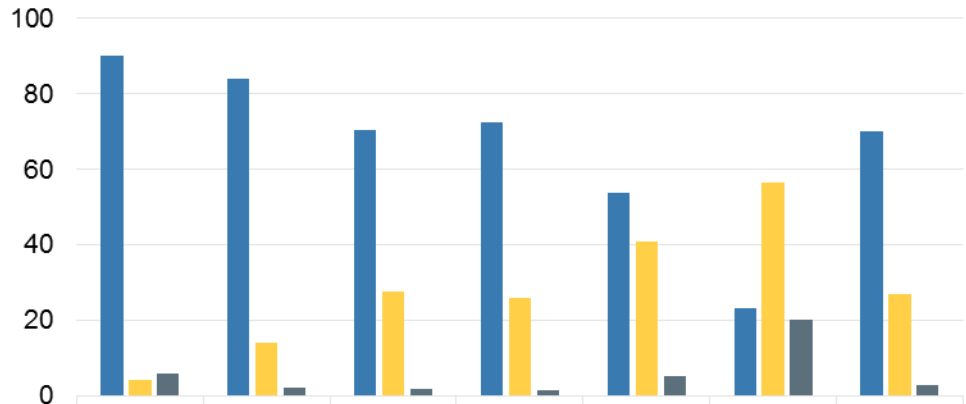
[6] West E and Nayar S (2016), *A Review of the Literature on the Experiences of Black, Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare System*, University of Greenwich.

parent incomes[7] or higher rates of poverty among BAME women compared to White British women[8]).

Part-time working is more common among female nursing staff (30%) than male nursing staff (8%), most likely reflecting greater caring responsibilities outside of work among female staff.

Perhaps unsurprisingly, given the ageing nursing workforce[9], levels of full-time working decline with age, with older nurses working fewer hours than their younger counterparts as they approach retirement and a greater proportion choosing to work part-time (Figure 3.1). Twenty per cent of those aged 65 and over work occasional and varied hours compared to less than six per cent in all other age groups.

Figure 3.1: Working patterns by age group (percentage)



	18-25	26-34	35-44	45-54	55-64	65 and over	Total
Full time	90.1	83.9	70.4	72.6	53.7	23.4	70.1
Part time	4.1	14	27.5	26	41	56.4	27
Occasional/various hours	5.8	2.1	2	1.4	5.3	20.2	2.9

Source: IES/ERL/RCN, 2017

3.2 Staffing and workload

Respondents were asked about the staffing levels in their workplace, frequency of working through breaks and how often they work when feeling unwell. These questions give an indication of the level of staffing resources and how this impacts on the day-to-day

[7] According to the Census 2011, 21 per cent of single parents are from a BAME (including those of other White origin, apart from White British), compared with 16 per cent nationally (ONS, 2013).

[8] Nandi A and Platt L (2010), *Ethnic Minority Women's Poverty and Economic Well Being*, Institute for Social and Economic Research: University of Essex.

[9] A 2016 study for the Migration Advisory Committee found that one in three nurses are due to retire in the next 10 years. Marangozov R, Matthews M and Buchan J (2016), *The Labour Market for Nurses in the UK and its Relationship to the Demand for, and Supply of, International Nurses in the NHS*, Institute for Employment Studies.

working lives of nursing staff. Overall, they provide a valuable insight into the kinds of pressures building up within the nursing workforce.

3.2.1 Experiences of short staffing are widespread

The majority of nursing staff (79%) felt that staffing levels were insufficient to meet patient needs. This is a marked increase from 2007 when 56 per cent of nursing staff agreed that there were insufficient staff to provide a good standard of care.

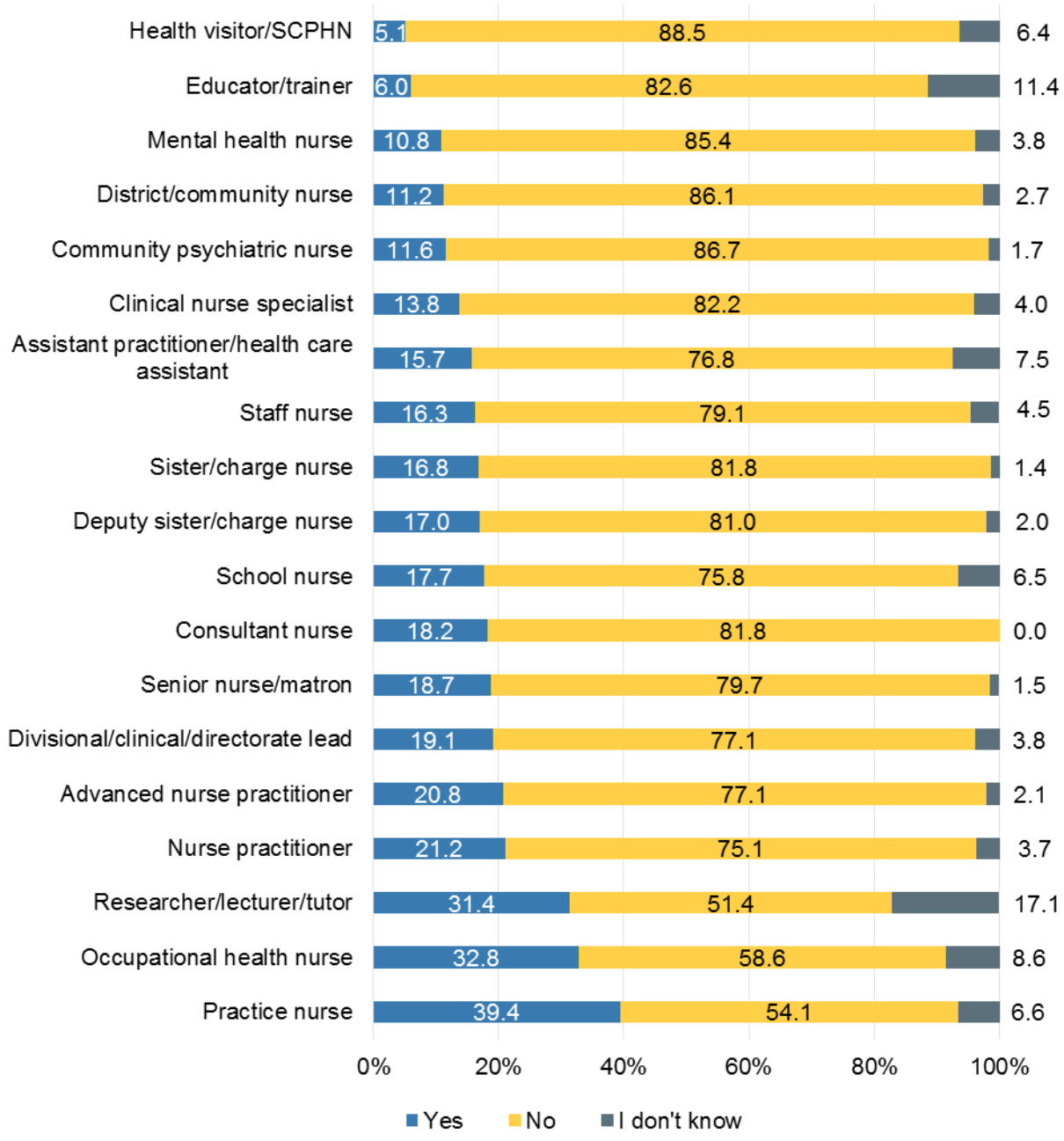
These figures were broken down by sector, area of practice and job title in order to explore those areas which may be particularly short-staffed. We also looked at any association between experiences of short-staffing and working additional hours to explore the impact of staffing levels on working patterns.

Insufficient staffing levels were most prevalent among those working in the NHS, where 83 per cent of nursing staff (excluding those in GP practices) felt staffing levels were insufficient, compared to 67 per cent of those working in the private or independent sector. Health visitors and specialist community public health nurses (89%), educator/trainers (83%), community psychiatric nurses (87%), district and community nurses (86%), mental health nurses (85%) were most likely to feel that nursing staff levels were insufficient, in comparison to other job roles (Figure 3.2). This is in line with recent evidence which has highlighted short-staffing in community and mental health nursing,[10] as well as a seven per cent drop in the numbers of mental health nurses in England since 2012.[11]

[10] RCN (2017), *Safe and Effective Staffing: Nursing Against the Odds,* Royal College of Nursing; RCN (2017 forthcoming), *The UK Nursing Labour Market Review 2017,* Royal College of Nursing.

[11] RCN (2017 forthcoming), *The UK Nursing Labour Market Review 2017,* Royal College of Nursing.

Figure 3.2: Sufficient nursing staff by job title (percentage)



Source: IES/ERL/RCN, 2017

Nursing staff who reported insufficient staffing levels at their place of work were also most likely to report working additional hours. Three-quarters (75%) of respondents who said there were not enough nursing staff in their workplace also said that they worked additional hours at least once a week, compared to 60 per cent of those who said there were sufficient numbers of staff. A nurse for 17 years commented on the additional pressure brought about by short-staffing by saying that, for the first time, she felt vulnerable because of staffing levels:

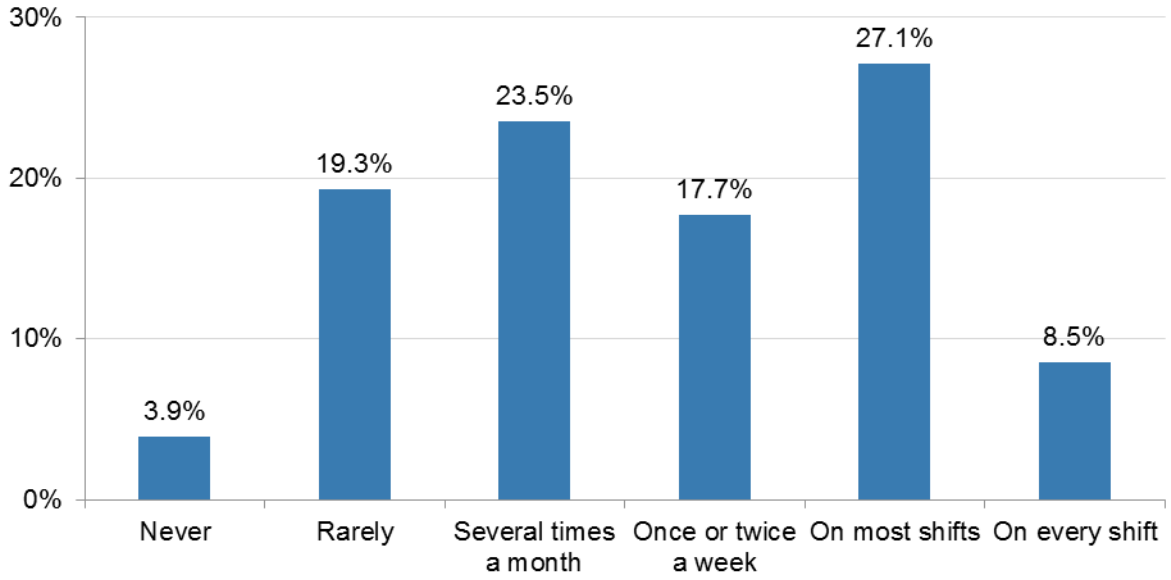
Most people are worried about their [registration] PIN all the time working under so much pressure without the right numbers of staff.

Ward Sister, South West England

3.2.2 Short-staffing is linked to poorer patient care

Staffing levels were strongly associated with the ability to provide adequate patient care. Most nursing staff (77%) felt that patient care was compromised several times a month or more because of short-staffing (Figure 3.3).

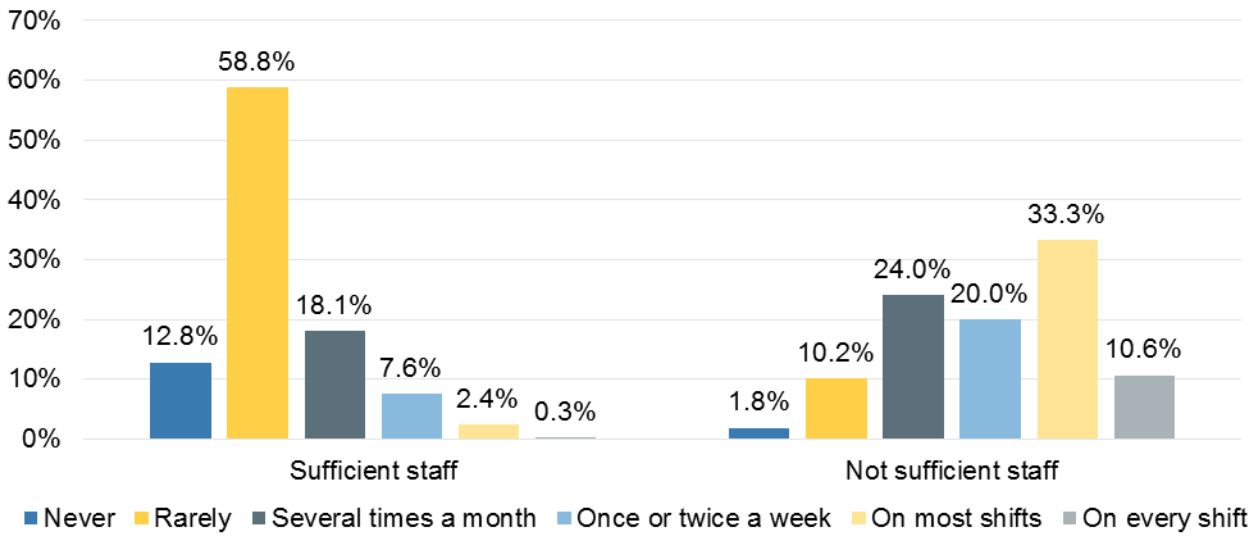
Figure 3.3: Views on how often patient care is compromised due to short-staffing (N=7,608)



Source: IES/ERLRCN; 2017

Most (72%) of those who stated that staffing levels were sufficient also reported that care was never or rarely compromised. By contrast, for those reporting insufficient staffing levels, just 12 per cent said that care was never or rarely compromised and 44 per cent stated it was compromised on most or every shift (Figure 3.4).

Figure 3.4: Sufficient staff and compromised care (N=7,582)



Source: IES/ERL/RCN, 2017

Nursing staff working in NHS hospitals were most likely to indicate that there were '*not enough staff in the workplace'* (88%) and that the '*workload is too high'* (80%). Nursing staff in GP practices (29%) and independent hospitals (31%) were more likely than nursing staff in other settings to point to a lack of necessary training.

Several nurses described the impact of short-staffing and workload pressures on patient care:

> *I leave work frustrated and worried that I have not spent enough time with people. That's hard. You can't leave every day feeling like that.*
>
> Ward Sister, South West England

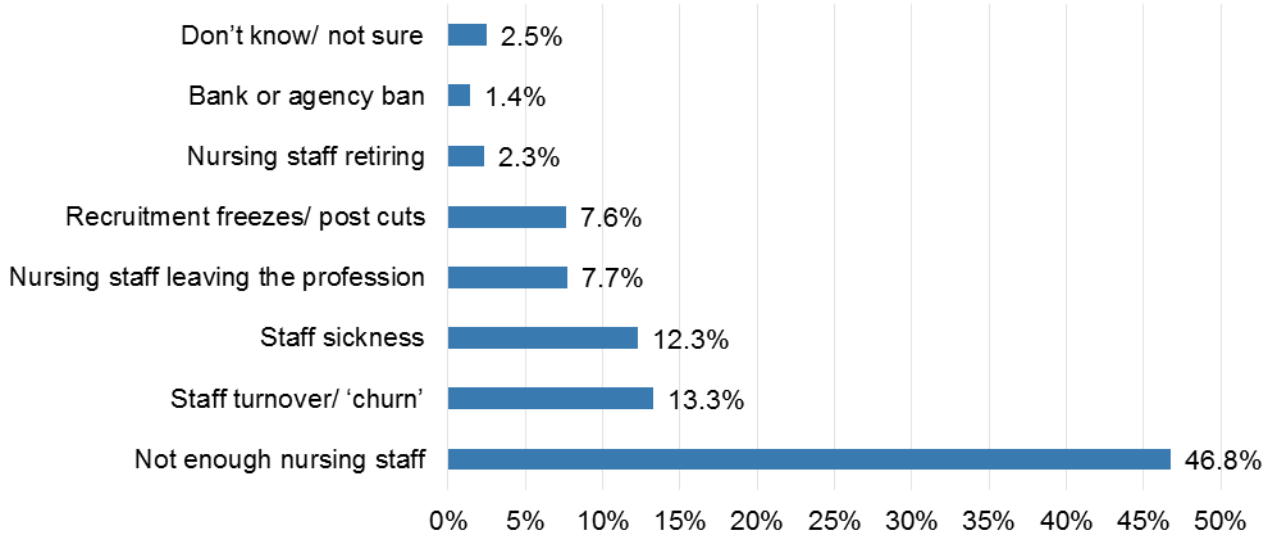
> *Now we're treating the target, not the patient. The focus is beating the clock and not necessarily looking at the patient properly.*
>
> Staff Nurse, North East England

However, the overriding reason given by nursing staff for short-staffing was 'not enough nursing staff' (47%) (Figure 3.5). Although many also attributed shortages to turnover and sickness, it was inadequate numbers of nursing staff that was seen as the key driver of shortages. These views are in line with recent evidence which found that there are nursing shortages across the UK and the care home and independent sectors are not immune.[12] It is also in line with a 2017 survey which found that 55 per cent of respondents

[12] MAC (2016), *Partial Review of the Shortage Occupation List. A Review of Nursing,* Migration Advisory Committee; Marangozov R, Matthews M and Buchan J (2016), *The Labour Market for Nurses in the UK and its Relationship to the Demand for, and Supply of, International Nurses in the NHS*, Institute for Employment Studies.

reported a shortfall of one or more registered nurses on their last shift (58 per cent for NHS providers and 25 per cent for independent providers).[13]

Figure 3.5: Views on why nursing shortages occur (N=7,608)



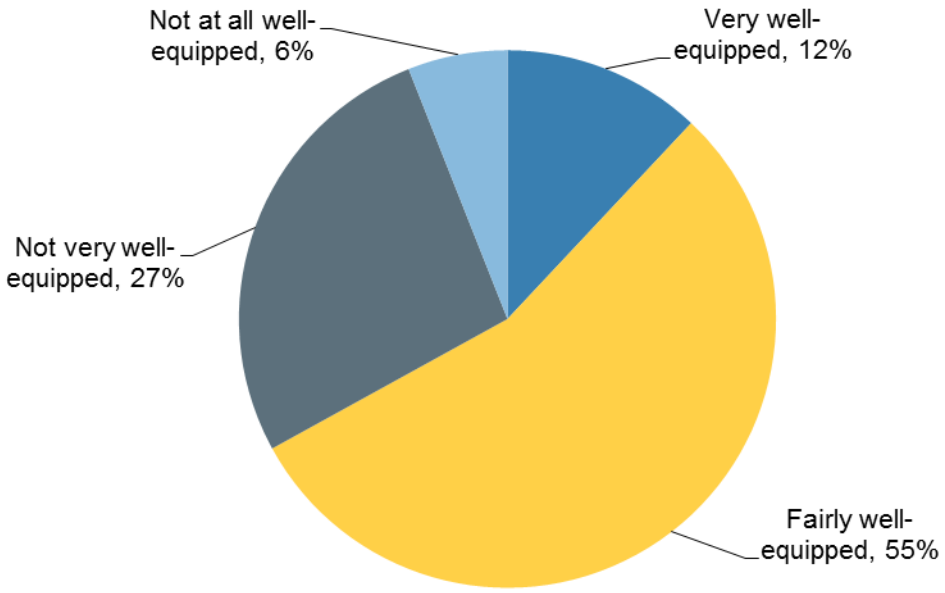
Source: IES/ERL/RCN, 2017

3.2.3 Short staffing is linked to nursing staff feeling ill-equipped in their role

Figure 3.6 shows that two-thirds of nursing staff felt at least '*fairly well-equipped'* in their role (12 per cent 'very' and 55 per cent 'fairly'). However, one-third did '*not feel very well-equipped',* with five per cent indicating that they were '*not at all well-equipped*'.

[13] RCN (2017), *Safe and Effective Staffing: Nursing Against the Odds*, Royal College of Nursing.

Figure 3.6: Feeling equipped (in terms of staffing, equipment, skills and training) in current role (2017)

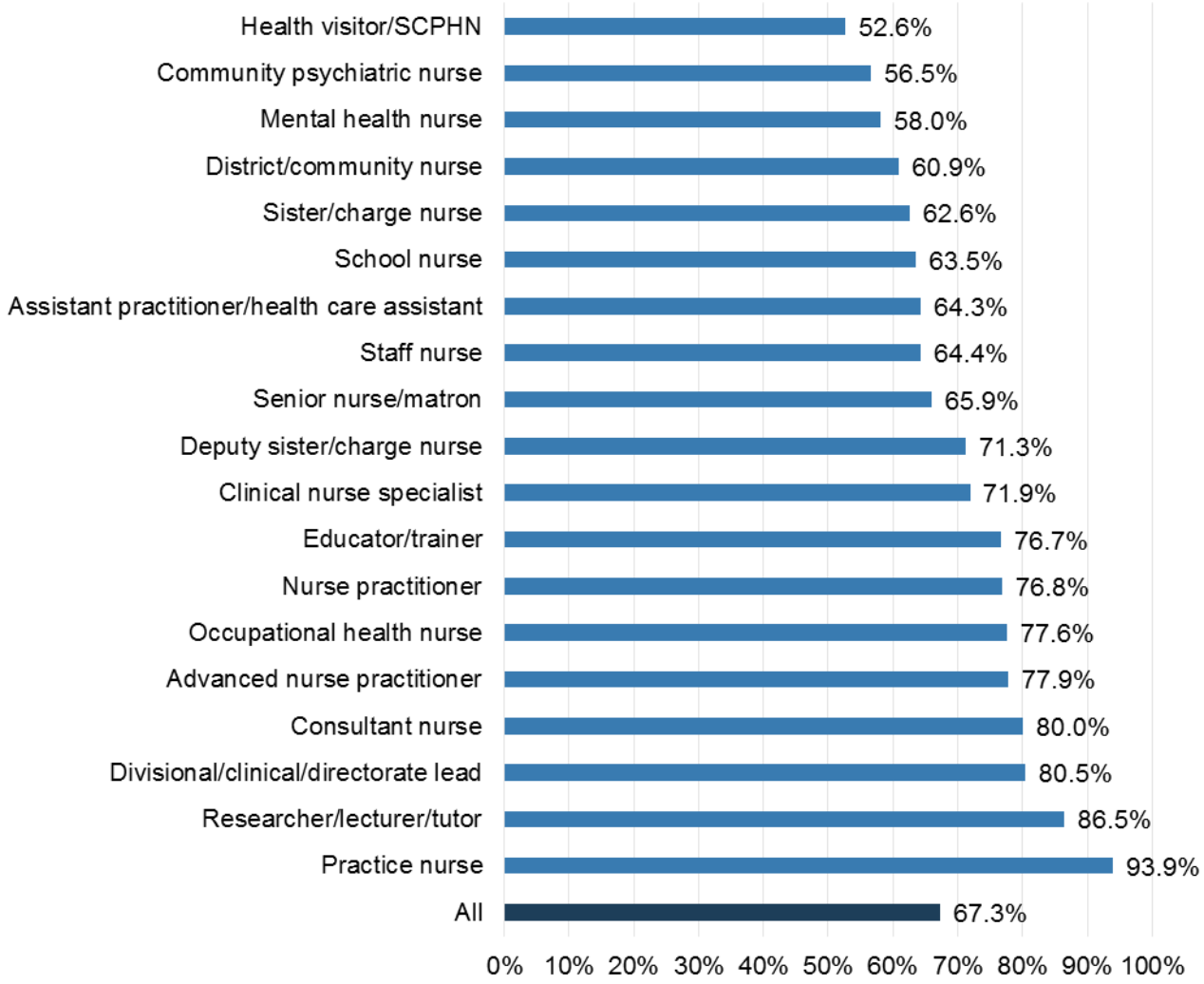


Source: IES/ERL/RCN, 2017

We explored respondents' replies to see whether there were any differences across settings, area of practice and job title. On the whole, there were few differences, with the exception of job title and sufficient staffing levels.

Figure 3.7 highlights those job titles where respondents felt '*fairly'* or *'very well-equipped'* to undertake their roles. Practice nurses fared best in this regard, with 94 per cent agreeing with the statement, followed by researchers/lecturers (87%). At the other end of the scale, just over half of health visitors (53%), community psychiatric nurses (57%) and mental health nurses (58%) stated they were fairly or very well equipped.

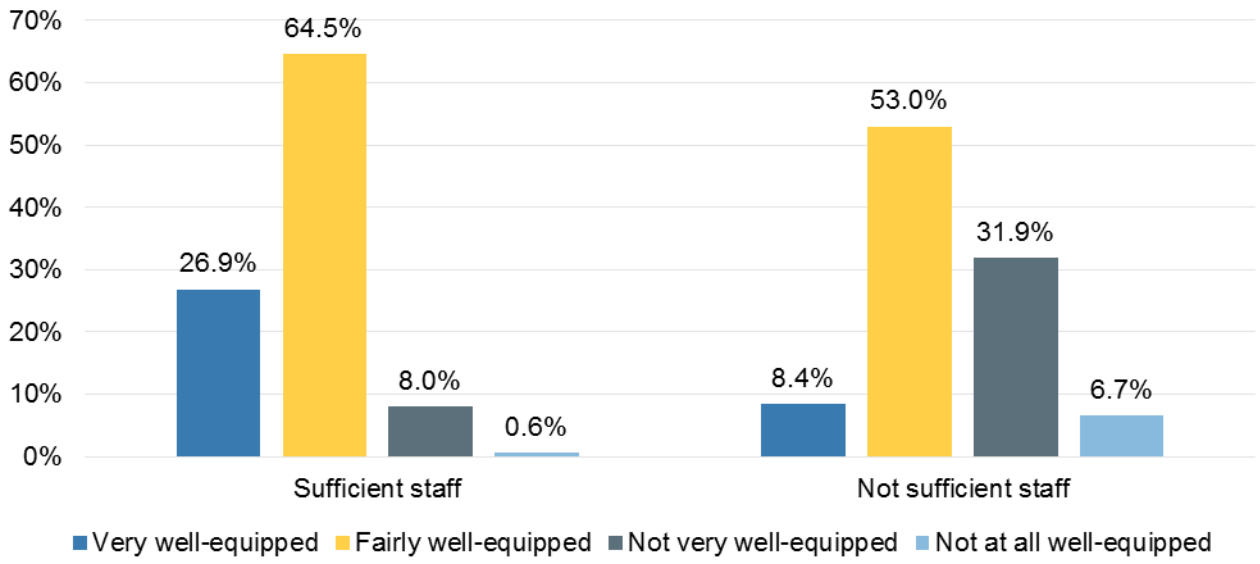
Figure 3.7: Feeling well-equipped (in terms of staffing, equipment, skills and training) in current job (by job title, 2017)



Source: IES/ERL/RCN, 2017

Our analysis also shows a close association between views on short-staffing and whether nurses felt well-equipped to carry out their role, in terms of staffing, equipment, skills and training. Where there was thought to be sufficient staffing, nursing staff were more likely to feel properly equipped to undertake their role. The majority (91%) of those who stated that their workplace had sufficient numbers of staff also said that they felt very or fairly well-equipped to do their role. By comparison, just 61 per cent of those who said there were insufficient staff said that they felt well-equipped to do their role (Figure 3.8).

Figure 3.8: Are there sufficient staff in your workplace and feeling well equipped (N=7,620)



Source: IES/ERL/RCN, 2017

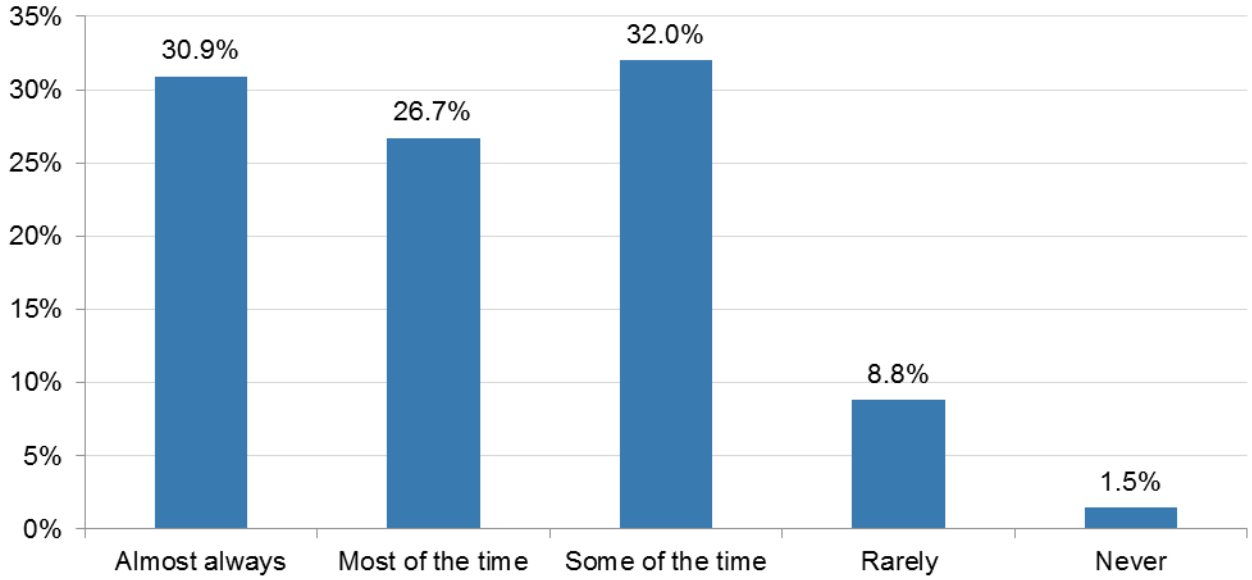
Feeling ill-equipped has a negative effect on staff morale and patient care. As one staff nurse put it:

> *Patient care is getting compromised because we don't have the right resources. Morale is low and that's because of staffing levels.*
>
> Staff Nurse, North West England

3.2.4 The majority of nurses work through their breaks

Working through breaks is an indicator of how busy nursing staff are in their working lives and the level of pressure they are working under, and to some extent has become normalised, as it occurs so frequently. The vast majority of nursing staff (90%) said that they worked through their breaks at least some of the time. One third (31%) reported that this almost always happened, 27 per cent that it happened most of the time, and 32 per cent that this occurred some of the time (Figure 3.9).

Figure 3.9: How often nursing staff worked through breaks (N=)

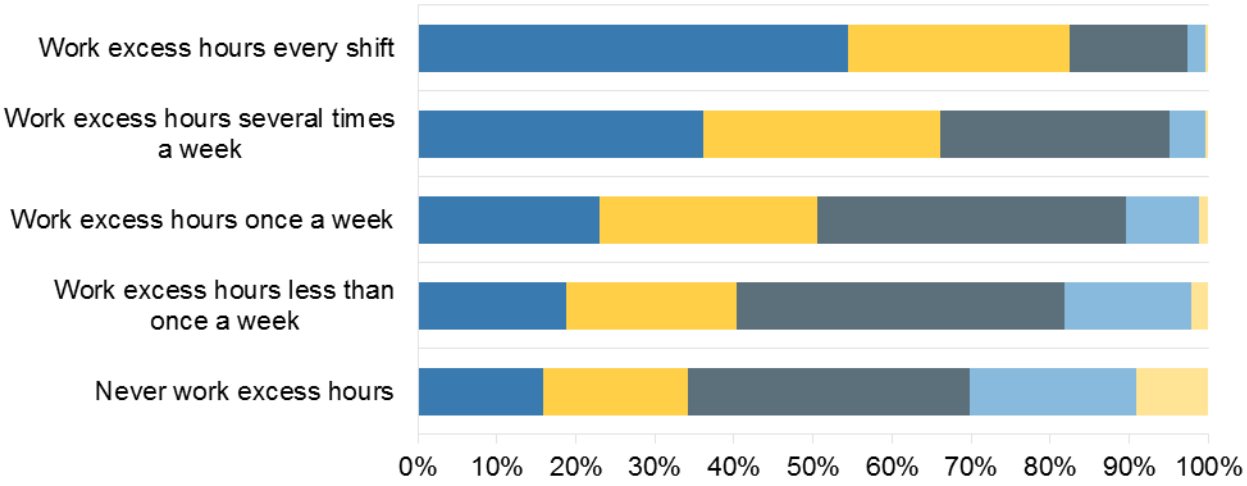


Source: IES/ERL/RCN, 2017

We explored these replies to see whether there were any differences by settings, area of practice, job title, or by whether respondents' worked additional hours (working additional hours is explored in detail in Chapter 6). On the whole, there were no differences, with the exception of area of practice and additional hours worked.

Nursing staff who always worked through breaks were also more likely to report working additional hours. Over half of those respondents who stated that they worked additional hours on every shift also said they almost always missed their breaks (Figure 3.10).

Figure 3.10: How often nursing staff work through breaks and work additional hours (N=7,632)

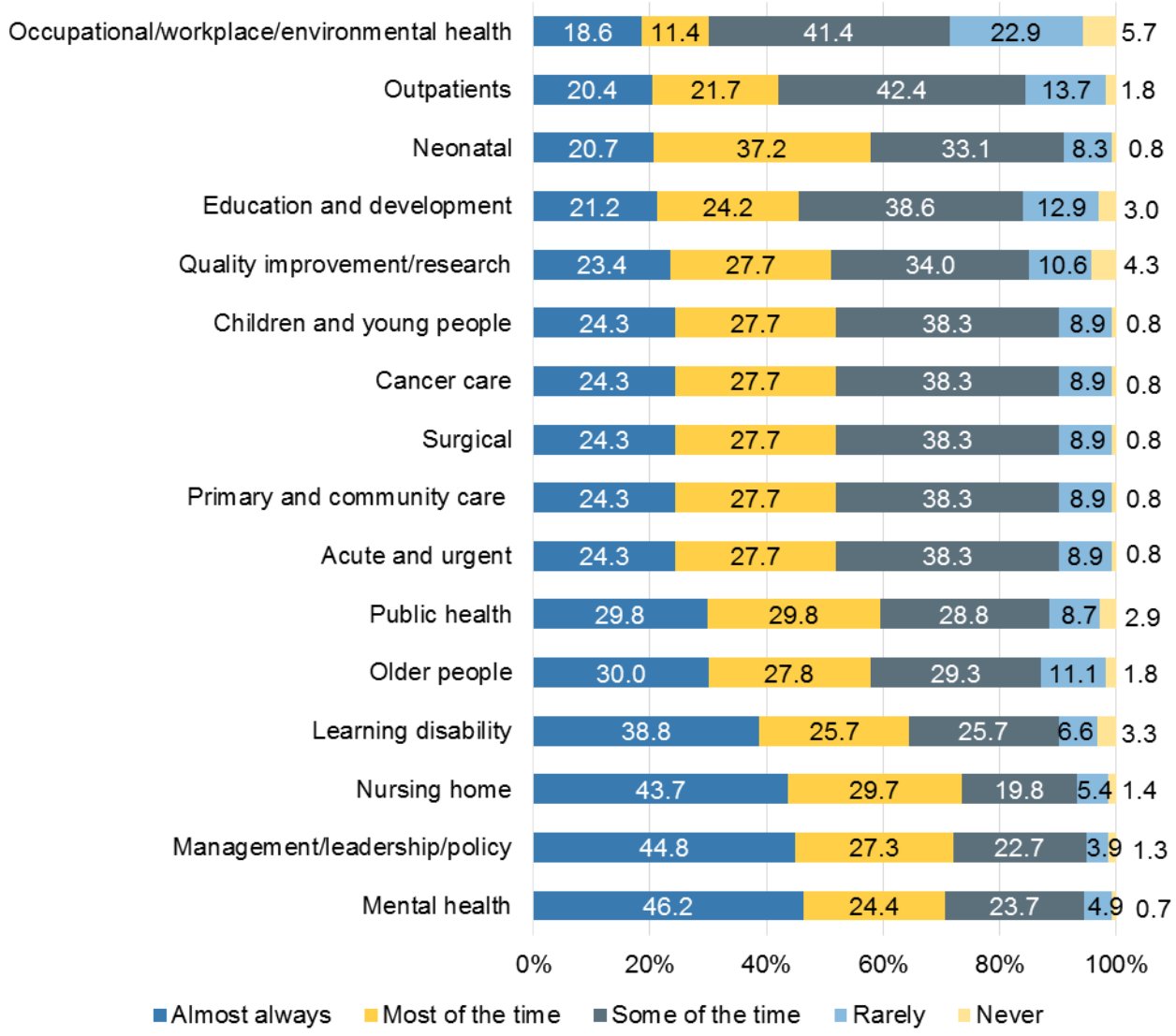


	Never work excess hours	Work excess hours less than once a week	Work excess hours once a week	Work excess hours several times a week	Work excess hours every shift
Almost always miss breaks	15.9%	18.7%	22.9%	36.1%	54.4%
Miss breaks most of the time	18.3%	21.5%	27.6%	30.0%	28.1%
Miss breaks some of the time	35.6%	41.5%	39.1%	28.9%	14.9%
Rarely miss breaks	21.2%	16.1%	9.3%	4.5%	2.1%
Never miss breaks	9.0%	2.1%	1.2%	.4%	.4%

Source: IES/ERL/RCN, 2017

We also found that nursing staff working in the fields of mental health (46%), management, leadership or policy (45%) or nursing homes (44%) were most likely to state that they always worked though breaks. Nursing staff working in the field of occupational or workplace health or in outpatient settings were least likely to miss their breaks (Figure 3.11).

Figure 3.11: How often nursing staff work through breaks by area of practice (percentage, N=7,604)

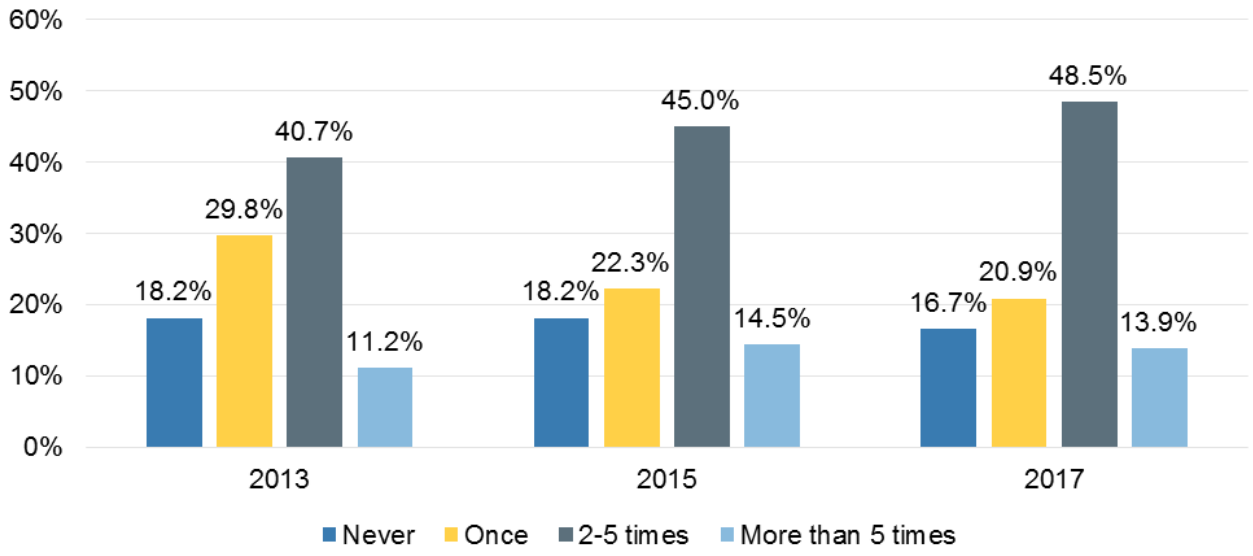


Source: IES/ERL/RCN, 2017

3.2.5 Presenteeism is more prevalent

Levels of 'presenteeism' have increased in recent years. Just under half (49%) of nursing staff said that they had gone to work when unwell at least two to five times in the past year (Figure 3.12), compared to 45 per cent who reported this in 2015 and 41 per cent in 2013.

Figure 3.12: How often nurses had gone to work despite feeling unwell



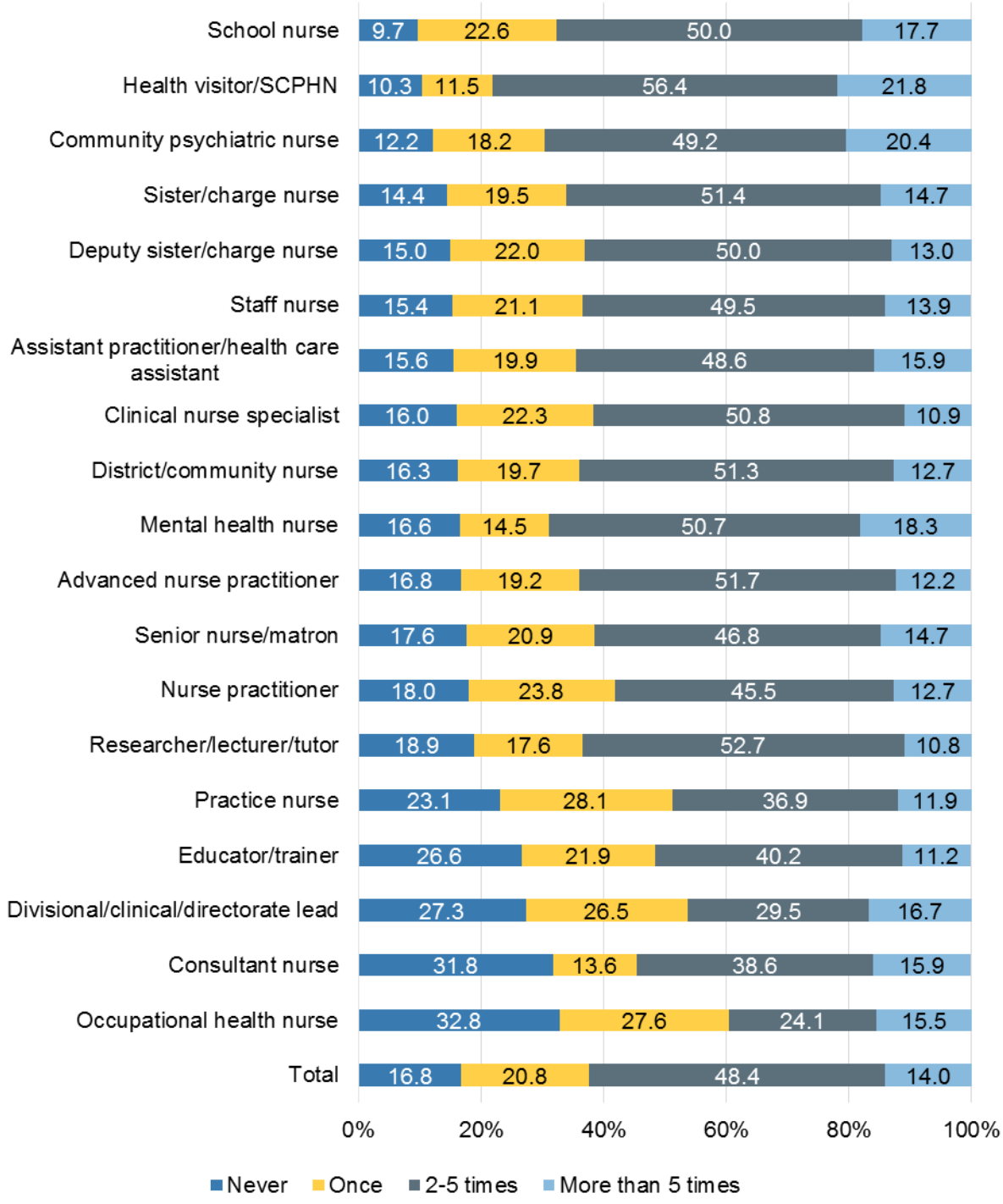
Source: IES/ERL/RCN, 2017

We explored responses by a range of different factors, such as job title and experiences of financial struggle. Where we found differences, we report these below.

Looking at levels of presenteeism according to area of practice, it is nursing staff working in mental health who are most likely to report going to work when feeling unwell two or more times in the last year: Health visitors or SCPHN nurses (78%), community psychiatric nurses (70%) and mental health nurses (69%) were the most likely to report this (Figure 3.13). This may reflect the particularly high pressures that mental health services are under and the shortage of mental health nurses in many NHS trusts and boards at the time of writing; for example, recent evidence shows that there has been a seven per cent drop in the numbers of mental health nurses in England since 2012.[14]

[14] RCN (2017 forthcoming), *The UK Nursing Labour Market Review 2017,* Royal College of Nursing.

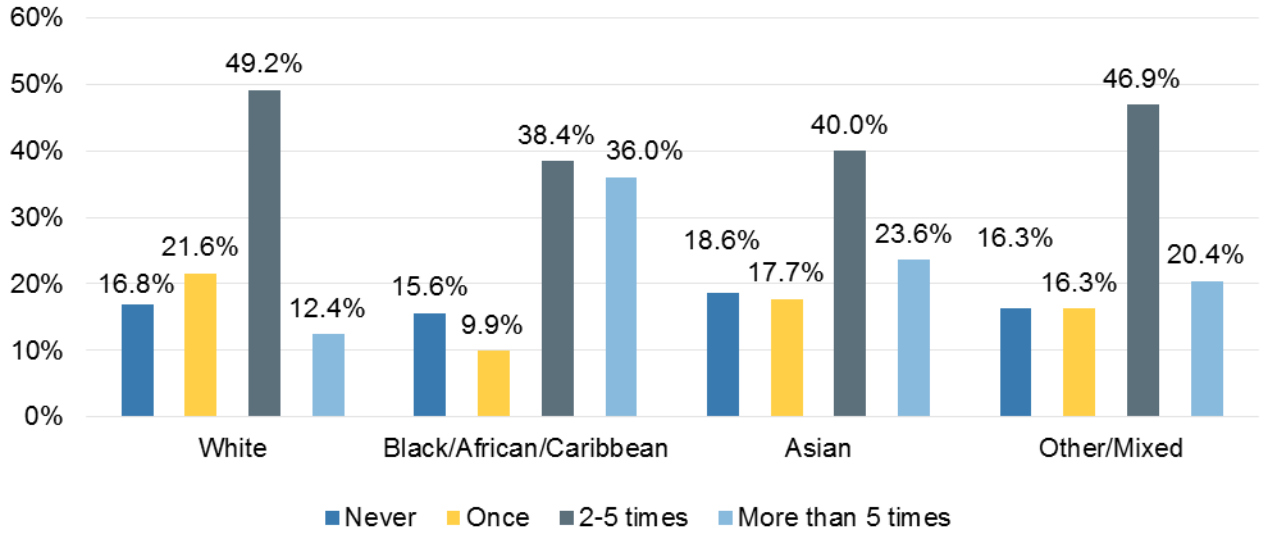
Figure 3.13: How often nurses have gone to work despite feeling unwell by job title (percentage)



Source: IES/ERL/RCN, 2017

Some groups reported particularly high levels of presenteeism. Black African/Caribbean nursing staff were much more likely to have gone to work when feeling unwell more than five times (36%), compared with White nursing staff (12%), mixed or other ethnicity (20%), or Asian respondents (24%) (Figure 3.14).

Figure 3.14: How often nurses have gone into work despite feeling unwell by ethnicity



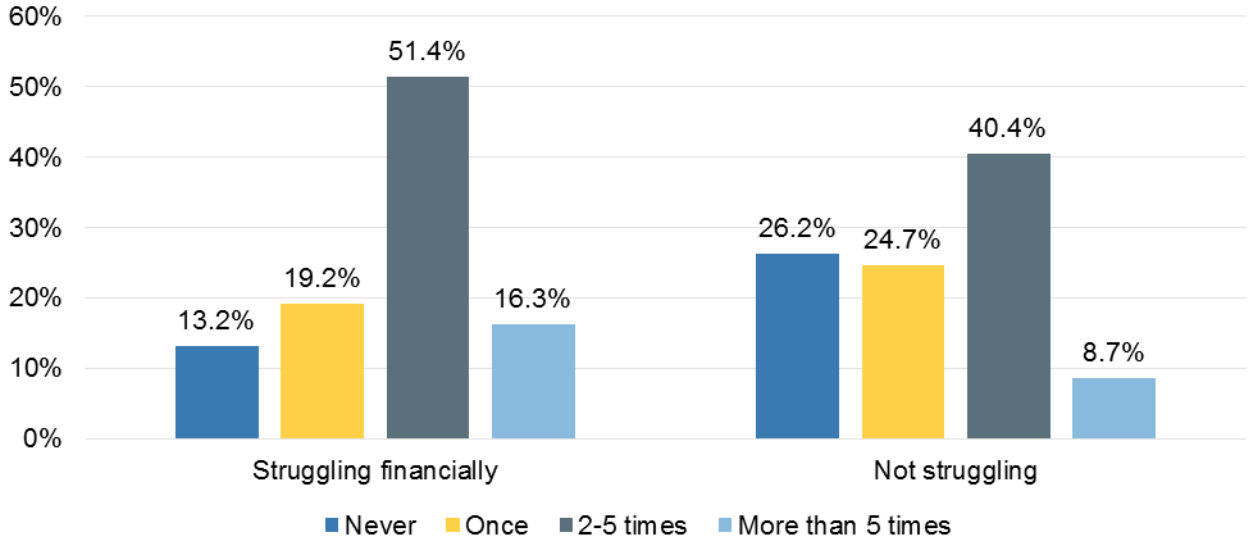
Source: IES/ERL/RCN, 2017

Nursing staff with disabilities were almost twice as likely to have gone to work ill more than five times (24%), compared with nursing staff who did not have a disability (13%).

Older nursing staff were less likely to report going to work when unwell than younger staff, with 21 per cent of 55-64 year olds and 41 per cent of those aged 65 or over never having done so, compared to 13 per cent of 18-25 and 14 per cent of 26-34 year olds.

We also see a strong association between levels of presenteeism and (1) working additional hours and (2) levels of financial security. These pressures are likely to be mutually reinforcing: staff experiencing financial or work pressures are more likely to work additional hours and fall ill. Eighty-seven per cent of those who had reported struggling financially had come to work in the past year despite feeling ill at least once, compared with 74 per cent of those who had not reported struggling (Figure 3.15).

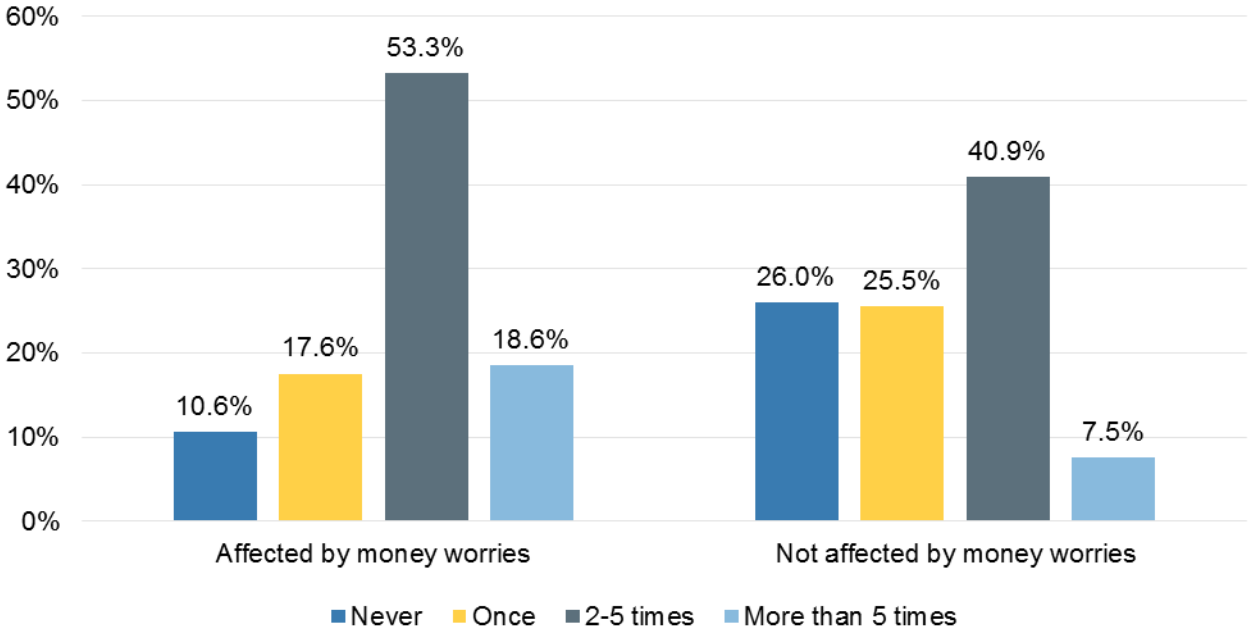
Figure 3.15: How often nurses have gone into work despite feeling unwell by whether experienced financial struggle (N=7,538)



Source: IES/ERL/RCN, 2017

Similarly, nine in ten (90%) nurses who reported being affected by money worries (by, for example, losing sleep) had come to work in the past year despite feeling ill, compared with 74 per cent of those who had not been affected by money worries (Figure 3.16).

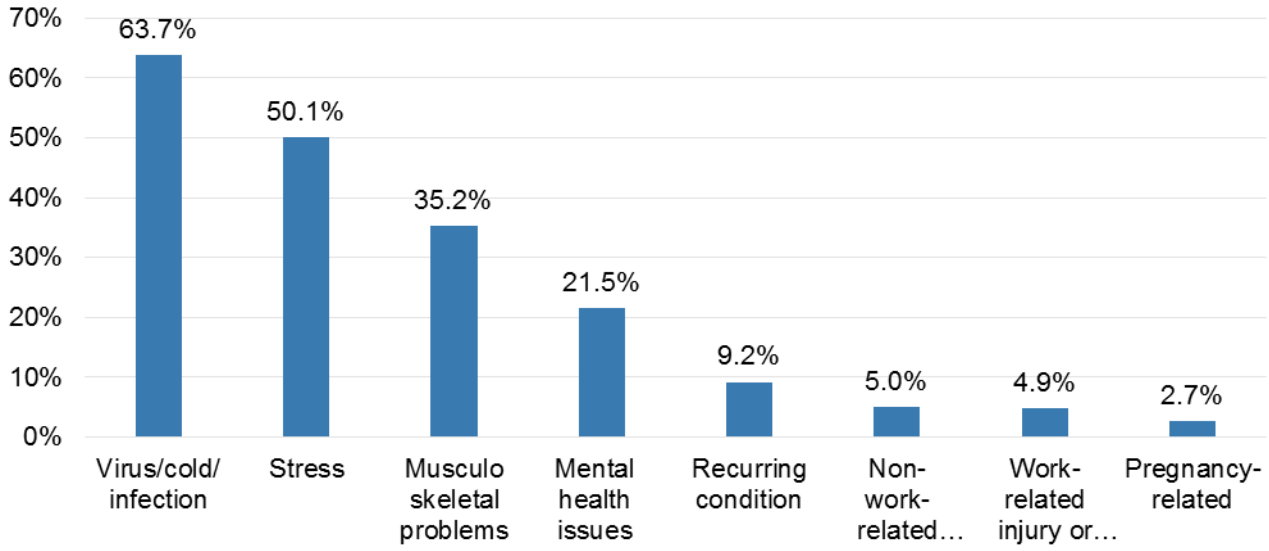
Figure 3.16: How often nurses have gone to work despite feeling unwell by whether been affected by money worries



Source: IES/ERL/RCN, 2017

The main reason cited for nursing staff having worked when not feeling well enough to do so was having a virus, cold or infection (64%) followed by stress (50%) and musculoskeletal problems (35%). It is notable that stress (50%) and mental health issues (22%) account for a high proportion of health problems (Figure 3.17).

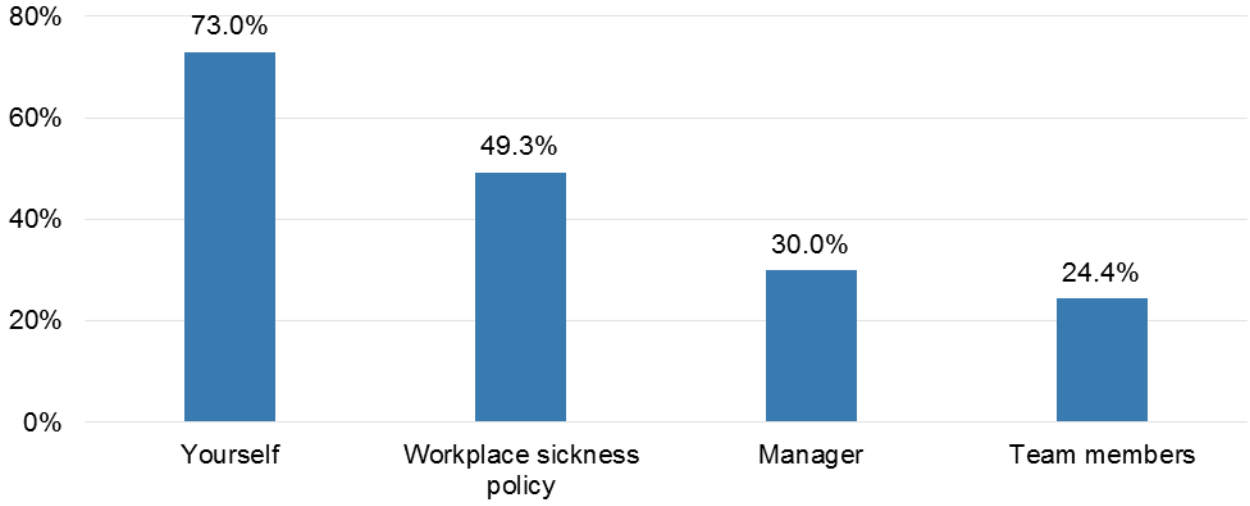
Figure 3.17: Reasons for working when unwell (N=6,348)



Source: IES/ERL/RCN, 2017

Among those nursing staff who stated that they had worked despite not feeling well enough to do so, three-quarters (73%) said they felt the pressure came from themselves to attend work, while just under half said the pressure came from the workplace sickness policy (Figure 3.18).

Figure 3.18: Source of pressure to work when unwell



Source: IES/ERL/RCN, 2017

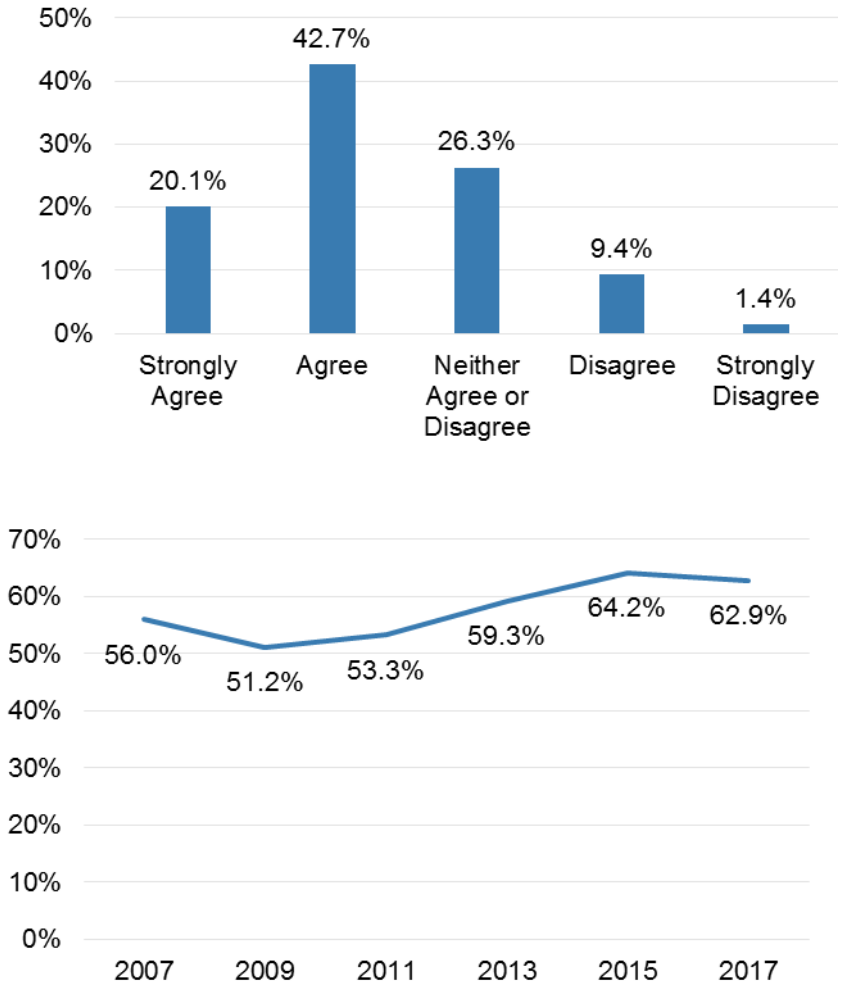
3.3 Overall job satisfaction has declined in recent years

The levels of staffing and workload described above are having a clear impact on overall views of working life and work-life balance among nursing staff.

3.3.1 Nursing staff feel pressurised at work and unhappy with working hours and shifts

Almost two-thirds (63%) of all respondents stated that they felt under too much pressure at work, with just 11 per cent disagreeing. The proportion reporting that they felt under too much pressure has risen from 53 per cent in 2011 (Figure 3.19).

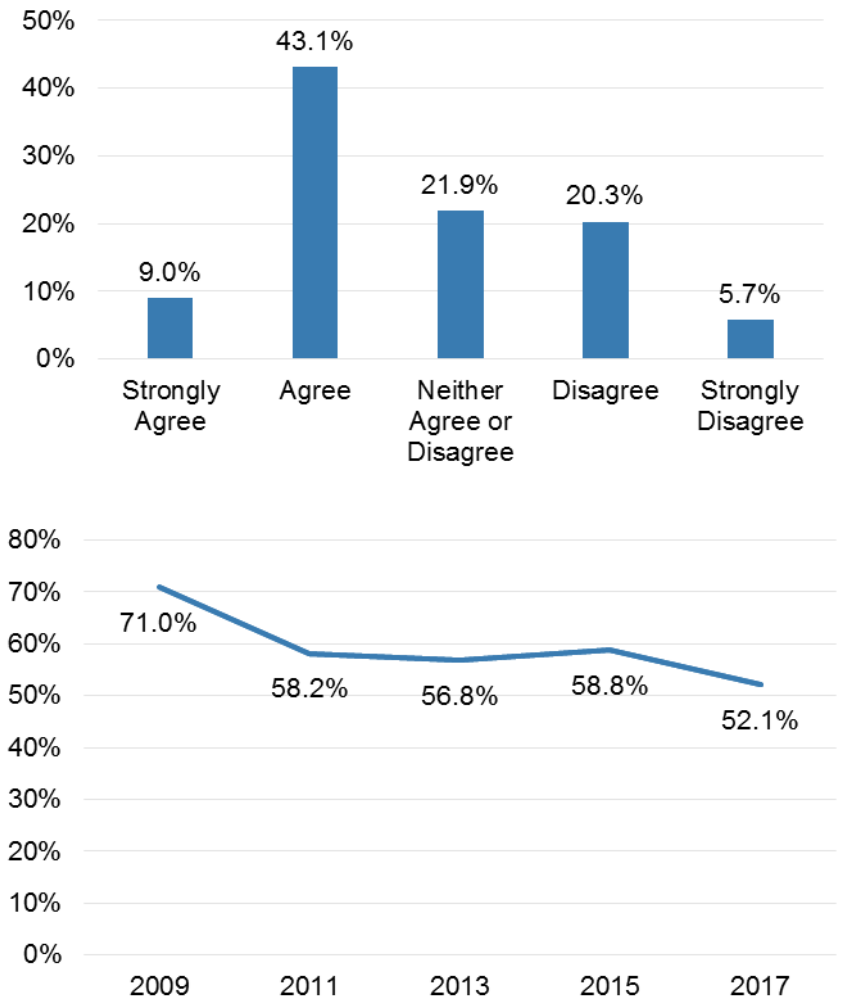
Figure 3.19: 'I feel I am under too much pressure at work' (N=7,595)



Source: IES/ERL/RCN, 2017

While just over half (52%) reported feeling happy with their working hours, this has dropped from 58 per cent in 2011 and 59 per cent in 2015 (Figure 3.20).

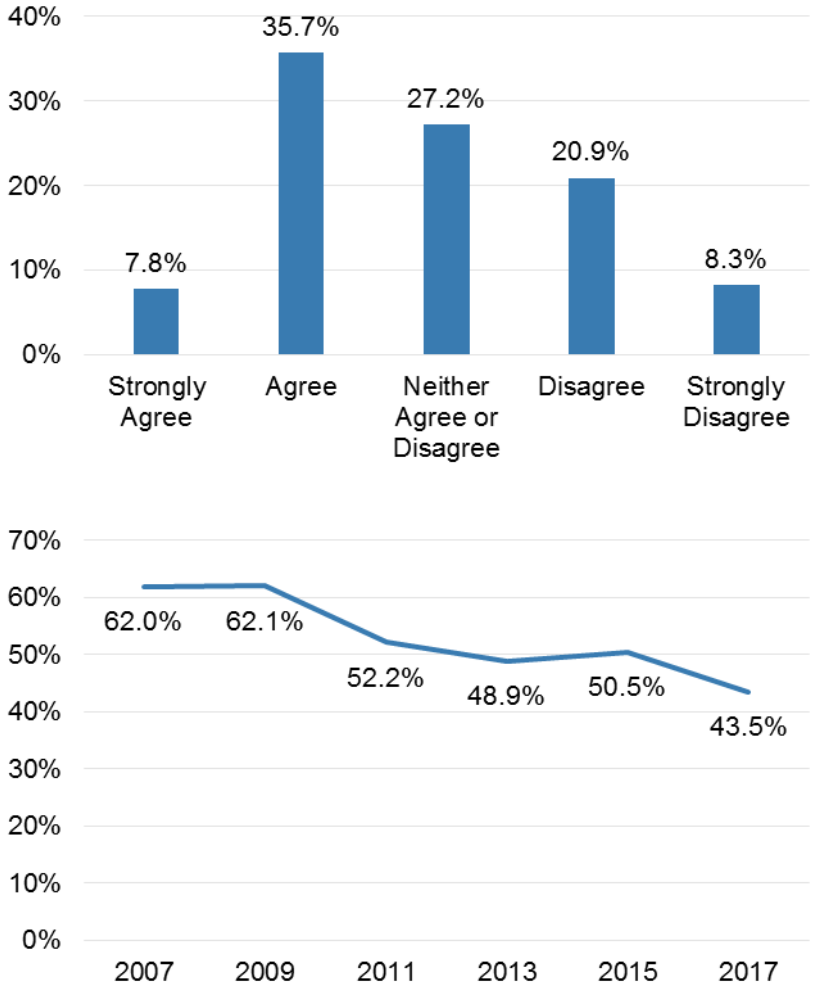
Figure 3.20: 'I am happy with my working hours' (N=7,580)



Source: IES/ERL/RCN, 2017

There has also been a drop in the proportion of nursing staff who are happy with the choice they have over their length of shifts. Just 44 per cent of respondents agreed that they were satisfied with the choice they had over length of shifts compared to 52 per cent in 2011. This year, just under a third (29%) disagreed with the statement (Figure 3.21).

Figure 3.21: 'I am satisfied with the choice I have over the length of shifts I work' (N=7,576)

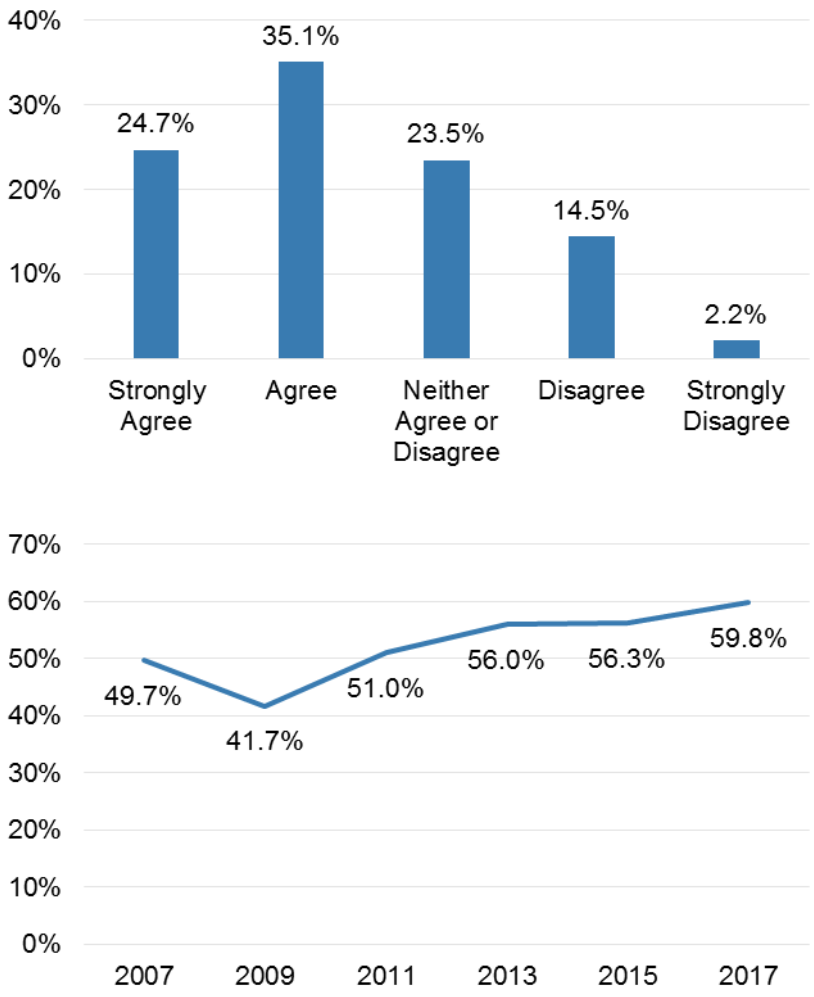


Source: IES/ERL/RCN, 2017

3.3.2 Most nurses are too busy to provide the care they would like

A large proportion (60%) of respondents agreed with the statement that *'too much of my time is spent on non-nursing duties'* with just 17 per cent disagreeing with the statement. The proportion of nursing staff who believe they spent too much time away from nursing care has increased from 51 per cent in 2011 (Figure 3.22).

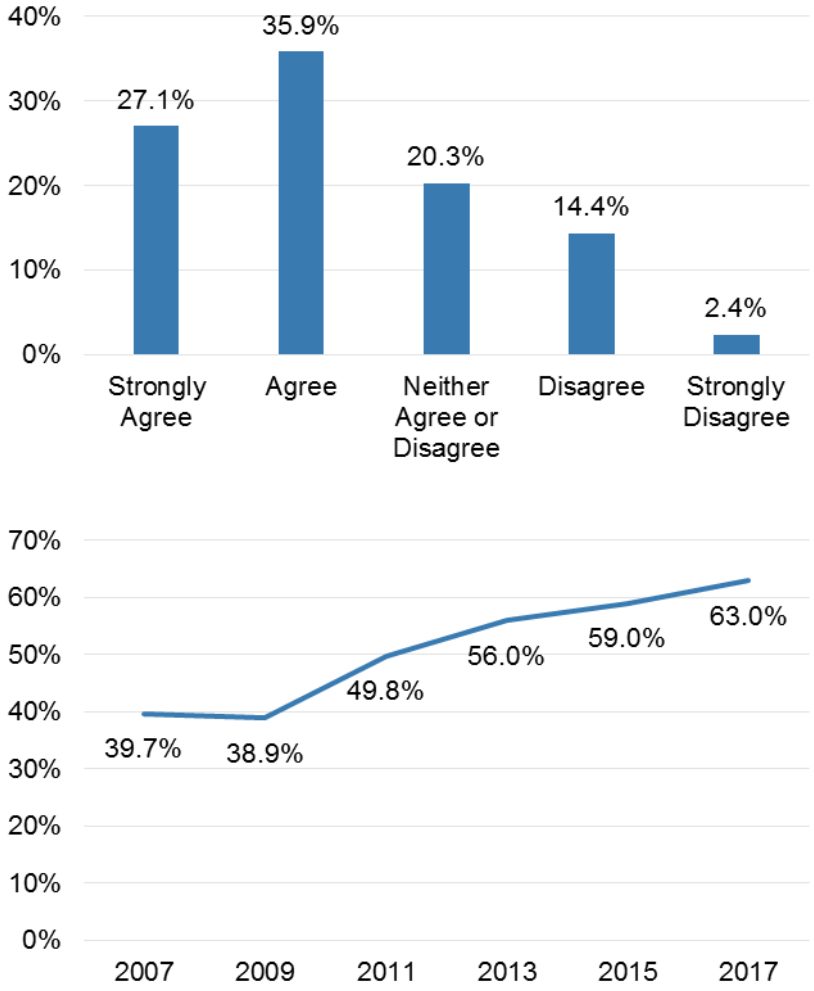
Figure 3.22: 'Too much of my time is spent on non-nursing duties' (N=7,576)



Source: IES/ERL/RCN, 2017

In 2011, half of all nursing staff agreed with the statement *'I am too busy to provide the level of care I would like'*. This has now risen to 63 per cent in 2017, with just 17 per cent disagreeing (Figure 3.23).

Figure 3.23: 'I am too busy to provide the level of care I would like' (N=7,561)

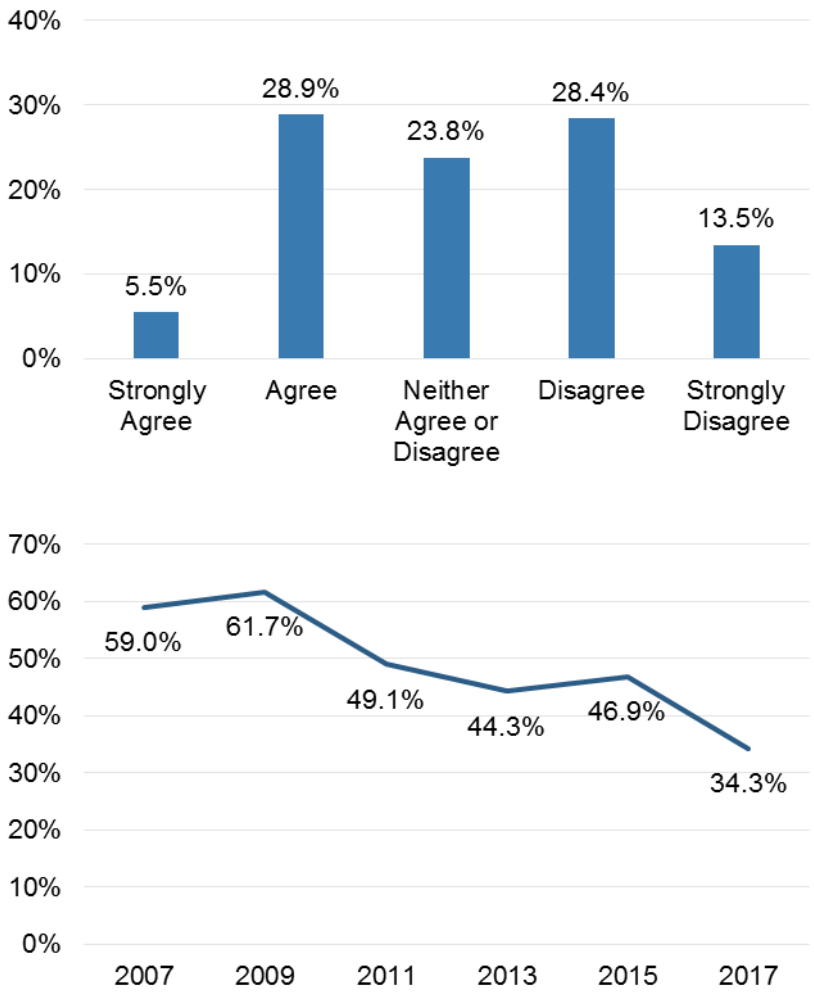


Source: IES/ERL/RCN, 2017

3.3.3 Most nursing staff feel unable to balance home and work lives

Survey findings show a sharp drop in the proportion of nursing staff who feel able to balance their home and work lives. Figure 3.24 shows that just 34 per cent felt satisfied with their work-life balance compared to 49 per cent in 2011. In total 42 per cent disagreed that they were able to balance home and work lives.

Figure 3.24: 'I feel able to balance my home and work lives' (N=7,586)



Source: IES/ERL/RCN, 2017

4 Abuse, Harassment and Bullying

This chapter explores nurses' experiences of abuse, harassment or bullying in their working lives. These topics were newly added to the membership survey for 2017 and so comparisons with previous years' surveys are not possible. The questions focused on the following topics: experiences of physical and verbal abuse from patients, service users or relatives; and bullying or harassment from colleagues.

The findings show that the growing work pressures for nursing staff, detailed in the preceding chapter, often feature against a backdrop of abuse, bullying and harassment in the workplace, which is particularly notable among nursing staff working in the fields of mental health, nursing homes and older people settings. Worryingly, the findings show that many cases go unreported. Nursing staff working in mental health and nursing homes are more likely than staff working in other areas to experience physical and verbal abuse, most likely because of the higher incidence of abuse among patients lacking full mental capacity.

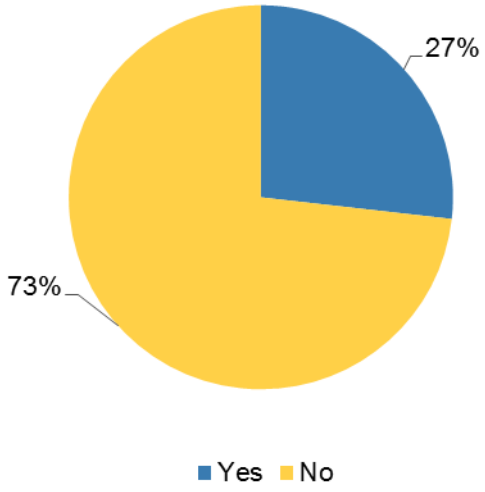
- Over a quarter of nurses (27%) have experienced physical abuse from patients, service users or relatives in the last 12 months, and a much higher percentage (68%) have experienced verbal abuse from the same groups.
- One in three nursing staff (31%) say that they have experienced bullying or harassment from colleagues in the last 12 months, with Black African/Caribbean and disabled nursing staff more likely to report this than other staff. In most cases where the abuse is not reported, it is because nursing staff do not think it is serious enough.
- Support for nursing staff is often lacking. Most nursing staff (70%) do not report bullying and harassment because they do not think that anything will change as a result but also because they do not think that they will get support from their manager or colleagues (50%).[15]

4.1 Physical abuse

Over a quarter of nurses (27%) had experienced physical abuse from patients, service users or relatives in the last 12 months, and a little under three-quarters (73%) had not experienced this (Figure 4.1).

[15] Respondents could select more than one reason for this survey question.

Figure 4.1: Experience of physical abuse from patients or service users in the past 12 months (N=7,608)



Source: IES/ERL/RCN, 2017

Wider evidence also indicates high levels of physical abuse against nursing staff. The 2016 NHS Staff Survey for England shows that 29 per cent of registered nurses in England had experienced physical abuse in the previous 12 months[16]; 11 per cent in Wales[17] and, according to the 2015 NHS Staff Survey for Scotland, 20 per cent of nursing and midwifery staff in Scotland.[18]

The findings on physical abuse were broken down by a range of different factors, such as pay grade, job title and ethnicity, to see if there were corresponding differences. Overall, we found none, with the exception of job title, work setting and ethnicity.

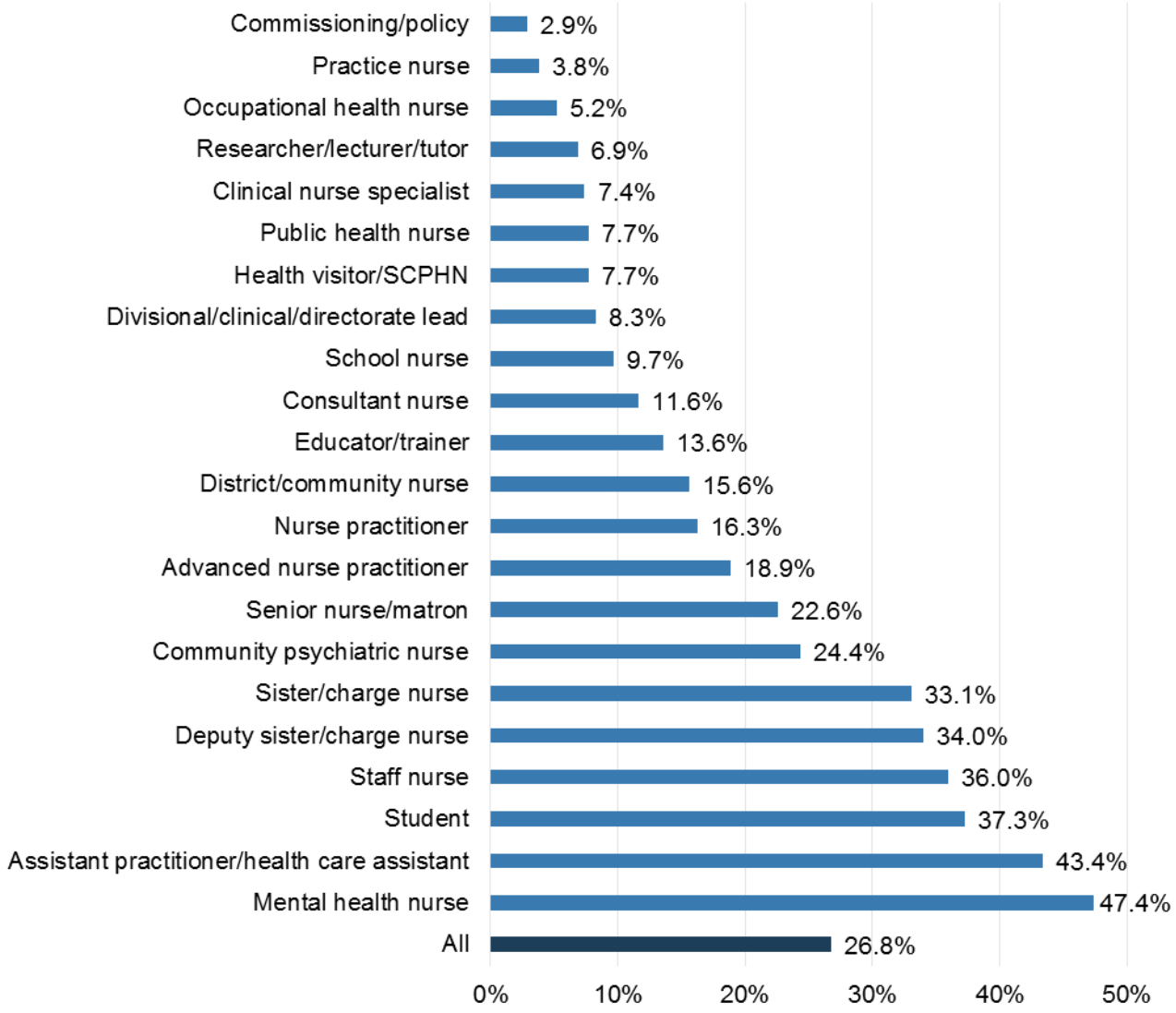
When looking at responses by job title, we found that mental health nurses, assistant practitioners/healthcare assistants and student nurses were much more likely to report having been physically abused in the last 12 months than nursing staff in other roles (Figure 4.2).

[16] NHS (2016), *2016 NHS Staff Survey*, National Health Service. http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/

[17] Welsh Government (2016), *NHS Wales Staff Survey 2016, National Report,* Welsh Government. Available at: http://gov.wales/docs/dhss/publications/161208nhs-survey-en.pdf

[18] Scottish Government (2015), *NHS Scotland Staff Survey 2015 National Report,* Scottish Government. *Available at:* http://www.gov.scot/Publications/2015/12/5980

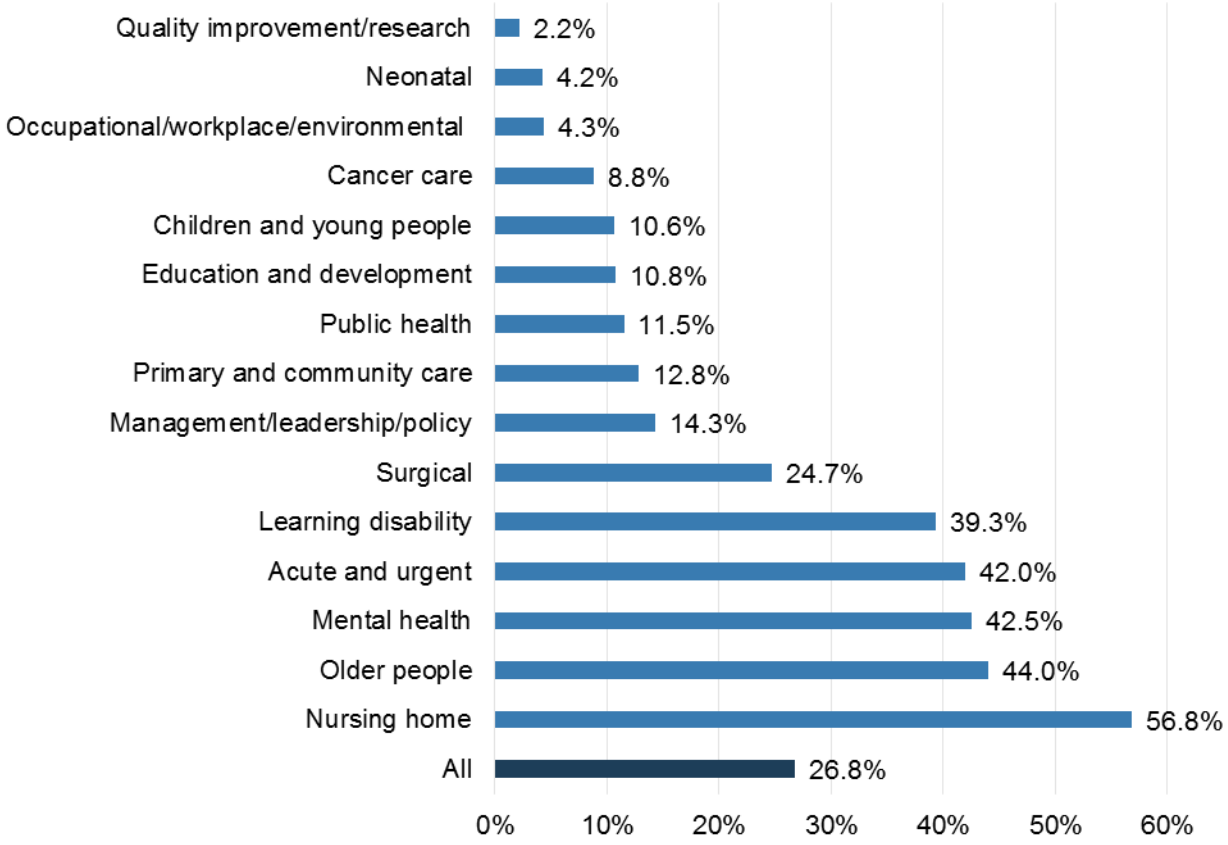
Figure 4.2: Experience of physical abuse from patients and service users in the last 12 months by job title



Source: IES/ERL/RCN, 2017

The highest levels of physical abuse reported among nursing staff were among those working in nursing homes (57%), older people settings (44%) and mental health settings (43%) (Figure 4.3).

Figure 4.3: Experience of physical abuse from patients and services users in last 12 months by area of practice



Source: IES/ERL/RCN, 2017

We also found that experiences varied by ethnicity: Black African/Caribbean nursing staff were more likely to report experiencing physical abuse (34%), compared to 24 per cent of Asian nurses and 26 per cent of White nursing staff.

The majority of nursing staff (63%) had chosen to report their last experience of physical abuse, but 37 per cent had not reported it. Among nursing staff who had not reported an incident of physical abuse, most (53%) said it was because they did not think it was serious enough, they weren't confident anything was going to change (36%) and they didn't find the time (33%) (Table 4.1).

Table 4.1: Reasons why did not report physical abuse

	%
I didn't think it was serious enough	53.5
I wasn't confident that anything would change as a result	36.4
I didn't find the time	32.7
I didn't think I would get support from my colleagues/management	16.8
I wasn't aware of the reporting process	3.2
I don't have access to good occupational health support	2.3
Other	13.6
Base N=100%	744

Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

Among nurses who had reported their last experience of physical abuse, half were satisfied with the outcome and half were not. The most common reasons among dissatisfied staff were: that there had been no action or that nothing changed as a result of reporting (58%), a lack of support from the Trust, management or representative (16%), and that feedback was not provided (15%). Views expressed included:

> *I do not receive any feedback and I feel it's just becoming a part of the role I undertake. Incidents are reported on such a regular basis and nothing changes, staffing levels are not reviewed and I regularly feel my registration is put at risk.*
>
> Sister/Charge Nurse, North West England

> *Because nothing happened. No follow-up, no police taking the case forward. Nothing.*
>
> Senior Nurse/Matron, East Midlands

> *I did not receive feedback on a potentially serious incident, support from high management or any communication regarding the incident.*
>
> Staff Nurse, West Midlands

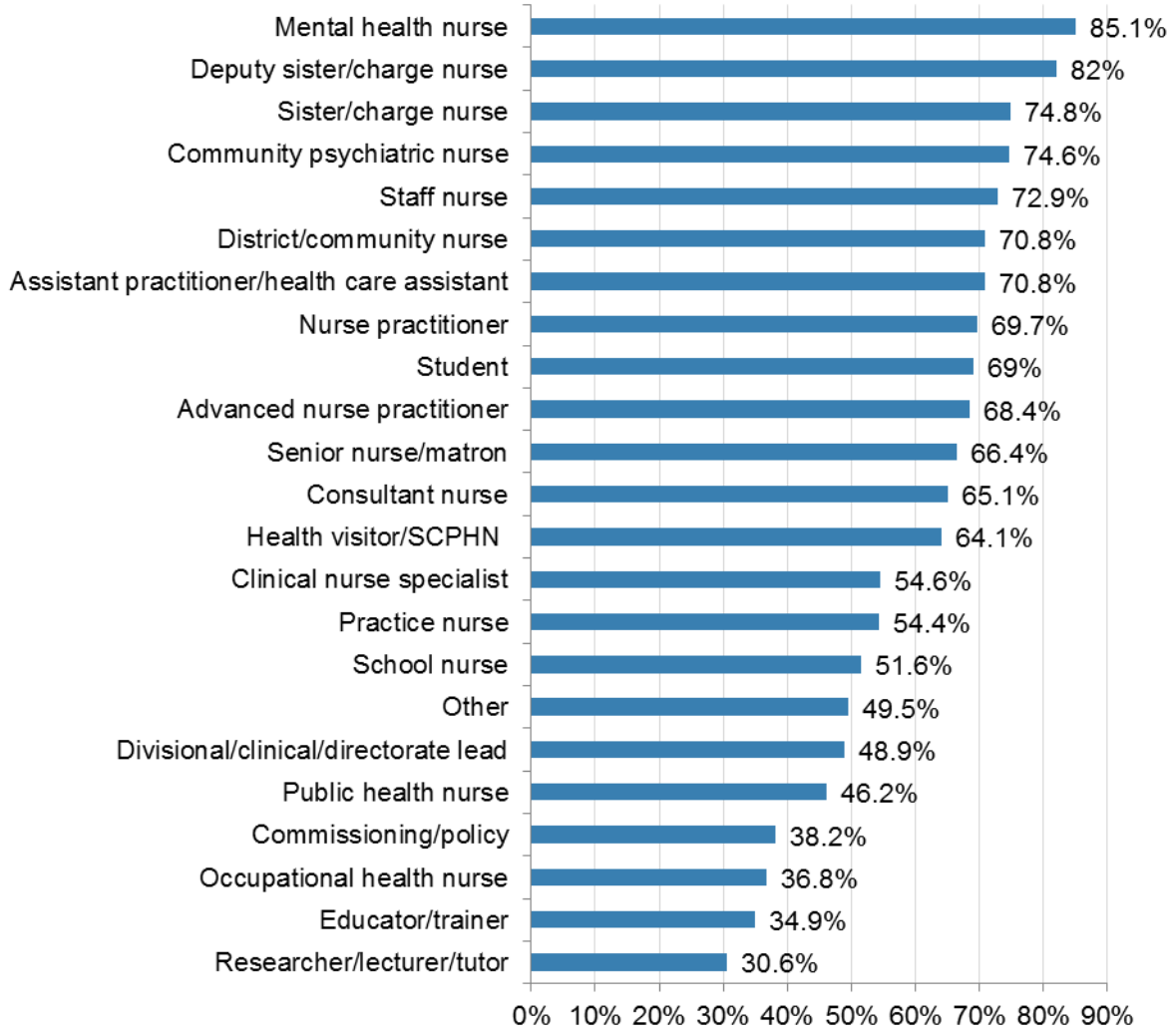
4.2 Verbal abuse

The majority of nursing staff (68%) had experienced verbal abuse from patients, service users or relatives in the last 12 months, and 32 per cent had not reported this.

We broke down this finding by a range of different factors to identify any significant differences among different groups of staff. The only differences identified were by job title, work setting and disability.

As with physical abuse, experiences of verbal abuse correspond closely with areas of practice and job titles. In particular, mental health nurses (85%) were the most likely to have experienced verbal abuse in the last 12 months followed by senior nurses and community psychiatric nurses (Figure 4.4).

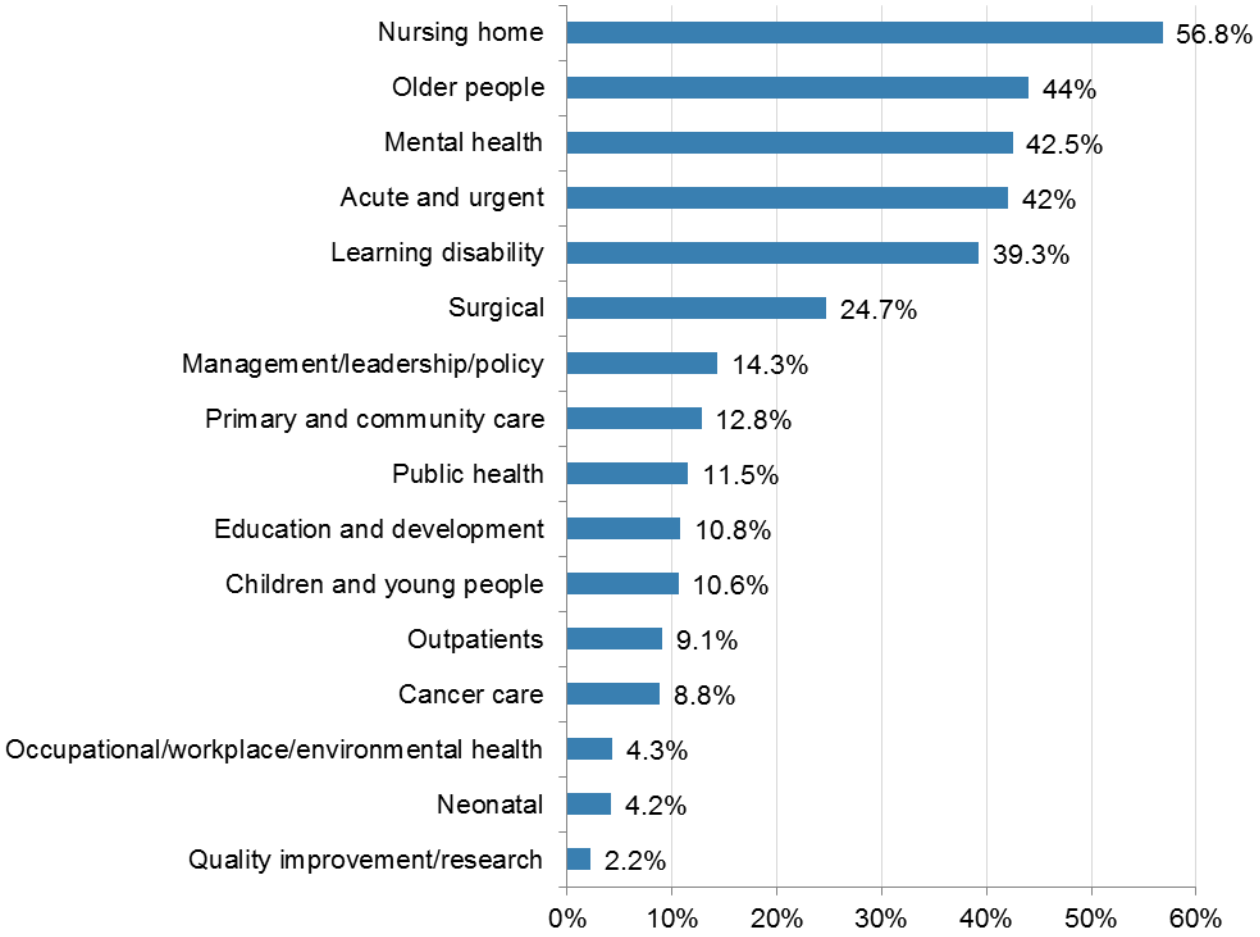
Figure 4.4: Experience of verbal abuse from patients or service users in last 12 months by job title



Source: IES/ERL/RCN, 2017

Nursing staff who experienced verbal abuse were more likely to work in nursing homes (57%), with older people (44%) and in mental health settings (43%) (Figure 4.5).

Figure 4.5: Experiences of verbal abuse from patients or service users in last 12 months by area of practice



Source: IES/ERL/RCN, 2017

A higher proportion of disabled nursing staff reported experiencing verbal abuse (72%), compared with nurses who are not disabled (66%).

Half of nursing staff who had experienced verbal abuse had reported the incident and half had not. The majority of nurses did not report verbal abuse because they did not think it was serious enough (52%), followed by a lack of confidence that anything would change as a result (41%), and not finding the time to report (33%).

> *Working in ED [Emergency Department], there is a lot of verbal abuse from patients, I only report something serious.*
>
> Staff Nurse, London

4.3 Bullying and harassment

Just under one-third of nursing staff (31%) stated that they had experienced bullying or harassment from colleagues in the last 12 months, and 69 per cent stated that they had not experienced bullying or harassment.

We analysed this finding by a range of different factors, such as job title, ethnicity and work setting, to see whether there were any differences across different staff groups. The only notable differences were by disability.

A higher proportion of nursing staff with a disability (45%) reported that they had experienced bullying, compared with a little under one-third of nursing staff without a disability (30%) (Table 4.2).

Table 4.2: Experiences of bullying or harassment from colleagues in the last 12 months by disability (percentage)

	Has a disability	No disability	Total
Experienced bullying/harassment	44.8	29.7	31.1
Not experienced bullying/harassment	55.2	70.3	68.9
Base N=100%	688	6,830	7,518

Source: IES/ERL/RCN, 2017

Among nursing staff who reported that they had experienced bullying or harassment from a colleague, 44 per cent had reported the incident, and 56 per cent had not.

The majority of nursing staff who had not reported bullying or harassment stated it was because they were not confident that anything would change as a result (70%). Half (50%) didn't think that they would get support from their manager or colleagues, and a little under half (47%) were concerned that it could count against them and their career progression (Table 4.3).

Table 4.3: Reasons why respondents did not report bullying or harassment from colleagues (N=1,310)

	%
I wasn't confident that anything would change as a result	70.2
I didn't think I would get support from my manager/colleagues	49.5
I was concerned it would count against me and my career progression	46.9
I didn't find the time	7.9
I don't have access to good occupational health support	3.7
I wasn't aware of the reporting process	2.1
Other	11.8

Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

Among nursing staff who had reported their experience of bullying or harassment from a colleague, a little over a quarter (28%) were satisfied with the outcome, and a little under three-quarters were not satisfied with the outcome.

In over one-third of 'dissatisfied' cases (35%), nursing staff stated that no action had been taken as a result of reporting, just under a quarter (22%) felt that nothing had changed, and 12 per cent felt there had been a lack of professionalism in how their report had been addressed (Table 4.4). Views expressed included:

Actual problem not dealt with. People just moved around.

Sister/Charge Nurse, North West England

Nothing changed despite informing Chief Nurse.

Consultant Nurse, South East England

Table 4.4: Reasons respondents are not satisfied with the outcome (N=757)

	%
No action taken	34.8
Nothing has changed	21.6
Lack of professionalism	11.7
Systemic problem	7.6
Caused more problems	4.4
Took too long	4.4
Resigned	3.9
Lack of support	3.7
Fear of addressing perpetrator	2.3
Caused stress	1.9
Lost job/sacked/moved	1.5
Advised/asked to drop case	1.2
In middle of reporting	1.2

Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

5 Pay and Grading

This chapter details views around pay and grading and reasons for these views among nursing staff.

Overall dissatisfaction with pay and grading is high; 61 per cent now think that their pay band/grade is inappropriate, significantly up from 39 per cent in 2015 and 37 per cent in 2013.

In the NHS, there are particularly low scores for dissatisfaction among nurses in Band 5. Consistent with the work pressures detailed in Chapter 3, **dissatisfaction with pay band/grade is closely related to the sense that their pay does not match the level of responsibility, the duties or the intensity of the job.**

Nursing staff working in the NHS at all Agenda for Change (AfC) pay bands/grades report financial pressure, but financial struggles are most acute in the lower bands. Compared to five years ago, more nurses in Bands 6 and 7 feel financially worse off than nurses in other bands. However, staff in Bands 1-4 and Band 5 are more likely than those in other bands to report financial struggles and money worries in the past year. The effect of money worries seems to be particularly manifest in Bands 1-4, where more nursing staff report that they have lost sleep as a result of money worries and that it has affected their duties at work.

Summary of key findings:

- More than half of nursing staff across all sectors (61%) now think that their pay band/grade is inappropriate, significantly up from the 39 per cent in 2015 and the 37 per cent in 2013 who reported the same. Only one-quarter (26%) of nursing staff now regard their pay band/grade as appropriate.
- The lowest scores for satisfaction with pay grade/band were for those in pay Band 5 in the NHS, where 75 per cent of all nurses feel that their pay band/grade is inappropriate, compared to 61 per cent in Band 6, 51 per cent in Band 7 and 35 per cent in Band 8.
- Dissatisfaction with pay band/grade is highly related to the sense that the pay does not match the level of responsibility and duties as well as the intensity of the job.
- More nursing staff in pay Bands 1-4 (74%) and 5 (67%) have experienced financial struggles in the last year than staff in other bands. When asked about specific financial struggles, again it is Bands 1-4 and Band 5 which report higher levels of struggle.
- More nursing staff in Bands 1-4 and Band 5 said that they had been affected by money worries recently. The effects of money worries is particularly manifest in Bands 1-4, where more nurses report losing sleep as a result, but also report a negative impact on their duties at work.

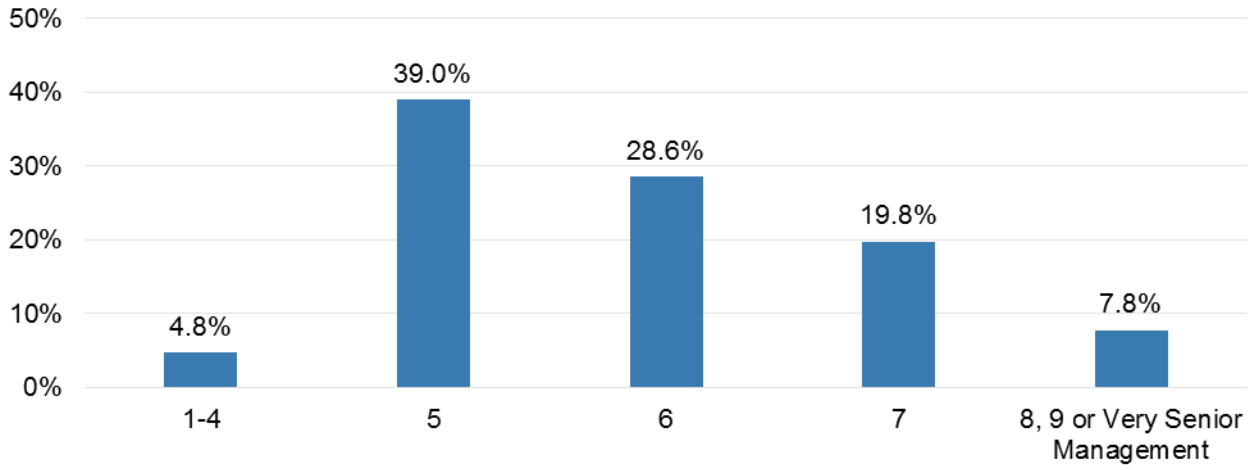
- Compared to five years ago, more nurses in Bands 6 and 7 feel worse off than nurses in other bands, suggesting that the impact of the pay restraint has had a widespread impact across all pay bands.[19]

5.1 Pay and grading arrangements

The majority of respondents to the survey (83%) are employed in the NHS and, consistent with that finding, 82 per cent are paid on the NHS Agenda for Change (AfC) pay structure.[20] Among the remaining respondents, 1.7 per cent are on clinical grades and 16.5 per cent are on other organisational pay systems. Of those on other pay systems, one-fifth are on AfC equivalent pay bands.

The majority of nursing staff on AfC pay bands are in Band 5 (39%), Band 6 (29%) or Band 7 (20%) (Figure 5.1).

Figure 5.1: Agenda for Change pay bands (N=6,388)



Source: IES/ERL/RCN, 2017

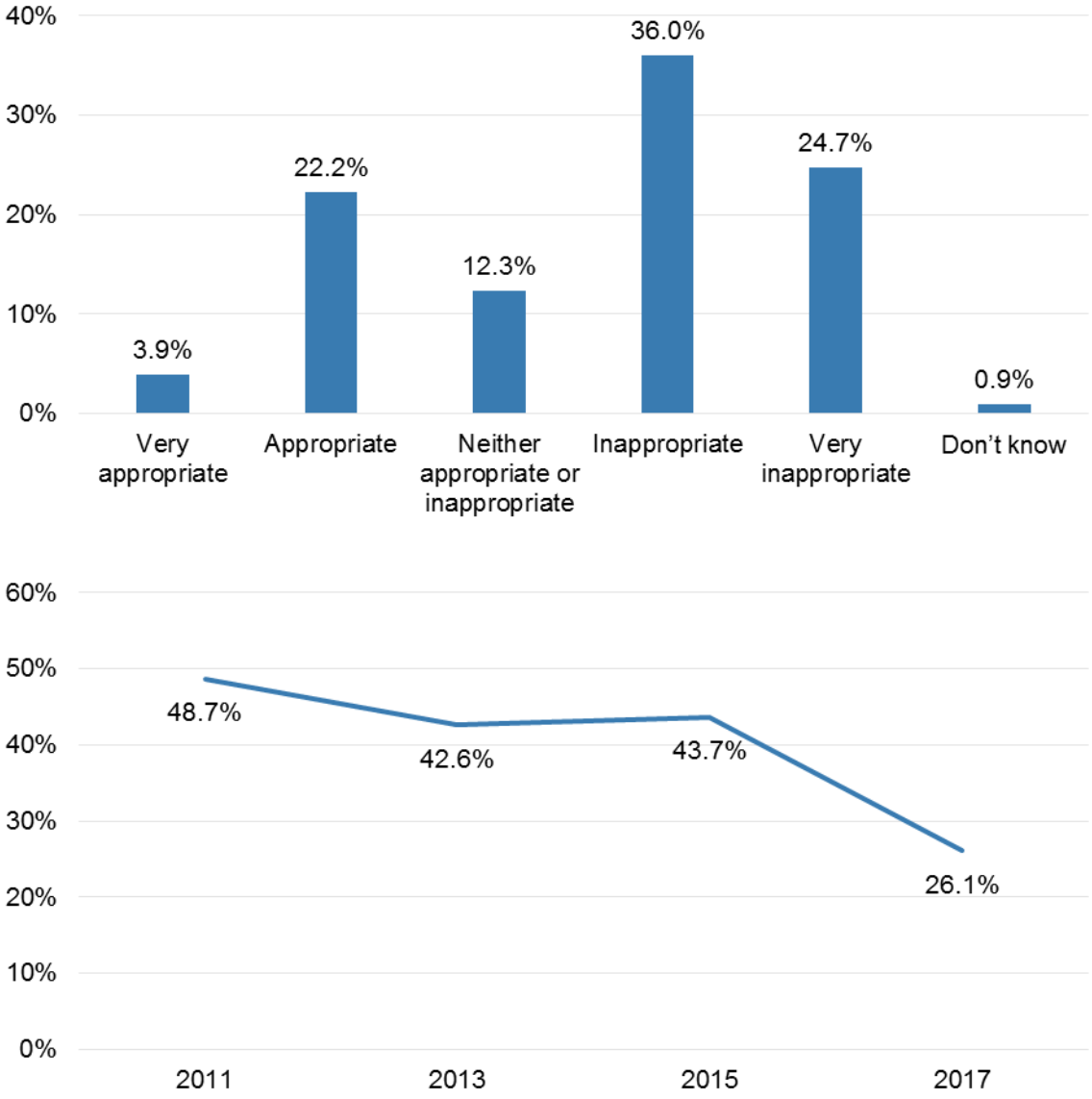
5.1.1 Most nursing staff are dissatisfied with their pay

Our analysis finds that satisfaction with pay band/grade appears to have declined substantially in recent years. The majority of nursing staff (61%) now think that their pay band/grade is inappropriate, and just 26 per cent think it is appropriate, significantly down from 44 per cent in 2015, 43 per cent in 2013 and 49 per cent in 2011 (Figure 5.2).

[19] Public sector pay was frozen in 2010 and in 2013, was capped at one per cent. In the Autumn Budget 2017, the Government pledged a pay rise for nursing staff but this was said to be dependent on the outcome of ongoing talks with the sector regarding pay reform.

[20] Agenda for Change (AfC) is the current grading and pay system for NHS staff, with the exception of doctors, dentists, apprentices and some senior managers.

Figure 5.2: 'Given your role and responsibilities, how appropriate would you say your current pay band/grade is?' (N=7,450). Comparison of very appropriate/appropriate with previous years



Source: IES/ERL/RCN, 2017

5.1.2 Dissatisfaction is more notable among BAME, Band 5 and younger nursing staff

Further to this, we asked respondents to rate their views about the appropriateness of their pay band/grade from 1 to 5, with 1 being very inappropriate and 5 very appropriate. The mean score to this question was 2.4 out of 5 and we analysed these results by gender, age, work setting, ethnicity, pay band, country and pay system/scale. There were no notable differences by gender or pay system/scale but there were notable differences by age, work setting, ethnicity, pay band and country. Table 5.1 shows the mean score of respondents with a breakdown of these variables by country and pay band.

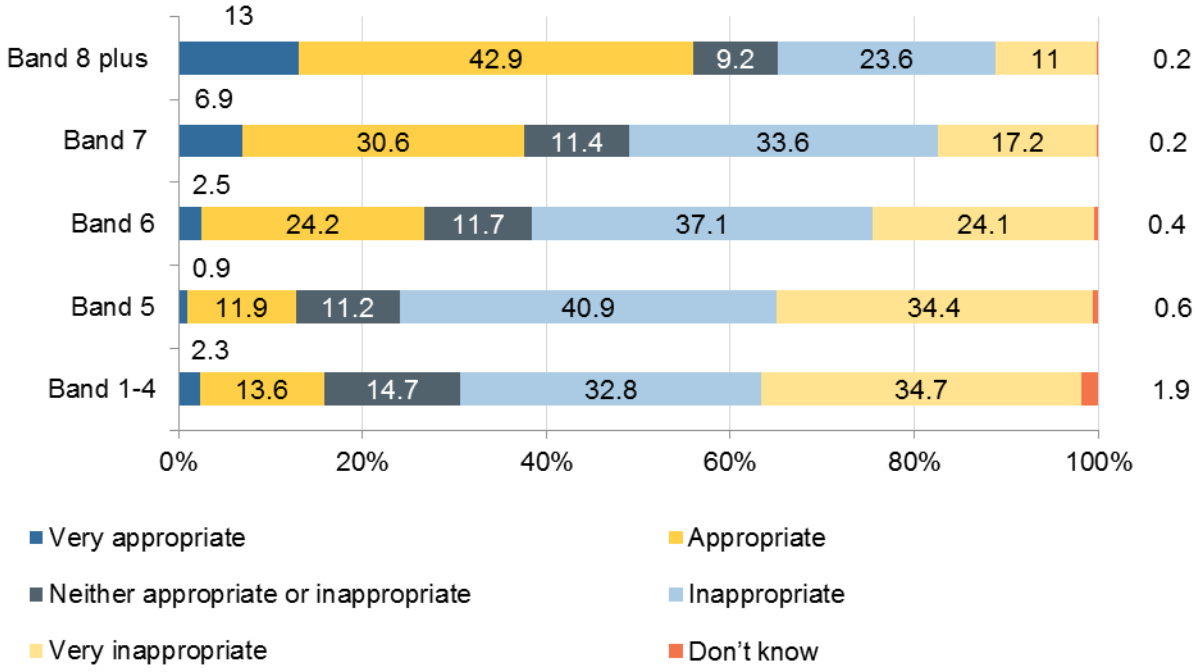
Table 5.1: Views about pay according to country and pay band (appropriateness score: 1 = very inappropriate, 5 = very appropriate)

	Number of respondents	Mean
Country		
Isle of Man	15	2.8
Channel Island	30	2.5
England	5,977	2.5
Wales	355	2.4
Scotland	769	2.4
Northern Ireland	230	2.2
Other	17	3.2
Pay band (grouped)		
Band 1-4	260	2.1
Band 5	2,462	2.0
Band 6	1,820	2.4
Band 7	1,255	2.8
Band 8 plus	498	3.2

Source: IES/ERL/RCN, 2017

From this table, it is possible to see that some of the lowest scores for views about appropriateness of pay band/grade are among Band 5 nurses working in the NHS. Figure 5.3 breaks down the scores for this and shows that 75 per cent of nurses in Band 5 feel that their pay band/grade is inappropriate, compared to 61 per cent in Band 6, 51 per cent in Band 7 and 35 per cent in Band 8.

Figure 5.3: Appropriateness of current pay by AfC pay band (percentage)



Source: IES/ERL/RCN, 2017

The findings above are also likely to explain why nursing staff from Northern Ireland expressed far less positive views about their pay than their counterparts in the Isle of Man, Channel Island or England (Table 5.1); Northern Ireland has the highest percentage of Band 5 nurses in the UK.[21] However, lower scores around the appropriateness of pay band/grade among Band 5 nursing staff are also consistent with the finding that they were also more likely to report financial struggle than staff in all other pay bands, with the exception only of Band 4 (see section 5.3 below).

Our analysis also shows lower scores for views about appropriateness of pay band/grade among Black African/Caribbean and Asian nursing staff (Table 5.2 below). This is somewhat consistent with the findings reported in Chapter 3 which showed higher levels of full-time working and presenteeism among BAME nursing staff, as well as greater levels of physical abuse reported by Black African/Caribbean staff.

[21] As reported by the RCN in Smyth J (2016), 'Nurses deserve a fair pay deal says RCN', *The Irish News*, 13th January. Available at: http://www.irishnews.com/news/2016/01/13/news/platform-nurses-deserve-a-fair-pay-deal-says-rcn-380413/

Table 5.2: Views about pay by broad ethnic group (appropriateness score: 1 = very inappropriate, 5 = very appropriate)

	Number of respondents	Mean
White	6,562	2.5
Black African/Caribbean	313	2.0
Asian	210	2.2
Other/Mixed	93	2.3
Prefer not to say	172	2.1

Source: IES/ERL/RCN, 2017

Lower scores for views about appropriateness of pay band/grade were also noted among younger age groups (18-25 and 26-34 year olds), consistent with the findings in Chapter 3 which show these age groups also reported higher levels of presenteeism and full-time working (Table 5.3). Perhaps unsurprisingly, given that the majority of nursing staff work in NHS hospital settings (see Chapter 3), Table 5.3 also shows lower scores for views among appropriateness of pay band/grade among those working in NHS hospital and community settings. This is also consistent with the finding from Chapter 3 which shows that those working in NHS hospitals are more likely to report insufficient staff and workloads which are too high.

Table 5.3: Views about pay by age and work setting (appropriateness score: 1 = very inappropriate, 5 = very appropriate)

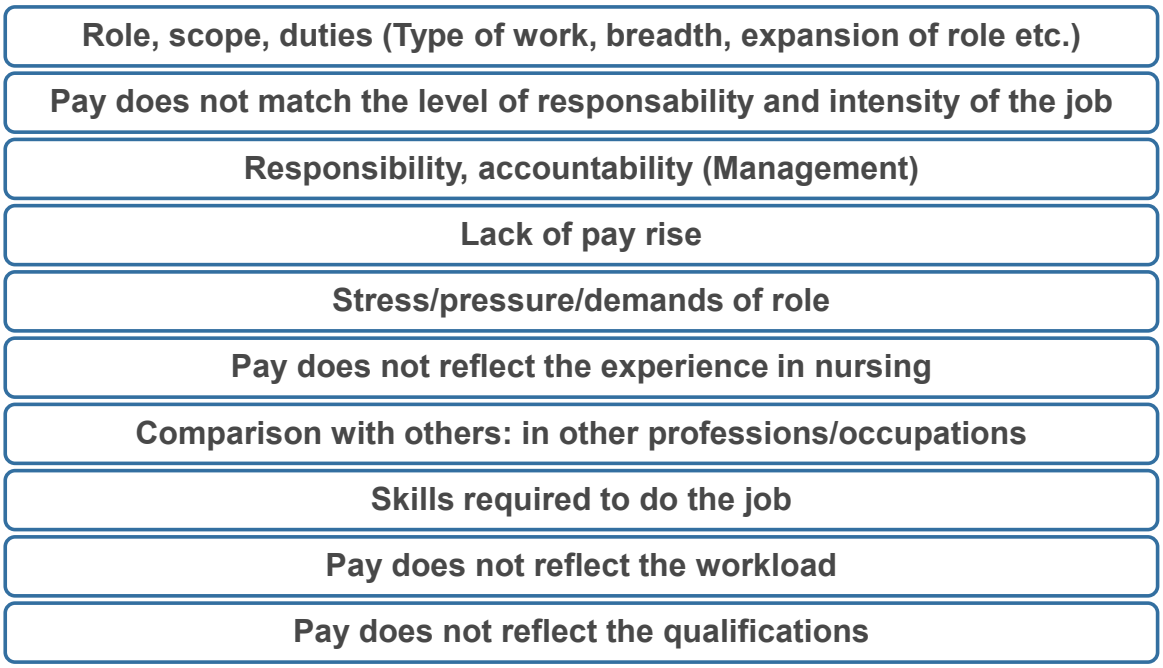
	Number of respondents	Mean
Age		
18-25	302	2.1
26-34	1,159	2.2
35-44	1,596	2.3
45-54	2,597	2.5
55-64	1,636	2.6
65+	89	2.8
Working setting		
NHS Hospital	4,185	2.3
NHS Community	1,531	2.4
GP Practice	387	2.8
Other NHS	318	2.9
Independent Hospital	161	2.6
Independent Care Home community	306	2.8
Agency Bank	66	2.8
Hospice/Charity/Voluntary	133	3.0
Other public sector/education	87	3.1
Other private sector	132	2.9
Other	79	2.9

Source: IES/ERL/RCN, 2017

5.1.3 Dissatisfaction is driven by a perceived mismatch between pay and the responsibility/ intensity of the job.

Nursing staff identified different reasons why they considered their pay band to be inappropriate. However, Figure 5.4, which ranks the top ten most commonly cited reasons, demonstrates that dissatisfaction is driven by a sense that pay no longer reflects the responsibilities, duties and intensity of the job.

Figure 5.4: Main reasons given for considering pay band/grade as inappropriate



Source: IES/ERL/RCN, 2017

The main reason for nursing staff feeling that their pay band/grade is inappropriate is the perception that their actual role and duties do not match with their banding or job description, which is often much lower:

> *[I am responsible for] lone working in community making autonomous decisions about children with complex health needs, I manage the duty rota and new community nursing referrals. [I am] in charge of caseload allocation for all teams and organise and chair discharge planning and multidisciplinary meetings. I feel these responsibilities would be more suited to a Band 7 role.*
>
> District/community Nurse, NHS Hospital other settings, AfC Band 6, South West England

> *It does not reflect the complexity of the role. As a lecturer with clinical responsibilities I have to remain updated in clinical practice, education and research and, as a minimum need a nursing, teaching and higher degree (masters) to remain in post.*
>
> Researcher/lecturer/tutor, Other public sector/education, Clinical Grade, North East England

Dissatisfaction is also highly related to the sense that the pay doesn't match the level of responsibility as well as the intensity of the job. In particular, the all-consuming nature of caring for patients now seems at odds with the level of pay and work pressures that many nurses face.

> *I have a lot of responsibility caring for end of life patients, and meeting all of the family and other loved ones' needs. An important job, for rubbish money.*
>
> District/community Nurse, live-in palliative nurse, clinical grade F, North West England

Too much responsibility for little pay. The hours and things we have to see and deal with whether that be rude public, clinical conditions, death.

Staff Nurse, NHS Hospital Unit, AfC Band 5, North West England

You are always a nurse. Walking down the street or in a pub. People don't appreciate that and we should get more support.

Staff Nurse, Band 5, South East England

6 Income, Additional Work/Hours and Financial Wellbeing

This chapter details respondents' views on income, additional work/hours and financial wellbeing.

Echoing the findings around work pressures that were detailed in Chapter 3, **most nursing staff (71%) work additional hours at least once a week, but only half of those are paid for those hours**.

The income and financial circumstances of nursing staff emerge as precarious. On the one hand, more nursing staff are primary earners in 2017 compared to 10 years ago (57 per cent compared to 48 per cent in 2007), meaning that their households are heavily dependent upon their income. On the other hand, **the majority of nursing staff (70%) feel financially worse off than they did five years ago**, with a higher proportion of nursing staff in AfC pay Bands 5, 6 and 7 reporting this than in other pay bands. Sixty per cent of nursing staff report financial struggles, particularly among pay Bands 1-4. **Over half of nursing staff said that they had had to cut back on food and travel costs over the past year**; **other financial struggles were around paying utility bills and missing rent or mortgage payments.** To stay financially afloat, many nursing staff, were working extra hours in their main job, borrowing money or taking on an additional job, often losing sleep or having to deal with money problems while at work.

Summary of key findings:

- Most nursing staff (71%) work additional hours at least once a week, yet only half of those say that they are paid for those hours. BAME staff, senior staff and those working in NHS settings are more likely to work additional hours.
- More nursing staff are primary earners compared to 10 years ago (57 per cent compared to 48 per cent in 2007), meaning that those households are heavily dependent upon the income of nursing staff.
- Yet, the majority of nursing staff (70%) feel financially worse off than they did five years ago, with a higher proportion of nursing staff in pay Bands 5, 6 and 7 reporting this than in other pay bands, perhaps hinting at the more widespread effect of the public sector pay cap, which has been in place since 2010. Health visitors, commissioning or policy nurses and community psychiatric nurses are also more likely to report feeling financially worse off than five years ago.
- Financial struggles are widespread among respondents (60 per cent report this), and particularly among AfC pay Bands 1-4.
- Nursing staff are struggling to make ends meet: over half of nursing staff (56%) say that they have had to cut back on food and travel costs over the past year, 21 per cent

have struggled to pay their gas and electricity bills, and 11 per cent have missed or been late with their rent or mortgage payments. Again, this is more notable among lower pay bands.

- Half of nursing staff (50%) have worked extra hours in their main job to meet their daily expenses over the past year; 40 per cent have borrowed money from family, friends or a bank; and 23 per cent have taken on an additional paid job to meet their daily expenses.
- Working an additional paid job was more prevalent in AfC pay Bands 1-5 and just over half of those who work an additional job say that this was in bank nursing. Ninety per cent of those who work an additional job describe the income from this work as 'indispensable' in keeping them financially afloat.

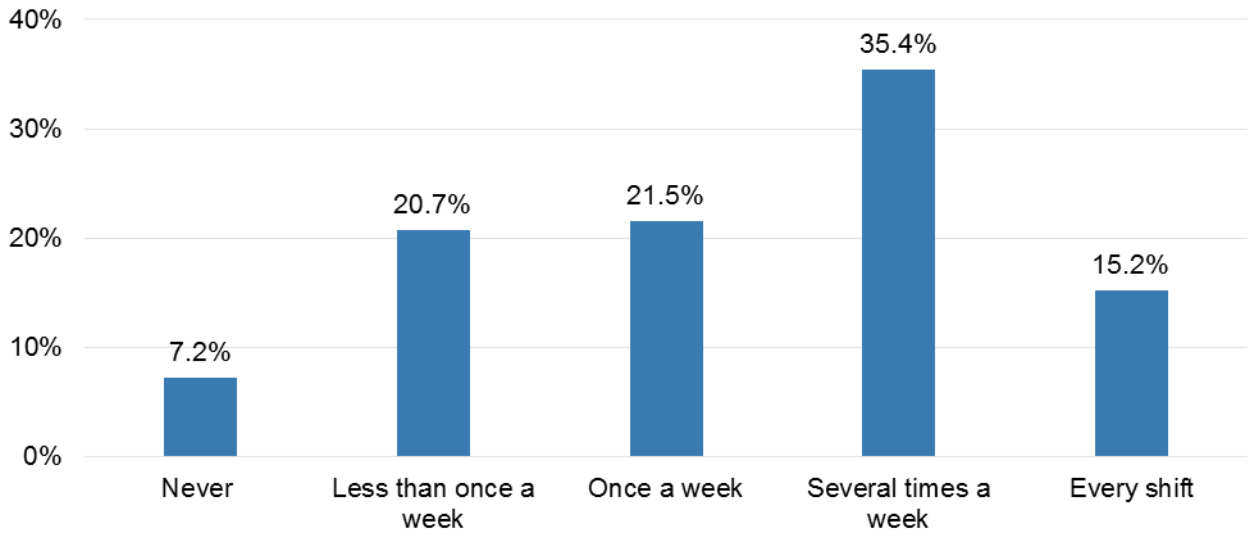
6.1 Working additional hours

Most nurses work additional hours and much of this is unpaid. When we explored differences between different groups, we found that nursing staff in NHS settings, senior staff and BAME nursing staff are more likely to report working additional hours.

6.1.1 Most nursing staff work additional hours, much of which is unpaid

The majority of nurses (71%) reported working additional hours at least once a week and this has increased substantially from 10 years ago, when only 58 per cent reported working additional hours. Fifteen per cent worked additional hours on every shift, 35 per cent did so several times a week, 22 per cent did this once a week, and 21 per cent reported working additional hours less than once a week. Just seven per cent of nurses did not work additional hours (Figure 6.1).

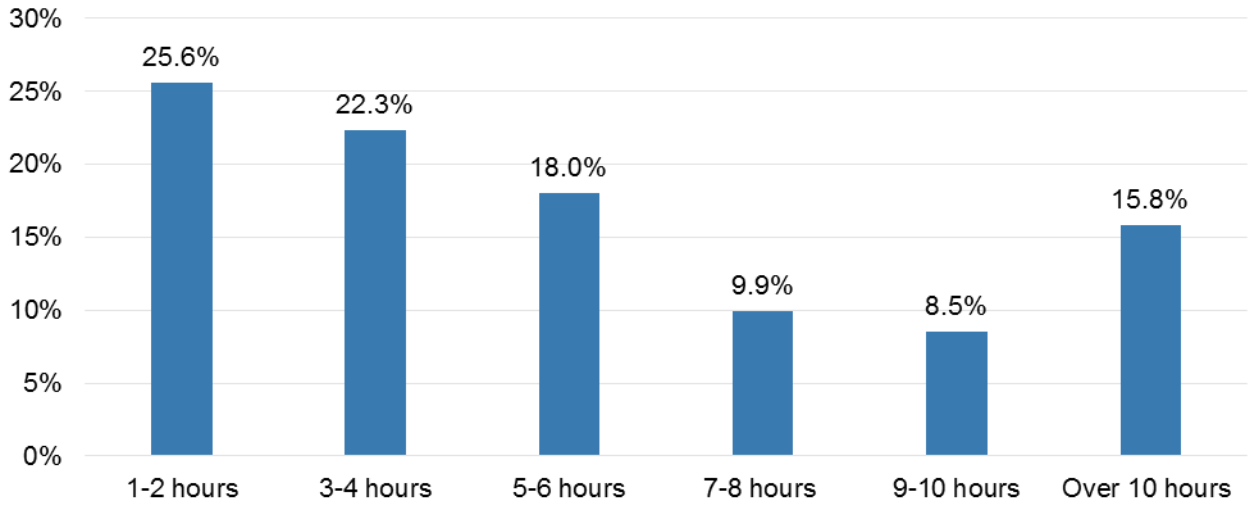
Figure 6.1: Working additional hours on top of contracted hours



Source: IES/ERL/RCN, 2017

Most nursing staff work between one and four additional hours per week (Figure 6.2).

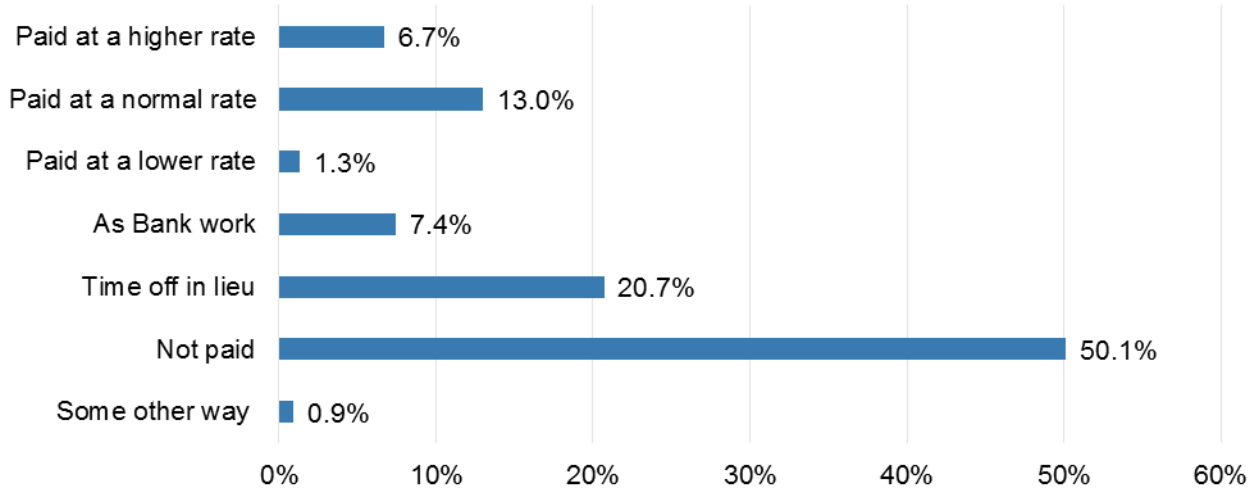
Figure 6.2: Average additional hours worked per week



Source: IES/ERL/RCN, 2017

Around half of all staff who work additional hours reported that these hours were unpaid, with most of these staff working in NHS settings (Figure 6.3).

Figure 6.3: Compensation for additional hours worked



Source: IES/ERL/RCN, 2017

One nurse described the impact that additional hours had on her and her personal/family time:

> *I feel on a daily basis that I am expected to work beyond what is reasonable and acceptable in terms of the number of patient visits allocated. This makes it extremely difficult to provide quality patient care, without it encroaching into my own personal/family time, which it does most days. We do not get our full unpaid one*

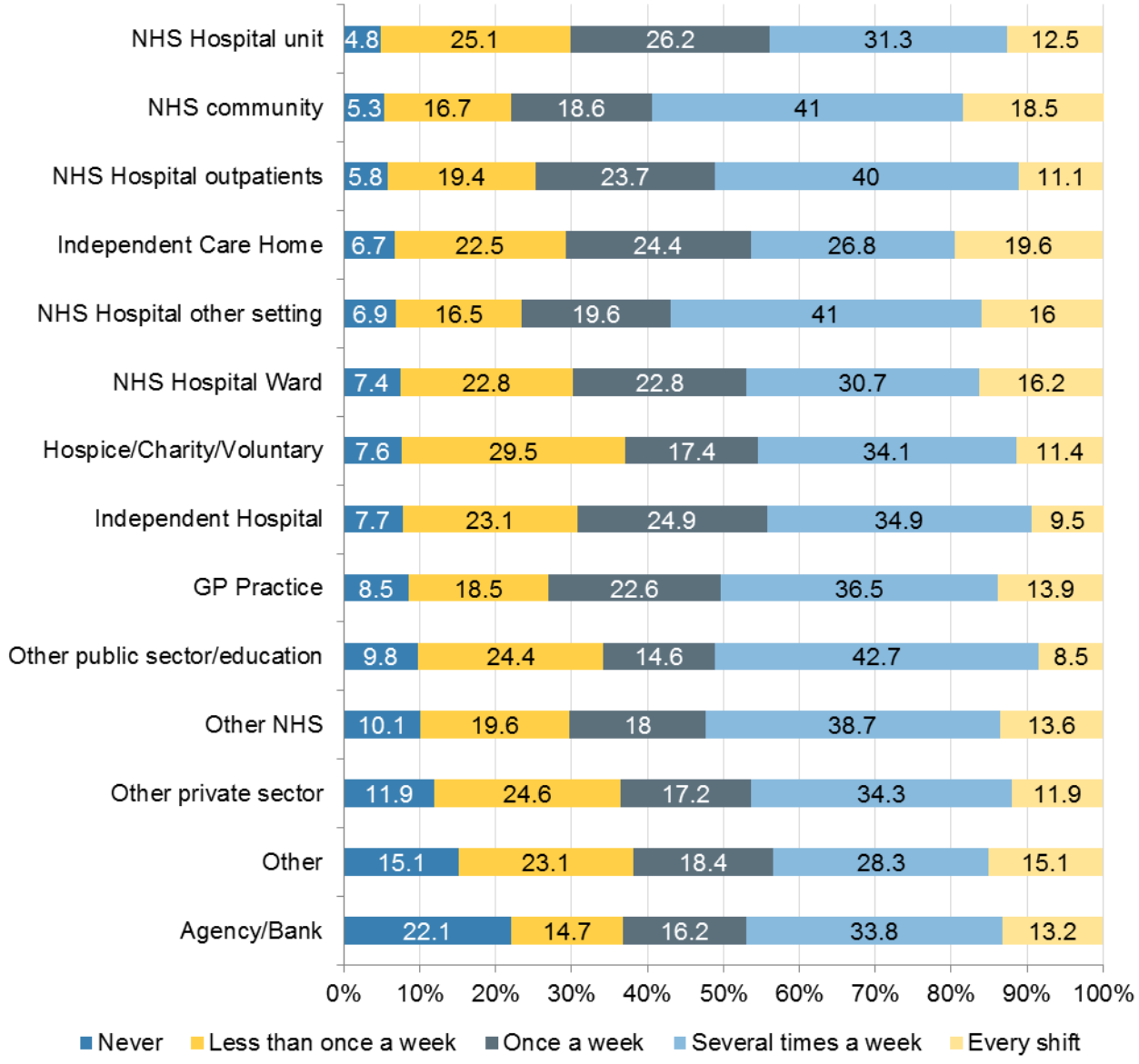
hour break, due to the increasing demands and workload, and I feel our service is running on staff goodwill.

Community Psychiatric Nurse, Yorkshire and Humberside

6.1.2 Working additional hours is more prevalent among NHS nursing staff, senior staff and BAME staff

Nursing staff working in NHS community settings (60%), NHS hospital other settings (57%), and other NHS settings (52%) were most likely to report working additional hours several times a week or more (Figure 6.4).

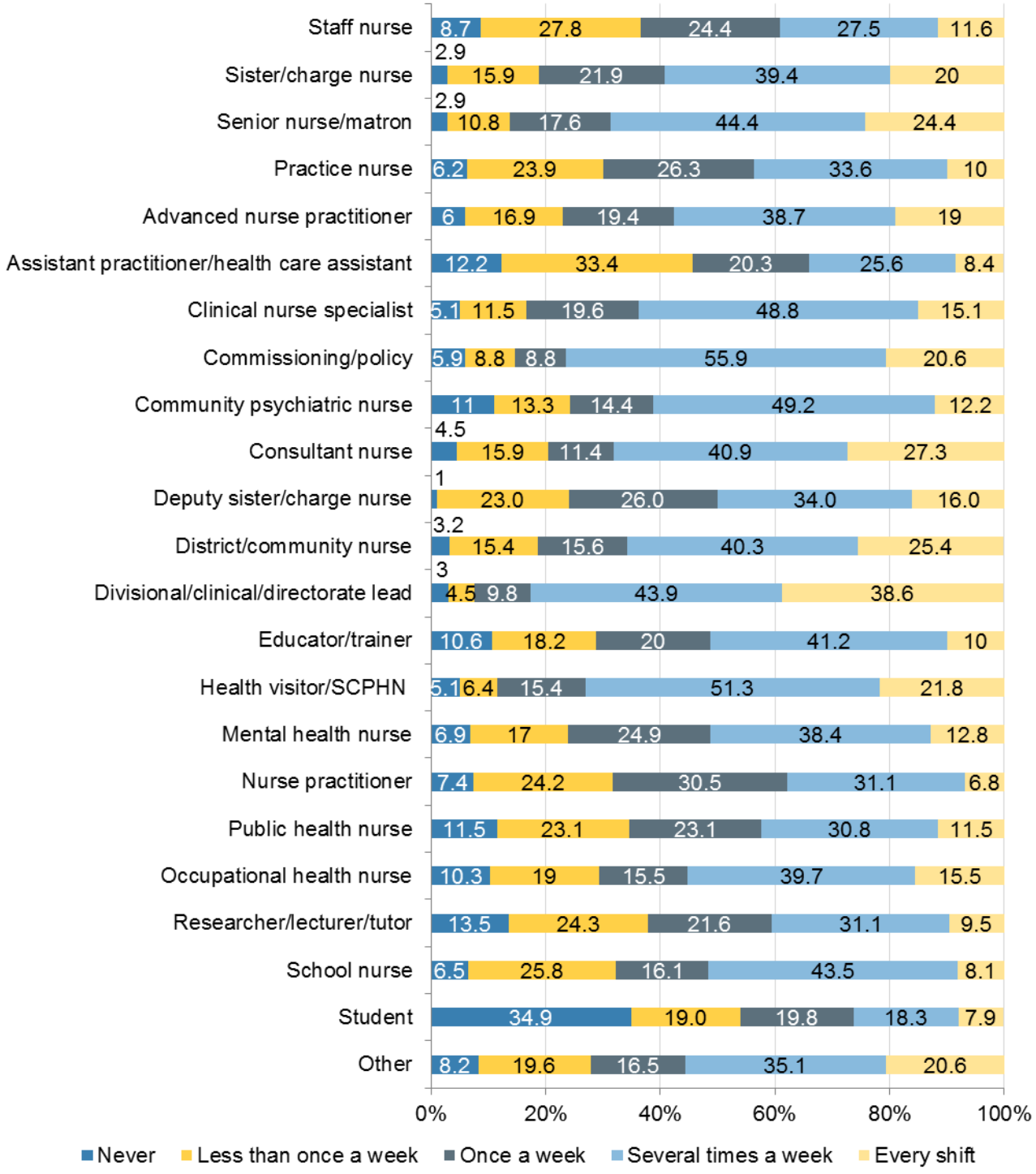
Figure 6.4: Working in excess of contracted hours by employment setting (percentage)



Source: IES/ERL/RCN, 2017

Senior nurses in higher bands (7 and 8) were more likely to work additional hours several times a week than nurses in Bands 5 and 6. Divisional, clinical or directorate leads (83%), senior nurses or matrons (69%), consultant nurses (68%) and district or community nurses (66%) were most likely to report working additional hours several times a week or more (Figure 6.5).

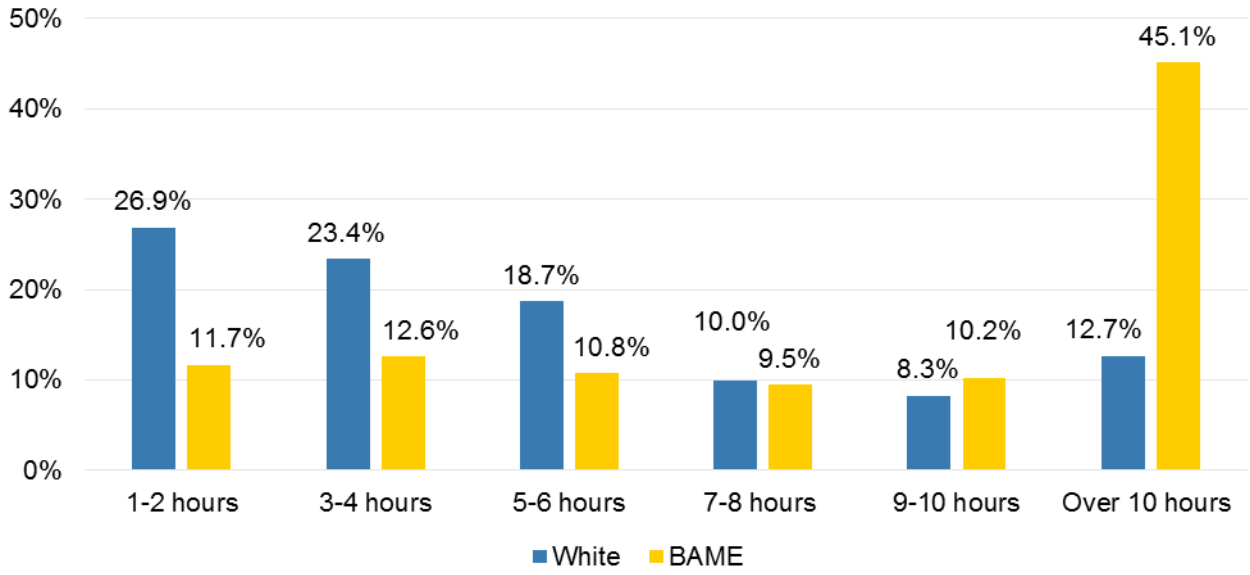
Figure 6.5: Working in excess of contracted hours by staff role (percentage)



Source: IES/ERL/RCN, 2017

BAME staff work considerably more than White nursing staff. BAME nursing staff were more likely to report working additional hours and more likely to be working more than 10 additional hours on average each week (45%), compared with nurses who identified as White (13%) (Figure 6.6).

Figure 6.6: Average additional hours worked per week by ethnicity



Source: IES/ERL/RCN, 2017

Again, some nurses not only described the impact that working additional hours had on themselves but also on patient care:

> *Staff rarely get off on time frequently working one to two hours on the end of each shift to complete notes or undertake jobs not able to be done by agency staff who have picked up the night shift. Frequently night shifts run straight into day shifts with no day off between, regardless of the rota policy stating this is mandatory. There are weeks where both day and night shifts are common. I feel this is detrimental to both myself and my patients.*
>
> Staff Nurse, Wales

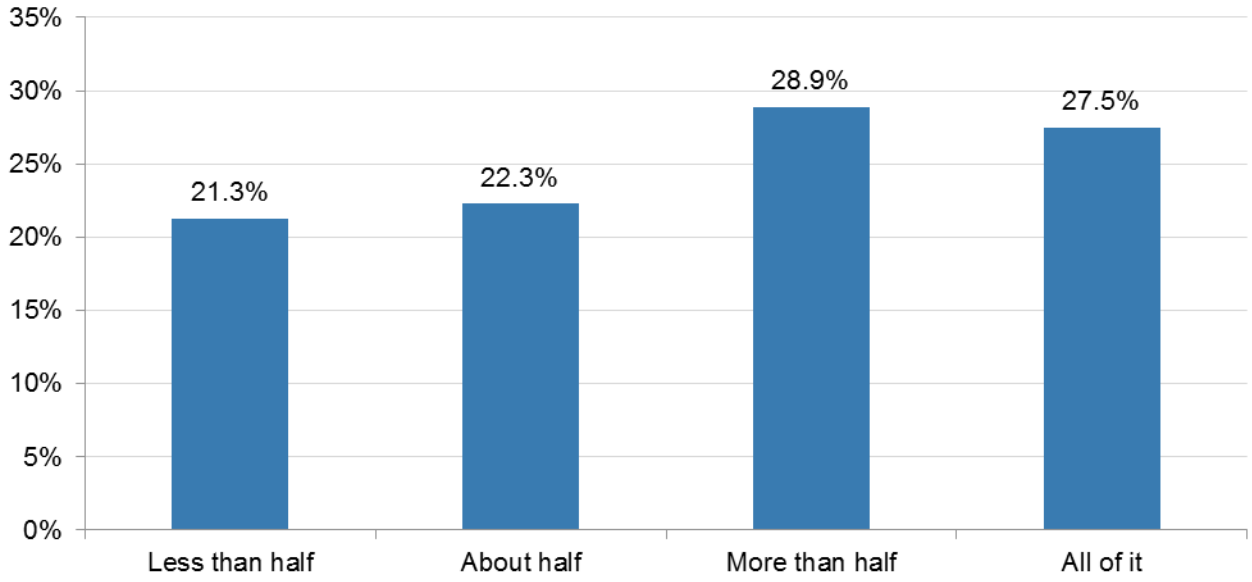
6.2 Income

While most nursing staff had some form of longer-term financial security in the form of having a pension scheme (93%), their current financial circumstances and income appear to be much more precarious and unstable. More nursing staff are primary earners in their households than 10 years ago and when we analysed the data across different groups, we found that they are more likely to be senior staff, staff who work full-time and/or BAME staff. Male nursing staff are also more likely to report being primary earners.

6.2.1 More nurses are primary earners in their households

More nursing staff are primary earners in their households than 10 years ago (57 per cent compared to 48 per cent in 2007), meaning that more households are dependent upon the income of nursing staff (Figure 6.7). Twenty eight per cent of nursing staff are sole earners in their household, and 29 per cent reported that they earned more than half of their household income.

Figure 6.7: Earnings as a proportion of household income



Source: IES/ERL/RCN, 2017

Unsurprisingly, senior nursing staff were more likely to report being the primary breadwinner. Senior nurses (such as divisional, clinical or directorate leads, matrons, deputy sisters and charge nurses earned all or most of their household income in the majority of cases; whereas practice nurses, school nurses and healthcare assistants are least likely to be the main breadwinner.

As might also be expected, nurses who worked for a greater number of hours were more likely to be the primary earner. Nurses who worked full-time earned all or most of their household income in 64 per cent of cases. By contrast, nurses who worked part time- were primary earners only 37 per cent of the time.

BAME nursing staff were also more likely to report being the primary earner. Thirty-six per cent of nurses identifying as BAME reported that they earned all of their household income, compared with 27 per cent of White nurses. Again, this may be explained by greater financial need among BAME groups as well as greater dependence on single parent incomes in some families (see Chapter 3).

Male nurses were more likely to be the primary earners in their households. Thirty-eight per cent of male nurses reported that they earned more than half of their household income, compared with only 28 per cent of female nurses. However, a similar proportion

of males and females reported being the sole earner in their household (28 per cent for males versus 27 per cent for females).

6.3 Financial circumstances

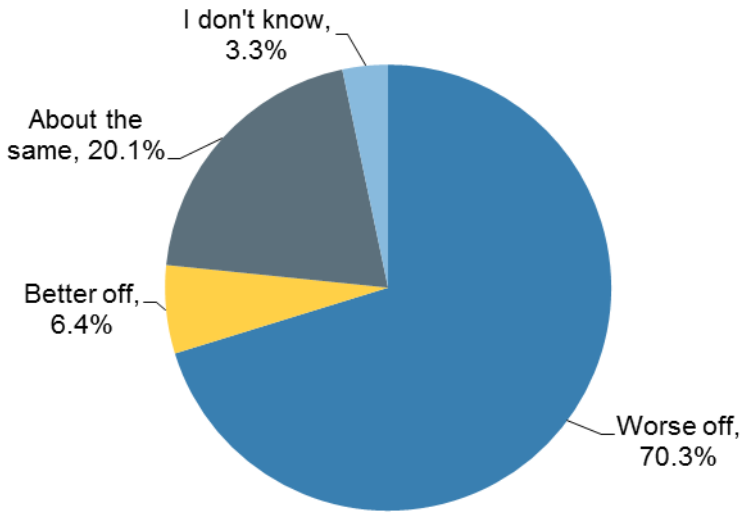
The financial circumstances of nursing staff appear to be worse than they have ever been. Nursing staff widely report financial struggles, particularly among the lower pay bands, many of whom are struggling to make ends meet. The financial situation for many respondents is precarious, with many resorting to working extra hours, borrowing money or taking on an additional job to survive. The personal cost of financial struggles is also apparent, with many nursing staff reporting that they had lost sleep as a result and that it was affecting aspects of their working lives too.

The details of these findings are reported below. Where we analyse survey findings by pay structure in this chapter, this has been by AfC pay band. Given that the majority of nursing staff are on NHS AfC pay bands (see Section 5.1), our analysis in this section focuses on this group. We explored the data by job roles and work settings. However, it was pay band which emerged as particularly important in determining experiences of financial struggle. Our analysis below reveals this close association between AfC pay band and the financial struggle reported by nursing staff, particularly nurses in the lower pay bands.

6.3.1 Nurses feel financially worse off

The majority (70%) of nursing staff said that they felt worse off financially compared to five years ago, and only six per cent said they felt better off (Figure 6.8). One in five (20%) reported that they felt about the same, and three per cent were unsure. This is up from 2015, when 51 per cent of nursing staff reported that they felt worse off than five years previously.

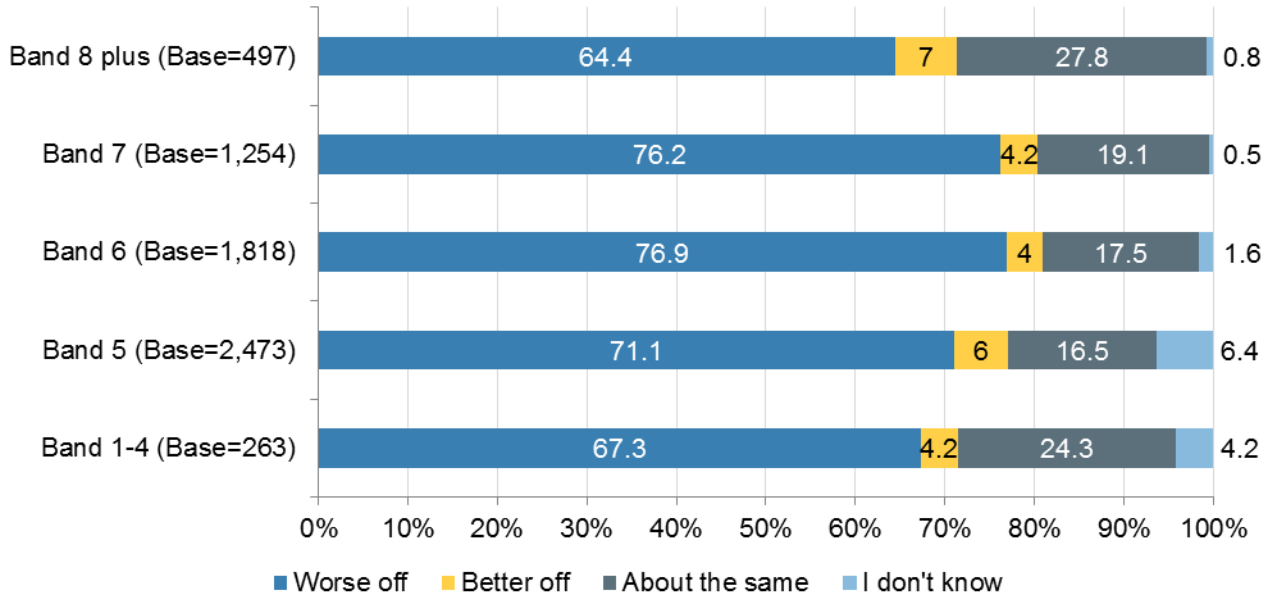
Figure 6.8: Financial situation compared to five years ago



Source: IES/ERL/RCN, 2017

Looking at differences by pay band we found that more nurses in Bands 6 and 7 felt worse off than nurses in other bands, perhaps hinting at the more widespread effect of the public sector pay cap, which has been in place since 2010.[22] Figure 6.9 shows that more nurses in Band 6 (77%) and Band 7 (76%) felt financially worse off compared to five years ago than nurses in Band 5 (71%) and Bands 1-4 (67%).

Figure 6.9: Financial situation compared to five years ago by AfC pay band



Source: IES/ERL/RCN, 2017

One Band 6 nurse described how she was 'broke' at the end of each month and felt financially much worse off than she did five years ago. She now claims for all her overtime saying, *'I can't afford goodwill anymore'* (Staff Nurse, West Midlands).

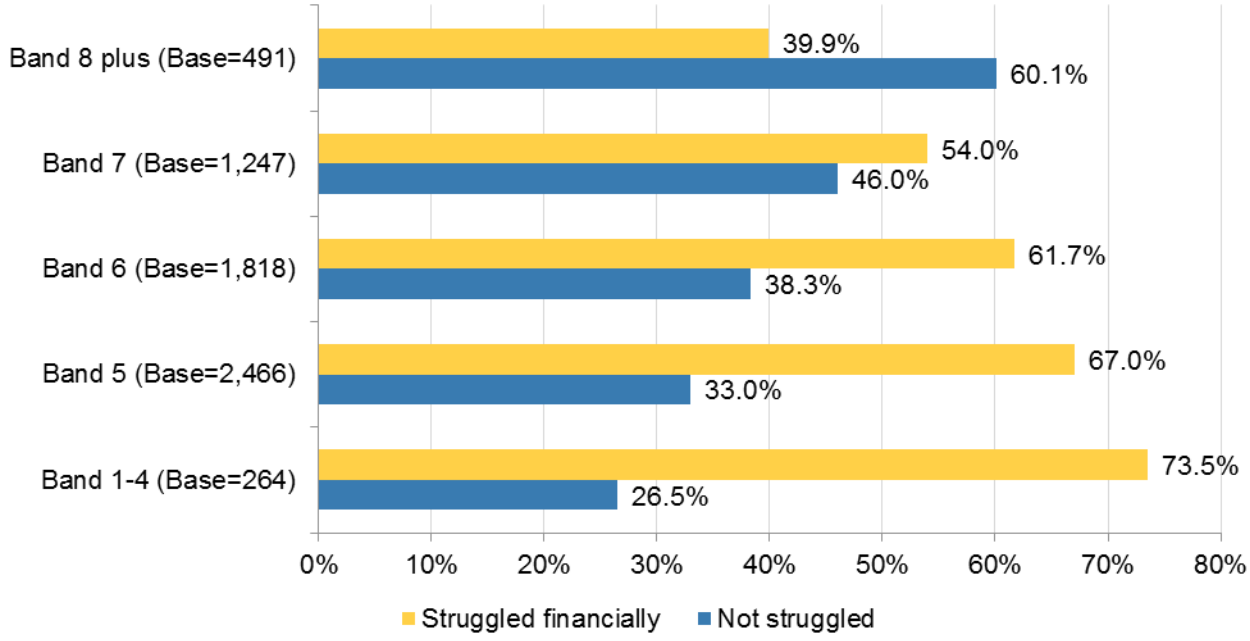
6.3.2 Experiences of financial struggles are widespread

Experiences of financial struggles over the past year are widespread among the survey respondents, and particularly those in the lower pay bands. Sixty per cent of all nursing staff reported financial struggles.

When analysed by AfC pay band, it is clear that financial struggles are more prevalent among nurses in the lower pay bands. More nurses in pay Bands 1-4 (74%) and pay Band 5 (67%) have experienced financial struggles in the last year than nurses in other bands (62 per cent in Band 6 and 54 per cent in Band 7) (Figure 6.10).

[22] Public sector pay was frozen in 2010 and in 2013, was capped at one per cent. In September 2017, the public sector cap was lifted in England and Wales for police officer and prison officers but remains in place for other public sector workers, including nurses. In the Autumn Budget 2017, the Government agreed to raise nursing pay depending on the outcome of ongoing pay talks.

Figure 6.10: Experienced financial struggle by AfC pay band

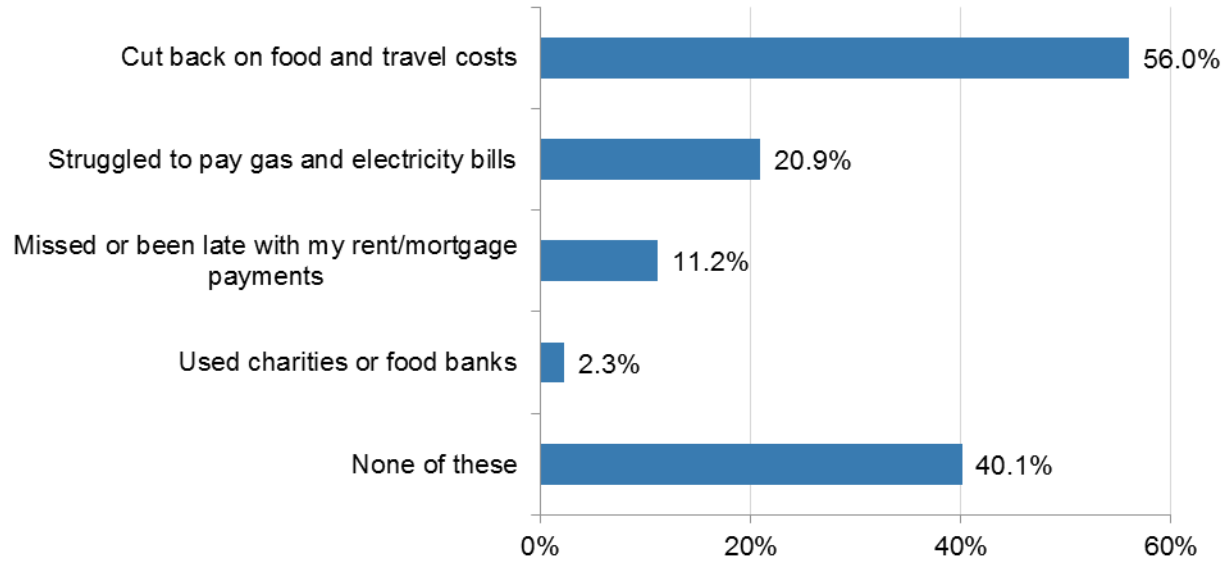


Source: IES/ERL/RCN, 2017

6.3.3 Nursing staff are struggling to make ends meet

Over half of nursing staff (56%) said that they had had to cut back on food and travel costs, 21 per cent had struggled to pay their gas and electricity bills, 11 per cent had missed or been late with their rent or mortgage payments, and two per cent of nurses reported that they had used charities or food banks (Figure 6.11)

Figure 6.11: Experiences of financial struggle over the past year

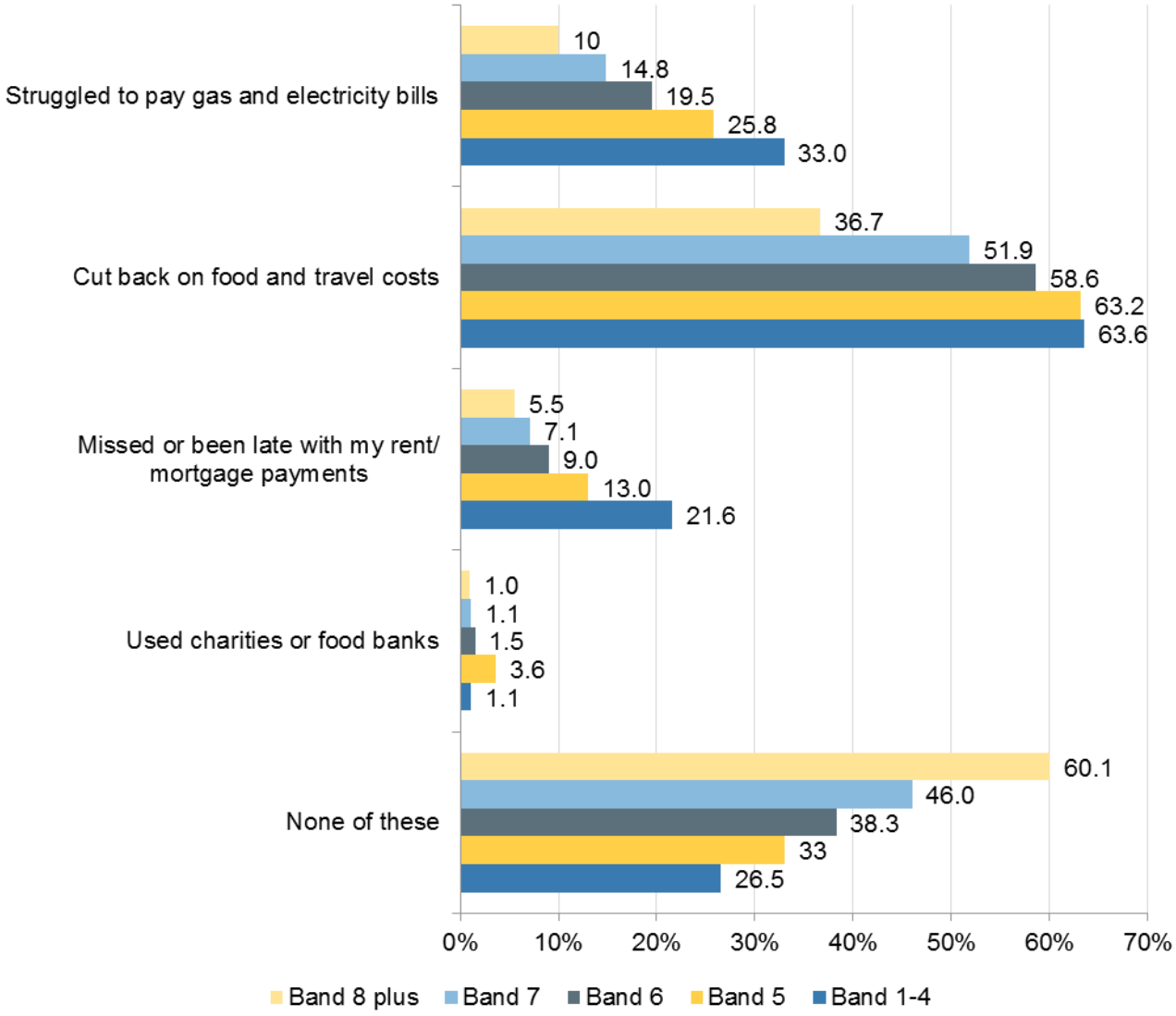


Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

Again, when looking at differences across pay bands, we found that experiences of financial struggles were more prevalent among lower AfC pay bands. Figure 6.12 shows nursing staff in AfC Bands 1-4 are much more likely to have missed or been late with rent/mortgage payments. Nurses in Bands 1-4 and Band 5 are more likely to report having to cut back on food and travel costs than other bands.

Figure 6.12: Experience of financial struggle over the past year by AfC pay band (percentage)



Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

One Band 6 nurse described how she struggled to pay bills and her rent each month, while another nurse described how she had no money left at the end of the month:

I'm just about managing – but that doesn't make it OK.

Mental Health Nurse, South West England

There is nothing left at the end of the month – nothing saved for a rainy day.

Staff Nurse, South West England

Nursing staff reported that they had had to resort to a number of different measures to make ends meet. Most nursing staff had had to work extra hours, borrow money or take

on an additional job to meet their daily expenses over the past year. Half of nursing staff (50%) had worked extra hours in their main job over the past year, 40 per cent had borrowed money from family, friends or a bank, 23 per cent had taken on an additional paid job to meet their daily expenses, and 6 per cent had taken out a payday loan (Table 6.1). As one nurse put it:

> *A lot of colleagues feel they have no choice but to work extra shifts to cope with living on the nursing wage.*
>
> Staff Nurse, North East

Table.6.1: Actions taken to meet everyday living expenses

	%
Worked extra hours in your main job	50.2
Borrowed money from family/friends/bank	39.8
None of these options	27.9
Taken on an additional paid job	23.2
Taken out a payday loan	6.0
Base N=100%	7,589

Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

More details of those who reported having taken on an additional job are provided below.

6.3.4 Reliance on additional paid jobs for extra income is high

As reported above, 23 per cent reported having to take on an additional job to make ends meet – approximately the same proportion that reported having an additional paid job in 2015 (22%). Most nurses who had taken on an additional paid job said that this had been in bank nursing (53%), followed by additional hours in their main job (34%), and agency nursing (30%). A minority of nurses worked additional jobs in NHS nursing management (3%), and care/nursing homes (5%) (Table 6.2).

Table 6.2: Other paid work in addition to main employment

	%
Bank nursing	53.1
Additional hours in my main job	34.3
Agency nursing	29.9
Non-nursing work	15.7
Non-NHS hospital	5.5
Care/nursing home	4.9
NHS nursing/management	2.9
Other	13.2
Base N=100%	1,754

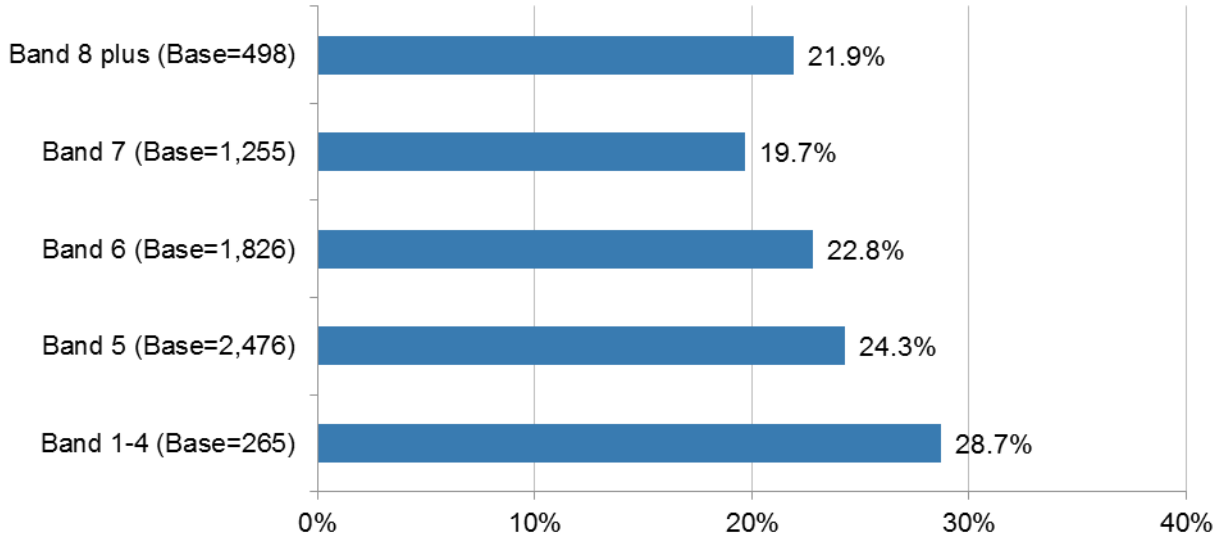
Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

It was clear from some responses that bank nursing was a preferable option for additional work since it offered nurses not just additional income, but potentially less stress and more flexibility too.

A higher proportion of nurses working in the lower AfC Bands 1-5 reported having an additional paid job, compared with nurses in Bands 7 and 8 (Figure 6.13). The fact that more nurses from these pay bands had to take additional jobs reflects the greater financial pressure that they are under.

Figure 6.13: Additional employment by AfC pay band



Source: IES/ERL/RCN, 2017

Table 6.3 shows that the majority of nursing staff took on additional work in order to provide additional income (90%), followed by maintaining staffing levels where they work

(47%), and to gain different experience (12%). One nurse reported having to work one bank shift every weekend to make ends meet and has now decided to change to agency working instead:

> *If you want people to stop working agency, pay them properly.*
>
> Clinical Nurse Specialist, South East England

> *A 0-1 per cent increment each year does not equate to the increasing responsibility that nurses have. That is why I don't blame some of my colleagues resorting to agency jobs because they get better pay than working in the NHS. If only the government would offer a more reasonable pay to healthcare staff, maybe hospitals will be able to retain most of their staff and need less from the agency staff.*
>
> Sister/Charge Nurse, Greater London

A minority of respondents took additional work because it was less stressful (10%), or to give themselves more flexibility in their working hours (7%) (Table 6.3).

Table 6.3: Reasons for doing additional work outside main employment

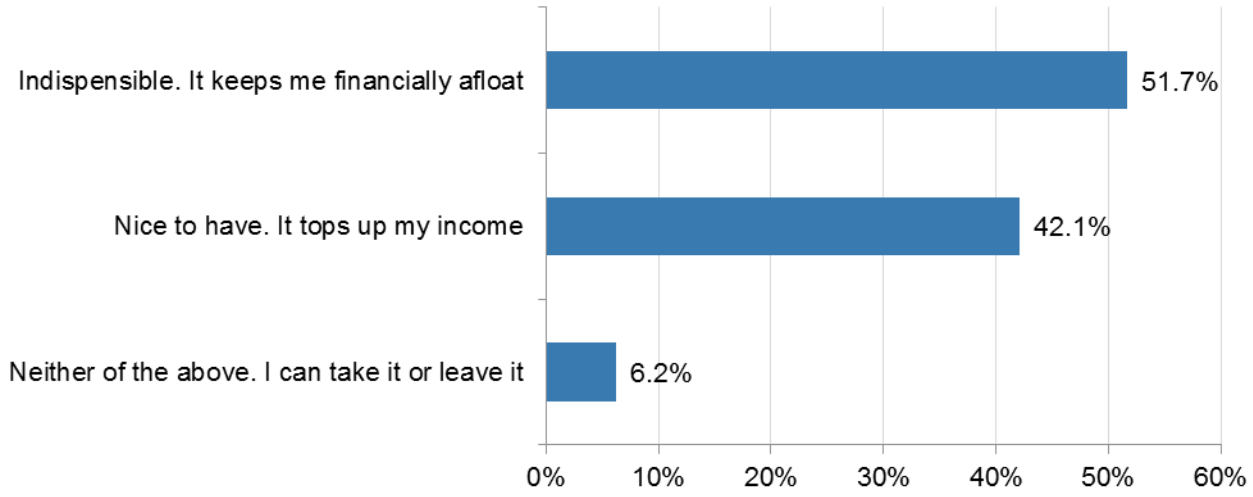
	%
To provide additional income	90.3
To maintain staffing levels where I work	46.8
To gain different experience	11.7
It is less stressful	9.3
Other	1.7
Base N=100%	4,472

Please note: respondents could select multiple responses

Source: IES/ERL/RCN, 2017

Worryingly, Figure 6.14 shows that the financial wellbeing of nursing staff who had additional jobs is heavily dependent on the income from these jobs. Nursing staff described the income from their additional job as '*Indispensable − it keeps me financially afloat'* (52%). Fewer (42%) described it as *'Nice to have. It tops up my income'*, and a very small minority described the income from their additional job as *'Neither of the above. I can take it or leave it'* (6%).

Figure 6.14: Views on the income generated from additional job



Source: IES/ERL/RCN, 2017

6.3.5 Financial struggles take a personal and professional toll on nursing staff

The cumulative effect of financial struggles has a knock-on impact on the personal and professional wellbeing of many nursing staff. Nursing staff were asked whether they had concerns regarding money and finances, and whether these had impacted on their lives. Forty-one per cent of nurses reported that they had lost sleep because of money worries, 24 per cent stated that they were considering leaving their job, 16 per cent admitted that they had spent time during work dealing with money problems, and 14 per cent reported that they had found it difficult to concentrate or make decisions at work because of money worries (Table 6.4).

Table 6.4: The reported effect of money worries

	%
Yes, I have lost sleep	40.9
Yes, I am thinking about leaving my job	23.7
I have spent time during work dealing with money problems	15.9
I find it difficult to concentrate/make decisions at work	13.6
None of these	41.5
Base N=100%	7,570

Please note: respondents could select multiple responses

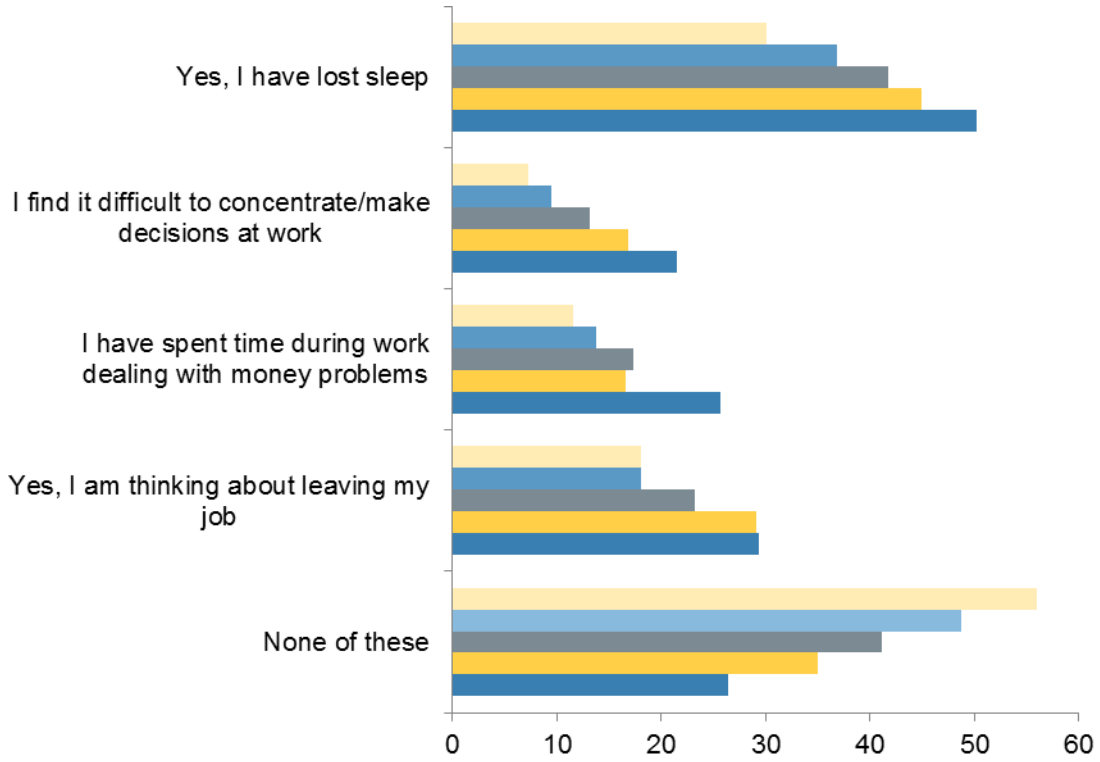
Source: IES/ERL/RCN, 2017

The effect of money worries, however, seems to be particularly manifest in Bands 1-4, where more nurses reported that they had lost sleep as a result of money worries and that it had affected their duties at work (Figure 6.15). A higher proportion of nurses in Bands 1-

4 also said that they had spent time at work dealing with money problems and had found it difficult to concentrate or make decisions at work.

Nurses in both Bands 1-4 and Band 5 were more likely to report that they are thinking about leaving their job because of money worries.

Figure 6.15: The reported effects of money worries by AfC pay band (percentage)



	None of these	Yes, I am thinking about leaving my job	I have spent time during work dealing with money problems	I find it difficult to concentrate/make decisions at work	Yes, I have lost sleep
Band 8 plus	56	18.1	11.6	7.2	30.1
Band 7	48.8	18	13.7	9.4	36.9
Band 6	41.1	23.2	17.3	13.2	41.7
Band 5	35	29.1	16.6	16.8	45
Band 1-4	26.4	29.4	25.7	21.5	50.2

Source: IES/ERL/RCN, 2017

The analysis above highlights a close association between lower AfC pay bands and the likelihood of reporting financial struggle. Again, this is consistent with higher levels of presenteeism among those in Bands 1-5 (as reported in section 3.2.5) and a greater likelihood of having taken on an additional paid job, as detailed above.

The personal cost of financial worries was summed up by one nurse who described the impact this had on her health and her self-esteem:

My financial situation is dramatic (I'm not exaggerating). Nursing wage is ok (ish) if there is another income in household. When my husband passed away two years ago I'm struggling with paying my bills. To support myself I worked overtime but it had an impact on my health. As a result I have recently undergone a heart operation and I was advised to take it easy (so no overtime and no additional income). I feel degraded as being qualified nurse I can't support myself.

Staff Nurse, Greater London

7 Career Satisfaction, Development and Progression

This chapter presents data on several interrelated themes regarding career satisfaction, progression and development.

Findings from this chapter show that **nursing staff are less likely to recommend nursing as a career than at any point in the last 10 years.** Exploring the findings in more depth, we found a strong association with a number of other issues which suggest that job **dissatisfaction is being driven by both unhappiness with pay banding and also the frequency with which nursing staff feel that patient care is compromised**, either because of work pressures or insufficient levels of staff. There is, therefore, a growing number in the workforce who have reservations about their careers, not only feeling that their pay is inappropriate but also that they are unable to provide the level of care that they would like.

Nursing staff are less likely to recommend nursing as a career and more than a third of nursing staff are seeking a new job. Nursing staff are most dissatisfied about being inappropriately banded in relation to their roles and responsibilities, and **opportunities to progress are perceived to be very limited**, with over half of nursing staff saying that they do not feel that they have opportunities to progress, mostly because of too few perceived opportunities to access training/development. Increasingly, nursing is seen as a 'dead end career' and this is having a knock-on effect on staff morale.

Summary of key findings:

- Nursing staff are less likely to recommend nursing as a career than at any point in the last 10 years, down from 51 per cent in 2007 to 41 per cent in 2017. Linked to this, there has been a similar decline in the proportion of nursing staff since 2007 who agree with the statement 'nursing is a rewarding career'.
- More than a third (37%) of nursing staff say that they are seeking a new job, compared to just under one quarter in 2007 (24%).
- Nursing staff who feel that they are inappropriately banded in relation to their role and responsibilities are the least positive about careers in nursing and are more likely to be seeking a new job.
- Half (54%) of nursing staff feel they do not have opportunities to progress in their current job. Nurses who first qualified outside of the UK are almost twice as likely as UK-qualified nurses to say that they 'don't know' whether they have opportunities to

progress, suggesting that ongoing uncertainty[23] about the status of EU nationals, post-Brexit, may be having a negative impact.

7.1 Few would recommend nursing as a career

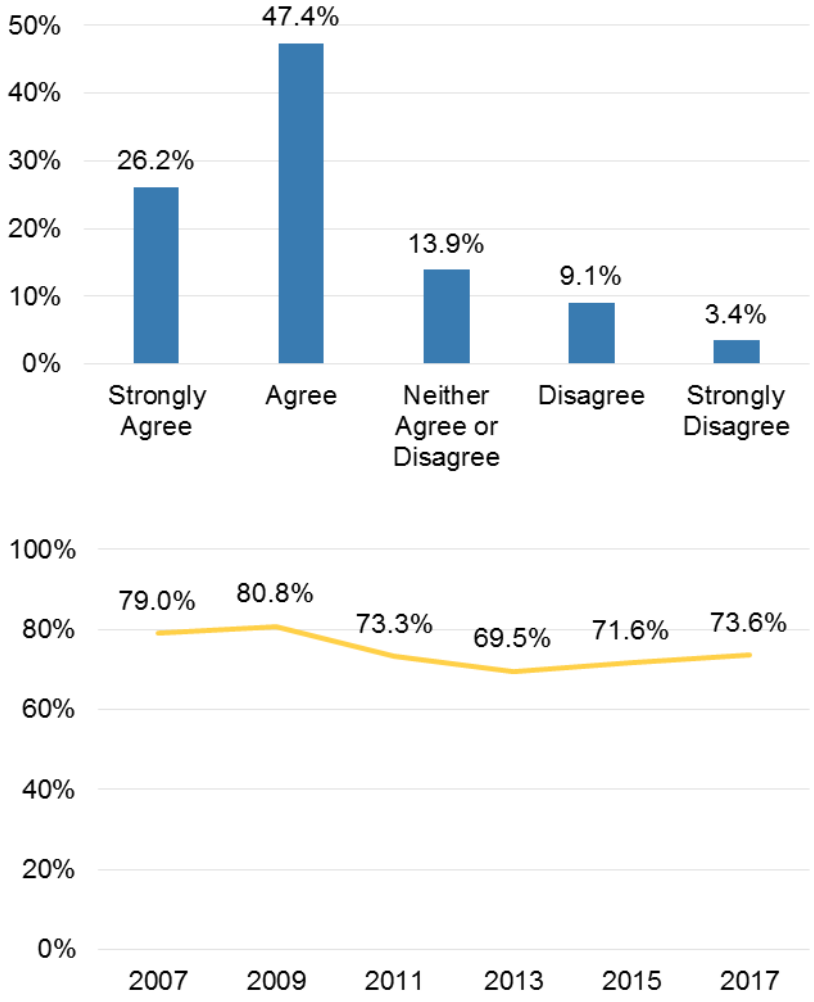
Why did I choose this for a career? When my daughter told me that she wanted to be a nurse, I was actually disappointed and thought 'Why would you want to do that'?

Band 8a Nurse Manager, Scotland

Six items were presented to respondents, five of which were the same as those presented in 2007, therefore offering a useful a benchmark on how nursing staff's views of their profession have changed in the last decade. '*I would recommend nursing as a career*' could be seen as an overview of how nursing staff feel about the state of the profession '*all things considered*'. By 2007, the previous decade had witnessed a steady improvement in the views of nursing staff about their profession, but today nursing staff are less likely to recommend nursing as a career than at any point in the past 10 years (Figure 7.2 below). Linked to this, there has been a similar decline in the proportion of nursing staff since 2007 who agree with the statement *'I think nursing is a rewarding career'* (down from 79 per cent in 2007 to 74 per cent in 2017) (Figure 7.1 below). Only one-third (35%) of all respondents agreed with the statement '*I would not want to work outside nursing'* - more or less the same figure as reported in 2007 (37%).

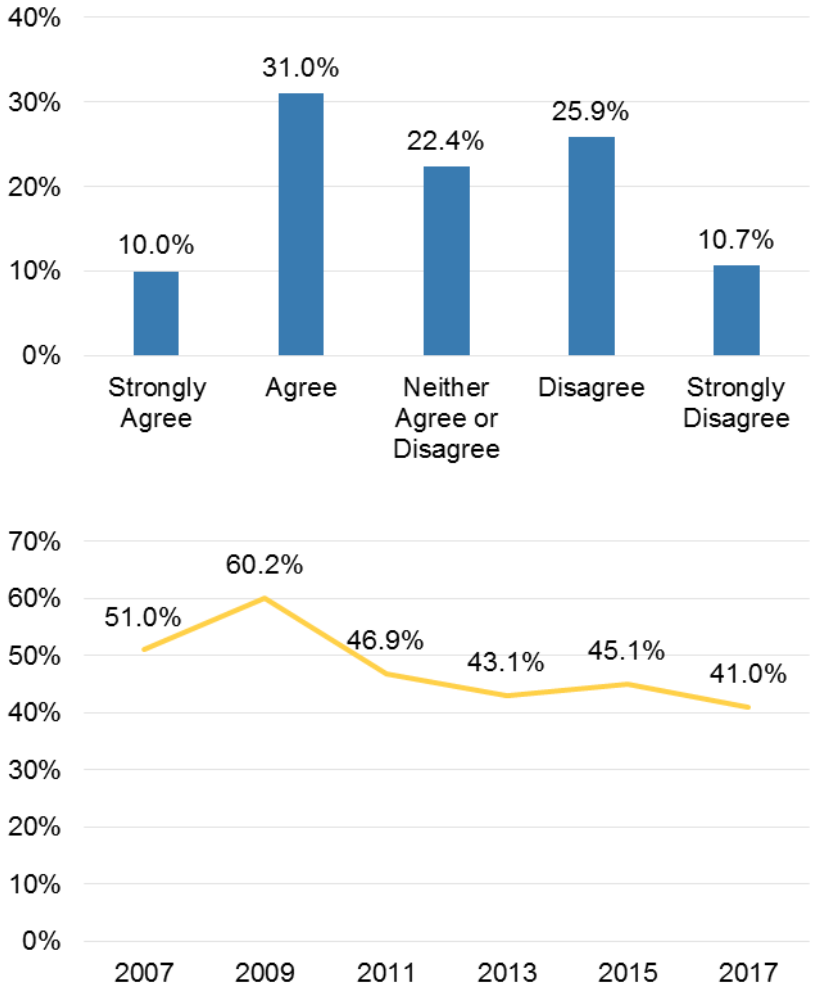
[23] At the time of writing.

Figure 7.1: Views on 'I think nursing is a rewarding career'



Source: IES/ERL/RCN, 2017

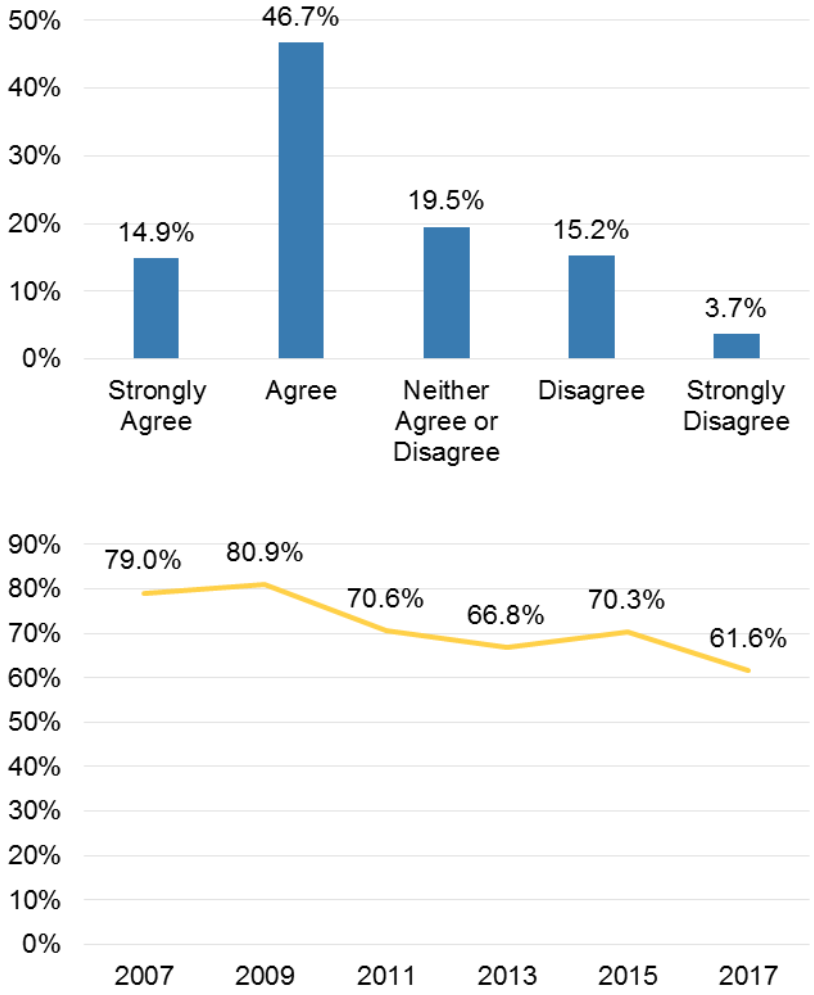
Figure 7.2: Views on 'I would recommend nursing as a career'



Source: IES/ERL/RCN, 2017

It is also apparent from this figure that there has been a significant fall in the proportion of nursing staff who agreed with the statement '*Most days I am enthusiastic about my job*' (from 79 per cent of all respondents in 2007 to 62 per cent this year) (Figure 7.3 below).

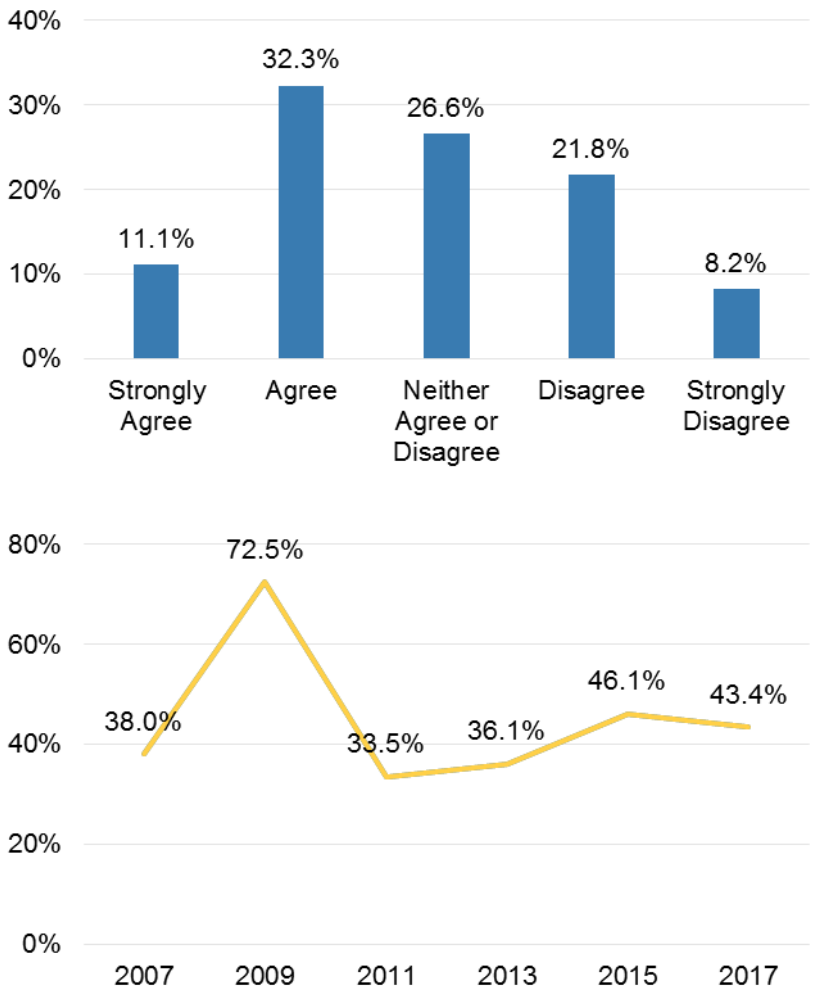
Figure 7.3: Views on 'Most days I am enthusiastic about my job'



Source: IES/ERL/RCN, 2017

More nursing staff today see the profession offering them a '*secure job for years to come'* than was the case 10 years ago. This could well be a result of nursing shortages in recent years and the need to recruit and train more nurses (Figure 7.4 below).

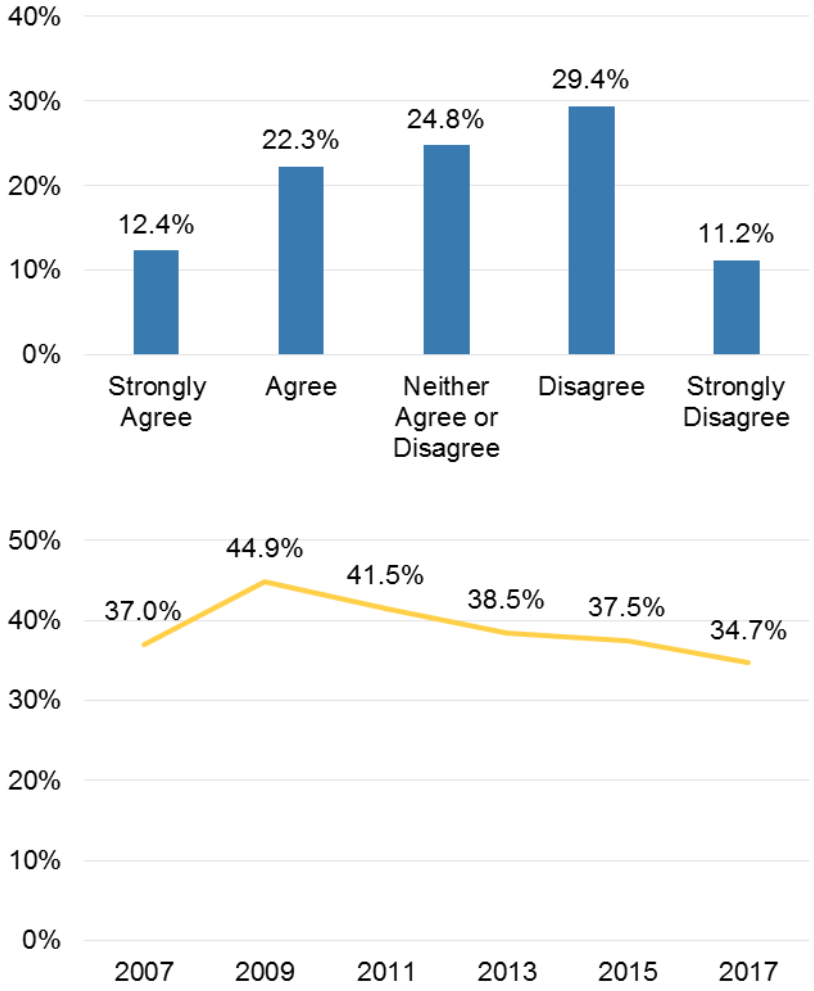
Figure 7.4: Views on 'Nursing will continue to offer me a secure job for years to come'



Source: IES/ERL/RCN, 2017

A further indicator of how nurses feel about their profession is reflected in responses to the statement '*I would not want to work outside nursing'.* A third of nurses (35%) reported that they would not want to work outside nursing showing a steady decline from 2007 and 2009 when nearer four in ten nurses said they would not want to work outside nursing.

Figure 7.5: Views on 'I do not want to work outside nursing'



Source: IES/ERL/RCN, 2017

Nursing staff working in GP practices and hospices/voluntary sector were more likely to have a positive view of nursing as a career than those in other areas of the NHS or the independent sector.

Analysis of the survey results shows a strong association between career satisfaction and pay band, with higher banded staff being more likely to recommend nursing as a career. This has been a feature of the employment survey with nurses who have progressed into higher graded and banded positions being more positive about their career than those on lower bands. For example, this year 41 per cent of Band 5 nurses would recommend nursing as a career compared to 54 per cent of Band 8 nurses.

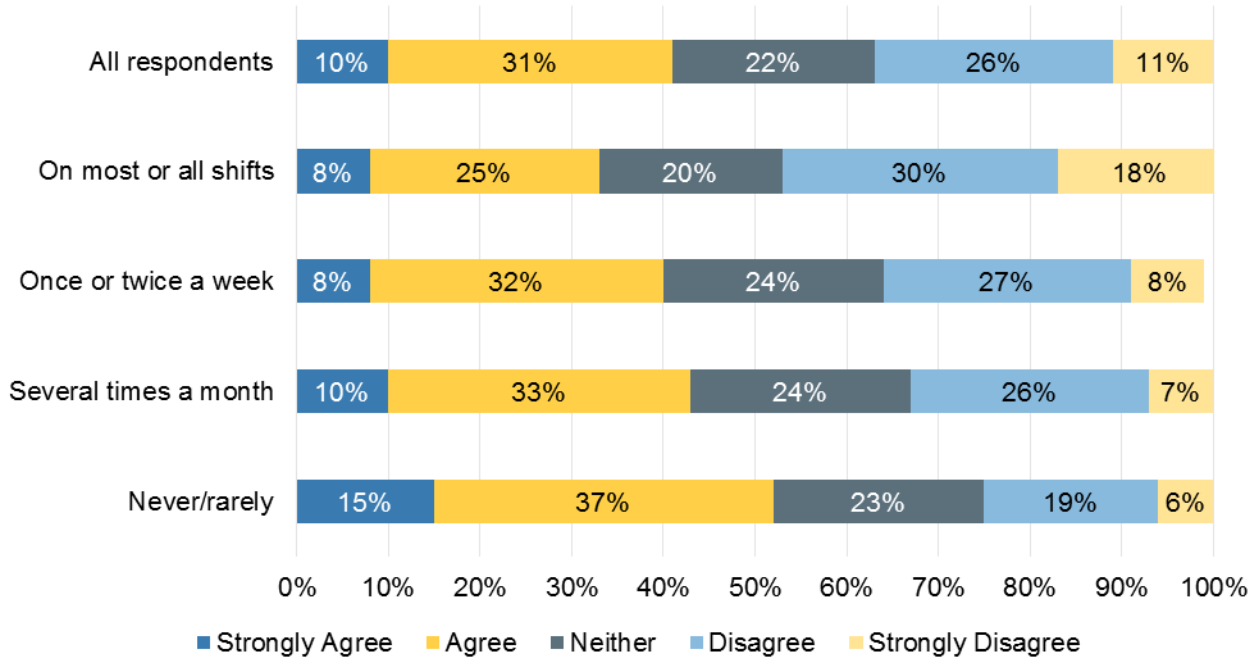
Career satisfaction also appears to be driven by perceptions of appropriateness of pay banding, showing it is not only the absolute level of pay but the feeling of fairness that makes the biggest difference to how people perceive nursing as a career. This is clear from the finding that just four in ten (39%) of nursing staff who said their pay band was not appropriate said they would recommend nursing as a career, while six in ten (59%) who said their pay band was appropriate said they would recommend it to others.

As well as feelings of fairness, perceptions about working in the nursing profession are clearly associated with views about patient care and the provision of sufficient staffing levels. For example, respondents who stated that patient care was frequently compromised were least likely to recommend nursing as a career. One nurse summed this up when they said:

> *After 33 years of nursing I decided to withdraw from the profession as I am disillusioned with the way nursing is heading. For me it's not about money it's about being able to deliver safe practice in an environment with staff shortages.*
>
> Staff Nurse, East of England

Where nursing staff perceived patient care to be more frequently compromised they were also least likely to recommend nursing as a career (Figure 7.6). For example, one-third (33%) of nursing staff working in areas where patient care was perceived to be compromised '*on most or all shifts'* agreed that they '*would recommend nursing as a career',* compared to more than half (52%) of those working in areas where care was only '*rarely or never'* compromised.

Figure 7.6: 'I would recommend nursing as a career' agreement by frequency of patient care being compromised (2017)



Source: IES/ERL/RCN, 2017

As might be expected, nursing staff who were seeking a new job or who had often gone to work despite feeling unwell were less inclined to recommend nursing as a career. Similarly, nursing staff who believed there were opportunities to progress in their current role were more likely to recommend nursing as a career.

Considering the item '*Most days I am enthusiastic about my job'* reveals very similar differences between nursing staff. Those who were working in environments where they

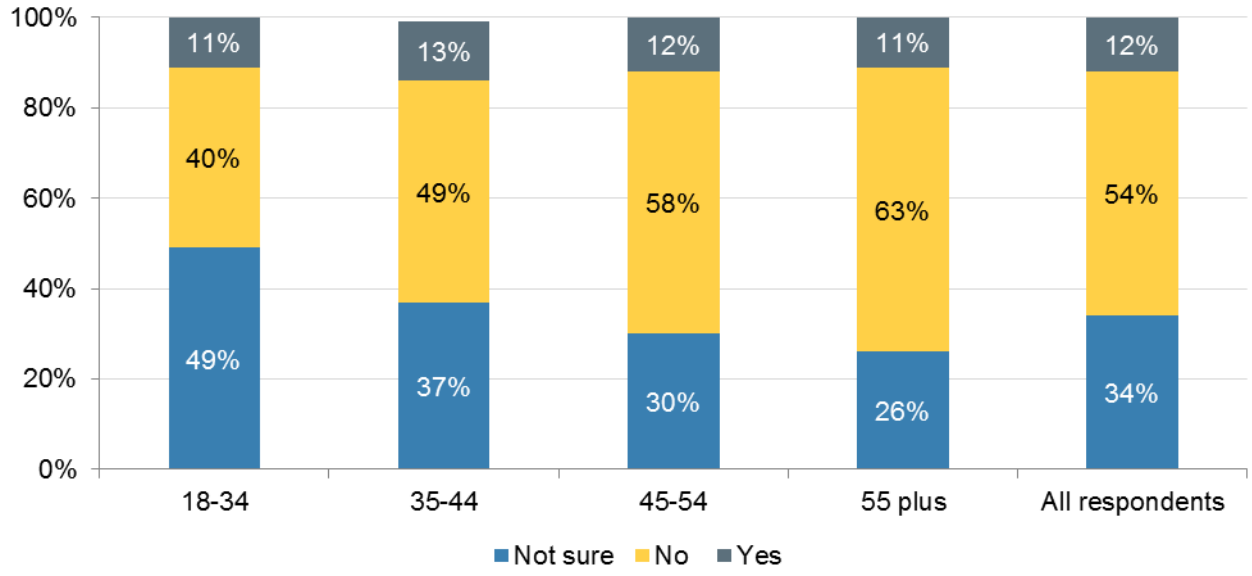
felt care was more often compromised, went to work whilst unwell, were seeking a change of job or felt opportunities to progress from their current role were limited were the least likely to agree with the statement '*Most days I am enthusiastic about my job'*.

7.2 Too few opportunities for staff progression

Our analysis shows a clear link between perceived opportunities to progress in a role and levels of job satisfaction. Just one-third (34%) of all nursing staff said they felt that there were opportunities to progress in their current job, half (54%) said they did not, and 12 per cent said they were not sure.

Perhaps unsurprisingly, age is a key factor influencing responses (Figure 7.7). Half (49%) of all nursing staff aged under 35 said they felt that there were opportunities to progress in their current role, compared to 37 per cent of those aged 35 to 44, 30 per cent of those aged 45 to 54, and 26 per cent of those aged 55 plus.

Figure 7.7: Are there opportunities to progress in your current job, by age band (2017)



Source: IES/ERL/RCN, 2017

This response pattern is also linked to '*time in current post'* with half (49%) of nursing staff who have been in post for less than a year indicating that there were opportunities in their current job, compared to 23 per cent of nursing staff who had been in post for 10 years or more.

Nearly twice as many nursing staff who first qualified outside the UK (21%) said they 'didn't know' whether they had opportunities to progress in their current job, compared to just 11 per cent of UK-qualified nurses. To some degree, this may reflect the post-Brexit context which has not offer EU citizens in the UK any certainty about their rights and status after March 2019, until only very recently.

> *I moved to the UK with my husband for good and we were planning a permanent life. Now I don't know where I stand.*

Agency Staff Nurse, Greek national working in the UK since 2013

Apart from not being sure about their future residency rights, at the time of the survey, some nurses also reported feeing 'unsafe' after the Brexit vote. For example, one staff nurse reported abuse from patients since the Brexit vote while another reported feeling 'unsafe'.

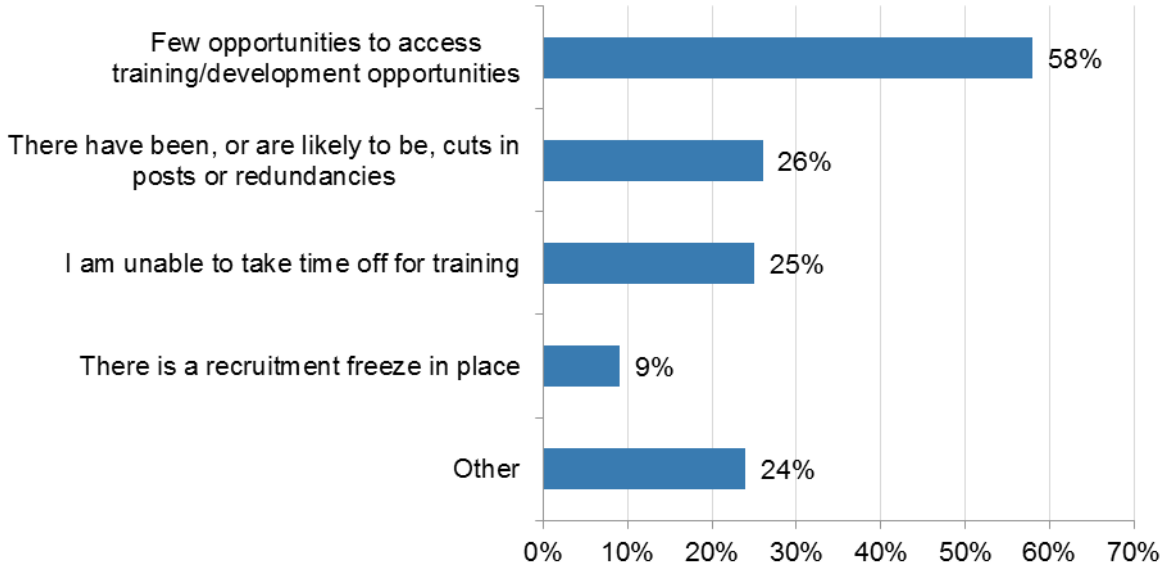
There are only minimal differences by workplace setting when looking at opportunities to progress.

Figure 7.8 shows that the main reason nursing staff feel there are few opportunities to progress in their current job is too '*few opportunities to access training and development opportunities'* (58%). '*Cuts in posts/redundancies'* was mentioned by one in four respondents (26%), and a similar proportion cited being '*unable to take time off for training'*. Just nine per cent indicated a '*recruitment freeze'* being in place where they work. One Band 5 staff nurse, working on an NHS hospital ward in London, described nursing as a 'dead end career' because there was no funding for training and development. Another staff nurse felt 'trapped' in her job:

> *I see all my friends progressing in their career and I think I want that but I'll never get there.*

Staff Nurse, Band 5, London

Figure 7.8: Reasons for lack of opportunities (no opportunities to progress, 2017) (N=4,105)



Source: IES/ERL/RCN, 2017

Being '*unable to take time off for training'* or having '*few opportunities to access training/development'* are aspects of progression and development that employers can control to some extent. Figure 7.9 presents the proportion of nursing staff who cited these as reasons for a lack of opportunities to progress in their current job. It is noticeable that nursing staff working in the NHS were most likely to cite both reasons (60 per cent of NHS nurses cited '*too few opportunities to access training/development',* compared to 51 per

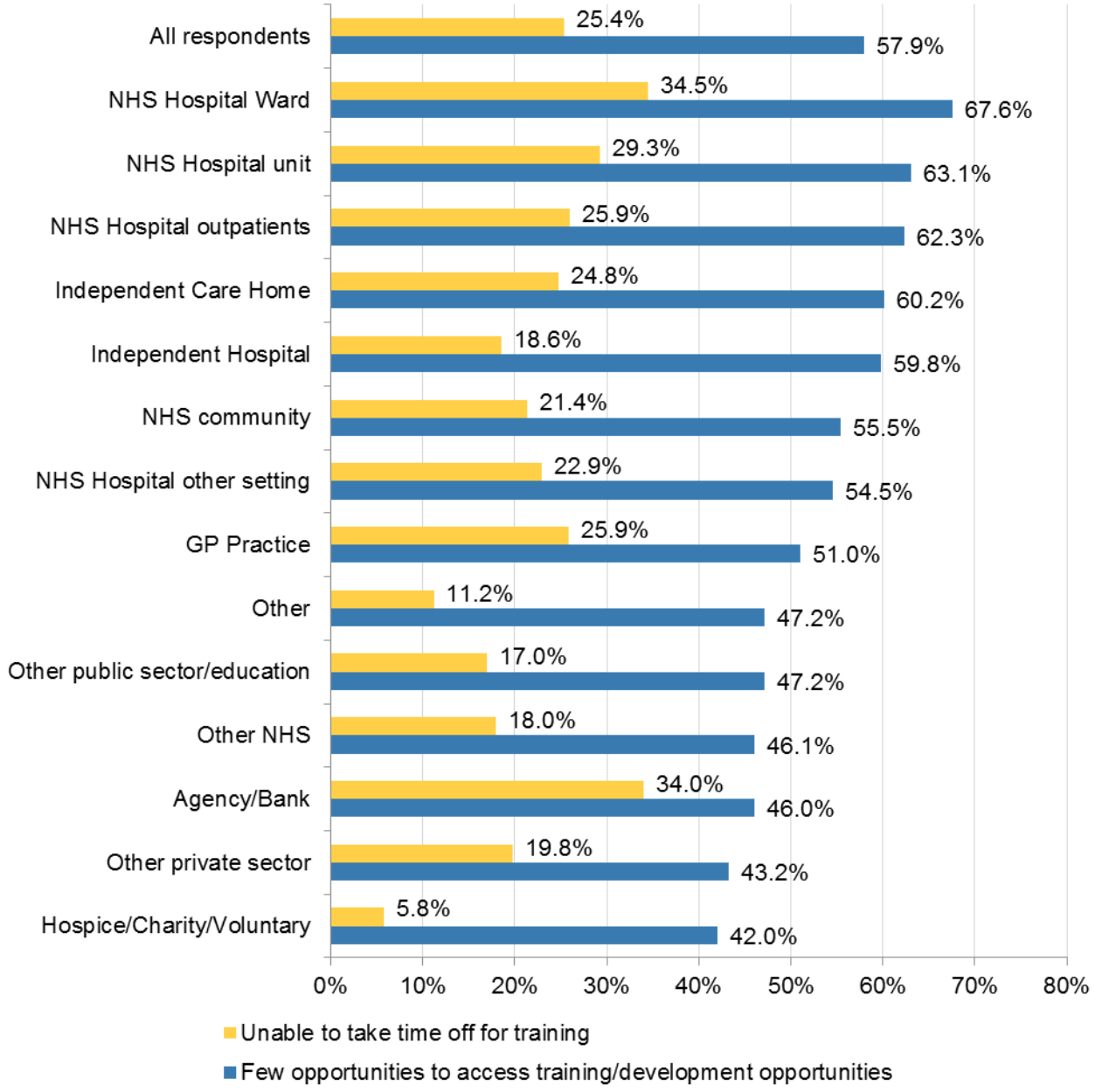
cent of nursing staff working in GP practices and 47 per cent of nursing staff working for other, non-NHS employers). Similarly, 27 per cent of NHS nursing staff said they were unable to take time off for training, compared to one in five (19%) of nursing staff employed in other, non-NHS, organisations. The figure shows that within the NHS, a higher proportion of nursing staff working in NHS hospitals, especially when working on wards, cite these reasons than is the case for nursing staff in other areas of the NHS. It is likely that short-staffing plays a role in limiting opportunities to train as one nurse put it:

> *The ward is constantly short-staffed and this means that there is no time to release nurses for training.*
>
> Staff Nurse, Band 5, London

However, these issues are not restricted to NHS settings; six in ten (60%) nursing staff working in independent care home and hospital settings said there were '*too few opportunities to access training/development'*.

Where other reasons were given for the lack of opportunities to progress, these tended to centre around lack of training generally, lack of appropriate posts to develop into/low turnover and posts blocked, own choice (especially where nursing staff were working for agencies/bank roles), working hours issues around access, and where nursing staff were at the top of their band and there was no likelihood of promotion (Figure 7.9).

Figure 7.9: Reasons for lack of opportunities (no opportunities to progress, 2017)



Source: IES/ERL/RCN, 2017

7.3 Many are seeking new jobs

More than a third (37%) of all nursing staff said they were seeking a new job, up from 31 per cent in the 2015 Employment Survey and from one quarter in 2007 (24%).This is consistent with wider evidence which shows a high number of vacancies in nursing and

midwifery in March 2017[24], high levels of staff turnover in some parts of the country[25], and, for the first time in recent history, more UK nurses and midwives leaving the profession than joining between 2016 and 2017.[26]

In NHS hospital wards, 41 per cent are seeking a new job, compared to 27 per cent of those in GP practices and 28 per cent of respondents working in hospices/voluntary sector.

The survey showed that the clearest link with the desire to find a new job was how appropriate respondents perceived their pay band/grade to be in relation to their role and responsibilities. Figure 7.10 demonstrates this relationship, showing that where nursing staff felt their band/grade was '*very inappropriate*', half (52%) were seeking a new job. This compares to just one in five to one in four nursing staff who thought their band/grade was '*very appropriate/appropriate*'. Where nursing staff felt there were no opportunities to progress in their current role, many more were seeking new jobs (48 per cent compared to 25 per cent of those who felt there were opportunities to progress).

> *There is a lack of progression opportunities which prompts many nurses to leave the ward. They become frustrated at reaching the top of Band 5 with high levels of skill and experience which are not matched by their pay.*
>
> Staff Nurse, Band 5, North East England

In addition to this, half (51%) of nursing staff, who indicated that they had experienced bullying or harassment from colleagues while at work, said they were seeking a new job, compared to 30 per cent of those who had not.

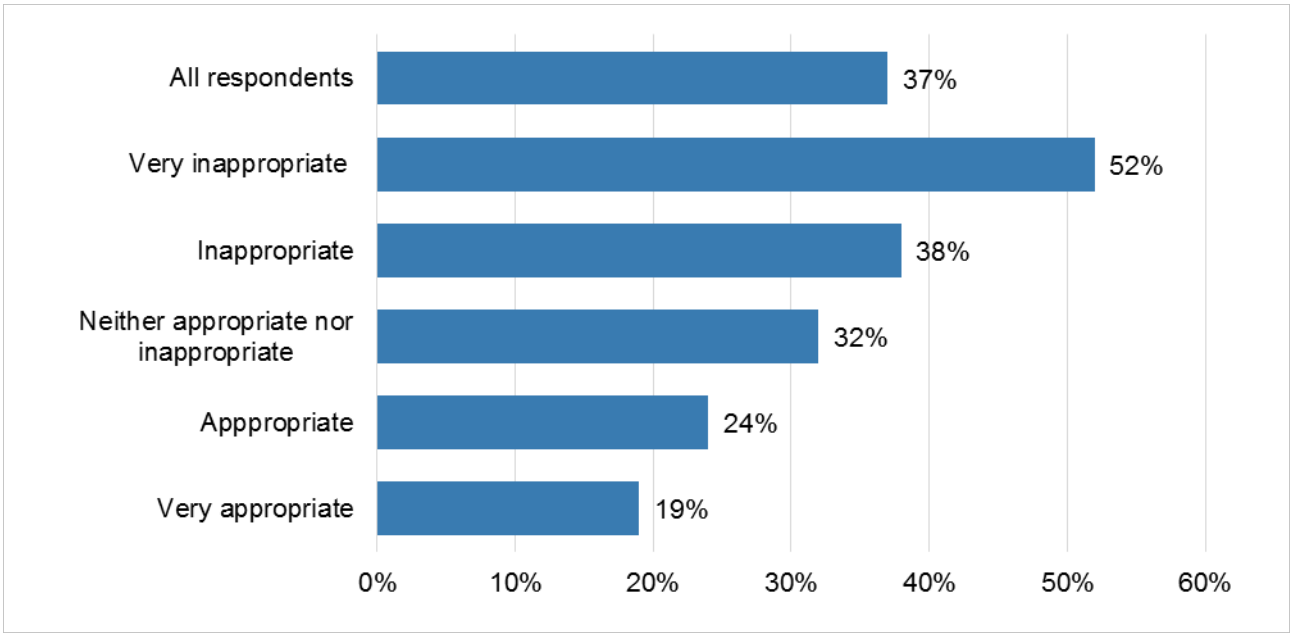
Four in ten (43%) of nurses on Band 5 were seeking a new job, compared to 38 per cent of those on Bands 1 to 4, 36 per cent of nurses on Band 6, 31 per cent on Band 7 and 35 per cent of nurses on Band 8 or higher.

[24] There are an estimated 40,000 registered nurse vacancies in England alone. See RCN (2017), *Safe and effective Staffing: The Real Picture,* Royal College of Nursing.

[25] Particularly London and the South East. See Marangozov R, Williams M and Buchan J (2016), *The Labour Market for Nurses in the UK and its relationship to the Demand for, and Supply of, International Nurses in the NHS*, Institute for Employment Studies.

[26] Nursing and Midwifery Council data, 2017. Between 2016 and 2017 45 per cent more UK registrants left the register than joined it. Nurses and midwives make up around 85 per cent of the register.

Figure 7.10: Seeking a new job by how appropriate band/grade is perceived (2017)



Source: IES/ERL/RCN, 2017

It is also noticeable that by job title, health visitors/SCPHN (54%), public and mental health nurses (48%) were significantly more likely to be seeking a new job than nurses working in other types of jobs.

Finally, it is also worth noting that where nursing staff were working in environments where patient care was thought to be compromised on most or all shifts, they were significantly more likely to be seeking new jobs (48 per cent compared to 24 per cent of nurses working in areas where patient care was rarely or never compromised).

> *Being the only registered nurse on the ward is anxiety provoking. Nurses are actively discouraged from reporting when the ward is not safely staffed and the job is dragging me down.*
>
> Staff Nurse, Band 5, moving from North West England to take up a nursing role in Australia in 2018

Those reporting that they are seeking new jobs were asked to indicate what sort of role they were looking for. Three in ten (29%) were seeking a similar role in the NHS, four in ten (39%) were seeking a different NHS role, one in four (24%) were seeking a similar role to the one they were doing outside the NHS, and a third (34%) were seeking a different role outside the NHS. Just 14 per cent were seeking work abroad and one in ten (10%) mentioned other paths. One-third of respondents mentioned two or more possible options (Table 7.1).

Table 7.1: Type of role sought, by employer group, those seeking new job (2017)

	Similar NHS role %	Different NHS role %	Similar role outside NHS %	Different role outside NHS %	Working abroad %	Other %	Base N=100%
NHS hospital ward	28	45	24	29	17	7	800
NHS hospital unit	26	44	20	38	18	7	367
NHS hospital outpatients	33	41	23	33	15	9	126
NHS hospital other	28	45	29	35	16	7	319
GP Practice	34	26	24	27	10	12	144
NHS community	31	44	20	38	9	12	554
Other NHS	40	39	27	37	8	5	146
Independent hospital	35	10	18	42	13	23	62
Independent care home	27	12	35	32	9	26	66
Agency/Bank	0	11	22	53	31	14	36
Hospice/Charity/Voluntary	34	26	21	37	3	24	38
Other public sector	36	21	32	32	14	21	28
Other private sector	31	25	22	38	15	20	55
Other	24	18	26	28	11	28	74
All respondents	29	39	24	34	14	10	2,815

Source: IES/ERL/RCN, 2017

Table 7.1 shows the roles being sought by nurses working in different sectors. The table suggests quite a bit of mobility between sectors but, regardless of sector, most nurses are looking for different roles either within or outside the NHS.

7.4 Mandatory training and appraisals

Our analysis showed no association between staff experiences of mandatory training and appraisals and career satisfaction.

Four-fifths (83%) of all nursing staff indicated that they had completed all their mandatory training, with half (54%) saying they had completed their last mandatory training in normal working time. One in five (20%) said it was done in their own time and one in four (26%) said it was done in both their own and work time.

There is little variation in the likelihood of nursing staff having completed their mandatory training, but staff working in agency/bank settings (83%) and independent care homes (43%) were much more likely than most other staff to have to complete the training in their own time.

Appendix A: The Nursing Workforce Today

The nursing workforce today is facing a unique set of challenges and unprecedented pressures. The purpose of this short section is to briefly summarise these issues in order to place the findings of the 2017 Employment Survey in context.

Today, the nursing workforce continues to be heavily reliant on international nurses; IES and OECD estimate that 12.7 per cent of UK nurses were foreign trained, compared to an OECD average of 5.9 per cent.[27] While international nurses always have played an important role in the NHS, they can be no substitute for long-term, strategic workforce planning. Without this, the workforce remains vulnerable because tighter immigration restrictions, the impact of Brexit and the global shortage of nurses will make it more difficult to recruit from abroad. There has already been a 96 per cent reduction in the number of EU nurses coming to the UK, post Brexit.[28]

There are also issues in the workforce around pay, retention, stress and burnout. In the context of public sector pay constraint since 2010, it is estimated that there has been a cumulative real term fall in weekly earnings of 13.8 per cent and a 7.8 per cent cumulative real term drop for nursing auxiliaries and assistants.[29] This is likely to be contributing to high leaving rates, with more nurses now leaving the Nursing and Midwifery Council (NMC) register than joining. Although the Government has pledged to raise pay, this is dependent upon ongoing pay negotiations with the sector. Stress and burnout also play an important role in the high leaving rates. A 2012 report found that 10 per cent of UK nurses intended to leave the profession.[30] In a European nursing survey, 42 per cent of UK nurses reported burnout (the highest of all 10 European countries surveyed), compared to the European average of 28 per cent.[31]

The combined effect of these trends is that demand continues to outstrip the supply of nurses. Evidence from 2016 found *that 'the national NHS nurse supply picture in England is showing problematic signs for the 'security of supply'*: the confidence that policy makers, planners and managers must have that current and future supply will meet

[27] OECD (2015), *Health at a Glance 2015.* Paris: OECD, p. 9; Marangozov R, Williams M and Buchan J (2016), *The Labour Market for Nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS,* Institute for Employment Studies.

[28] The Health Foundation (2017), 'New data show 96% drop in nurses from EU since July last year', The Health Foundation. Available at: http://www.health.org.uk/news/new-data-show-96-drop-nurses-eu-july-last-year [Accessed 12 December 17]

[29] RCN (2017 forthcoming), *The UK Nursing Labour Market Review 2017,* Royal College of Nursing.

[30] Heinen M et al. (2012), 'Nurses' intention to leave their profession: A cross-sectional observational study in 10 European countries', *Journal of Nursing Studies*, Vol. 50 No. 2, pp. 174-184.

[31] Heinen M et al (2012) 'Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries', *Journal of Nursing Studies,* Vol. 50 No. 2, pp. 174-184.

requirements.'[32] For example, recent data from UCAS, shows a 23 per cent drop in the number of students applying to study nursing at university in 2017.[33] This, combined with restricted NHS Trust budgets and the removal of the nursing bursary, means that supply in the nursing workforce is looking more uncertain now than ever before. In the meantime, demand for health and social care services continue to grow. Recent research has identified population growth among those aged 85+ as one of the most significant drivers of future healthcare demand on NHS Trusts.[34]

The Government has introduced a number of measures designed to support the workforce, including the introduction of the assistant practitioner role and the nursing associate role, and funding for 10,000 additional training places by 2020 for nurses, midwives and allied health professionals. Despite this, there are ongoing concerns around the future supply and demand of nursing staff in the UK given the 'perfect storm' of issues that have emerged in recent years.

Given this context, the RCN Employment Survey 2017 provides an important insight into the kind of workforce issues that are impacting nurses and their career decisions.

[32] Marangozov R, Williams M and Buchan J (2016), *The Labour Market for Nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS,* Institute for Employment Studies, p. 14.

[33] UCAS (2017), *Applicants for UK higher education down: 5% for UK students and 7% for EU students,* UCAS. Available at: https://www.ucas.com/corporate/news-and-key-documents/news/applicants-uk-higher-education-down-5-uk-students-and-7-eu-students [Accessed 12 December 2017]

[34] Marangozov R, Williams M and Bevan S (2016), *Beyond Brexit: Assessing key risks to the nursing workforce in England*, Institute for Employment Studies. Available at: http://www.employment-studies.co.uk/resource/beyond-brexit-assessing-key-risks-nursing-workforce-england

Appendix B: Respondent profile

This section highlights the employment, demographic and educational level of nursing respondents who took part in the survey. As mentioned in the preceding chapter, the profile of respondents is sufficiently similar to the RCN membership that it can be said to be representative of the membership as a whole.

The majority of respondents (91%) described their current employment situation as employed and working. Most (83%) work for the NHS and over half (61%) work in hospitals, with a further 18 per cent working in community-based settings. Just over one third of respondents (35%) identified their main job title as staff nurse and a further 18 per cent identified as senior nurses.[35]

Most respondents (90%) are female and the majority of respondents are aged 45 or over. In addition, around one in ten (nine%) reported that they have a disability. Most respondents (89%) identified their ethnic group as White, with four per cent identifying as Black African/Caribbean, three per cent as Asian/Asian British, and one per cent as mixed or multiple ethnic background.

The majority of respondents (81%) work in England, 10 per cent work in Scotland, five per cent in Wales and three per cent in Northern Ireland.

Seven per cent of respondents first registered as a qualified nurse outside of the UK, with over half (58%) of those qualifying outside the European Economic Area, mainly from African and Asian countries (particularly the Philippines, India, Nigeria and South Africa). Among those who first registered as a qualified nurse in the European Economic Area, the main countries of origin are Romania, Portugal and Italy.

Employment profile

Current employment situation

The majority of respondents (91%) described their current employment situation as employed and working (Table B 1). Other respondents described themselves as being retired but still in paid employment, employed but on either sick or maternity leave, a student, fully retired or unemployed.

[35] Including sisters, charge nurses, ward managers, matrons and nurse managers.

Table B 1: Which of the following best describes your current employment situation? (All respondents)

	No.	%
Employed and working	6,963	90.8
Retired but still in paid employment	298	3.9
Employed but currently on maternity or sick leave	200	2.6
Student	147	1.9
Fully retired	34	0.4
Unemployed	21	0.3
Other	6	0.1
Total	7,669	100

Source: IES/ERL/RCN, 2017

Main employer and location of work

Table B 2 shows that 83 per cent reported that they work for the NHS (excluding GP practices) including for NHS Bank, NHS 111/NHS 24 helpline, an NHS commissioning organisation or other NHS employer, such as a health board. Six per cent were working for independent/private health care providers and five per cent for GP practices. Other employers include charities, private companies, nursing agencies and social enterprises.

Table B 2: Who is the employer for your main or usual job? (All respondents)

	No.	%
NHS (excluding GP practices)	5,813	77.9
Independent/private health care or social care provider	418	5.6
GP practice	397	5.3
NHS Bank	179	2.4
Charity/voluntary sector/hospice	136	1.8
NHS commissioning organisation (e.g. CCG, CSU)	117	1.6
Private company/industry	104	1.4
Other	71	1.0
Nursing agency	70	0.9
Other NHS employer (e.g., health board, CQC, Public Health England, Health Education England)	42	0.6
Further/higher education	34	0.5
Other public sector (e.g. armed forces, criminal justice)	27	0.4
NHS 111/NHS 24/helpline	25	0.3
Local authority/other public body	16	0.2
School	12	0.2
Total	7,461	100

Source: IES/ERL/RCN, 2017

Looking at the main location of work, 61 per cent were employed in hospitals, including hospital wards (28%), specialist units (15%), outpatients/day care (six%) or another hospital setting (6%). A further 18 per cent of respondents worked in a community-based setting (Table B 3).

Table B 3: Where do you currently spend most of the time in your main or usual job? (All respondents)

	No.	%
All hospital settings	4,552	61.0
Hospital ward	2,057	27.5
Community	1,334	17.9
Hospital unit	1,087	14.6
GP practice	536	7.2
Across different hospital settings	522	7.0
Hospital outpatients	444	5.9
Other hospital setting	442	5.9
Care home	338	4.5
Office environment	219	2.9
Various/across organisations	102	1.4
Hospice	84	1.1
Further/Higher education	70	0.9
School	62	0.8
Prison service	57	0.8
Industry/workplace	43	0.6
Other	36	0.5
Call centre	24	0.3
Ambulance trust	11	0.1
Total	4,137	100

Source: IES/ERL/RCN, 2017

Main job title and area of practice

Just over one third of respondents (35%) identified their main job title as staff nurse. Senior nurses (including sisters, charge nurses, ward managers, matrons and nurse managers) made up 18 per cent of survey respondents (Table B 4).

Table B 4: Which one of the following job titles best describes your main or usual job? (All respondents)

	No.	%
Staff nurse	2,643	34.5
Sister/charge nurse	912	11.9
Clinical nurse specialist	673	8.8
Senior nurse/matron	457	6.0
District/community nurse	414	5.4
Assistant practitioner/health care assistant	322	4.2
Mental health nurse	293	3.8
Advanced nurse practitioner	289	3.8
Practice nurse	263	3.4
Nurse practitioner	191	2.5
Community psychiatric nurse	185	2.4
Educator/trainer	172	2.2
Divisional/clinical/directorate lead	133	1.7
Student	128	1.7
Other	105	1.4
Deputy sister/charge nurse	101	1.3
Health visitor/SCPHN	78	1.0
Researcher/lecturer/tutor	74	1.0
School nurse	63	0.8
Occupational health nurse	58	0.8
Consultant nurse	45	0.6
Commissioning/policy	34	0.4
Public health nurse	27	0.4
Total	7,660	100

Source: IES/ERL/RCN, 2017

The most common areas of practice identified by respondents were acute and urgent care (20%) and primary and community care (18%) (Table B 5).

Table B 5: Which of the following best describes the area of practice in your main or usual job? (All respondents)

	No.	%
Acute and urgent	1,895	24.9
Primary and community care	1,334	17.5
Mental health	733	9.6
Surgical	717	9.4
Children and young people/young adults	575	7.5
Older people	444	5.8
Outpatients	387	5.1
Cancer care	340	4.5
Nursing home	222	2.9
Management/leadership/policy	154	2.0
Learning disability	152	2.0
Education and development	132	1.7
Neonatal	121	1.6
Other	123	1.6
Public health	104	1.4
Quality improvement/research	94	1.2
Occupational/workplace/environmental health	70	0.9
E-health/telecare	22	0.3
Total	7,619	100

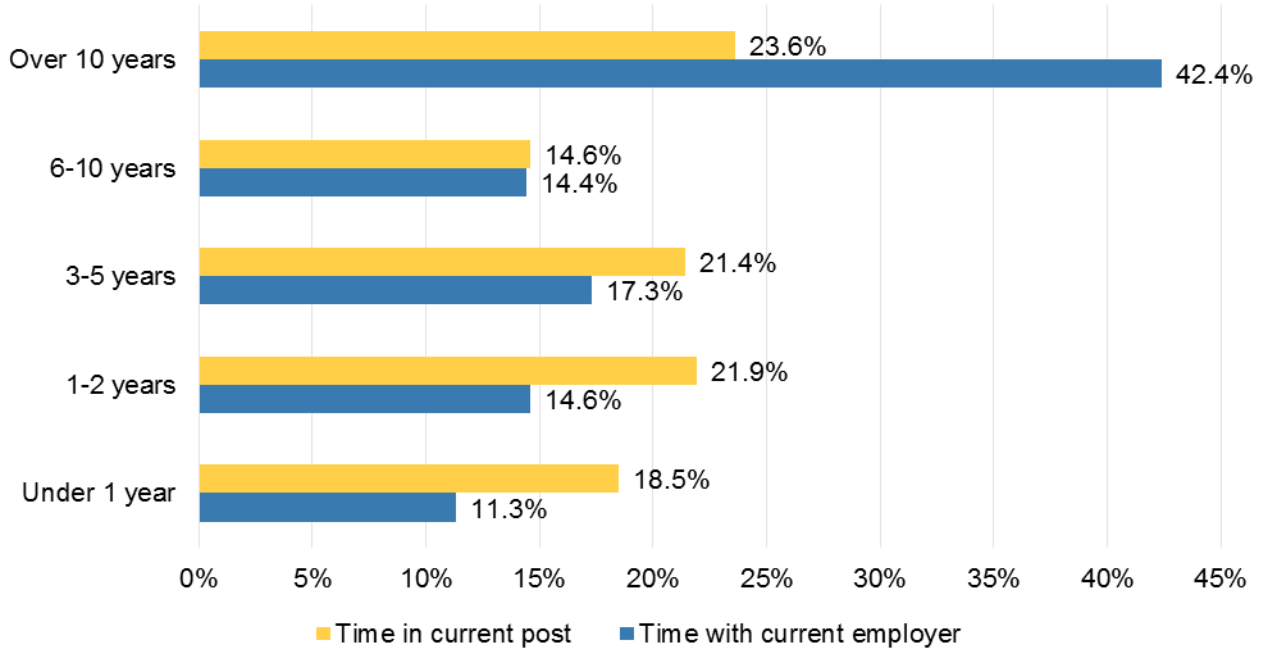
Source: IES/ERL/RCN, 2017

Length of service with current employer and time in current post

Respondents were asked how long they have been employed both with their current employer and in their current post. Over two fifths (43%) of respondents had been with their current employer for over 10 years and another fifth (19%) between five and 10 years (Figure B 1).

Almost half of respondents had been in their current post for more than five years and one in four had been in post for more than 10 years.

Figure B 1: Time with current employer and current post



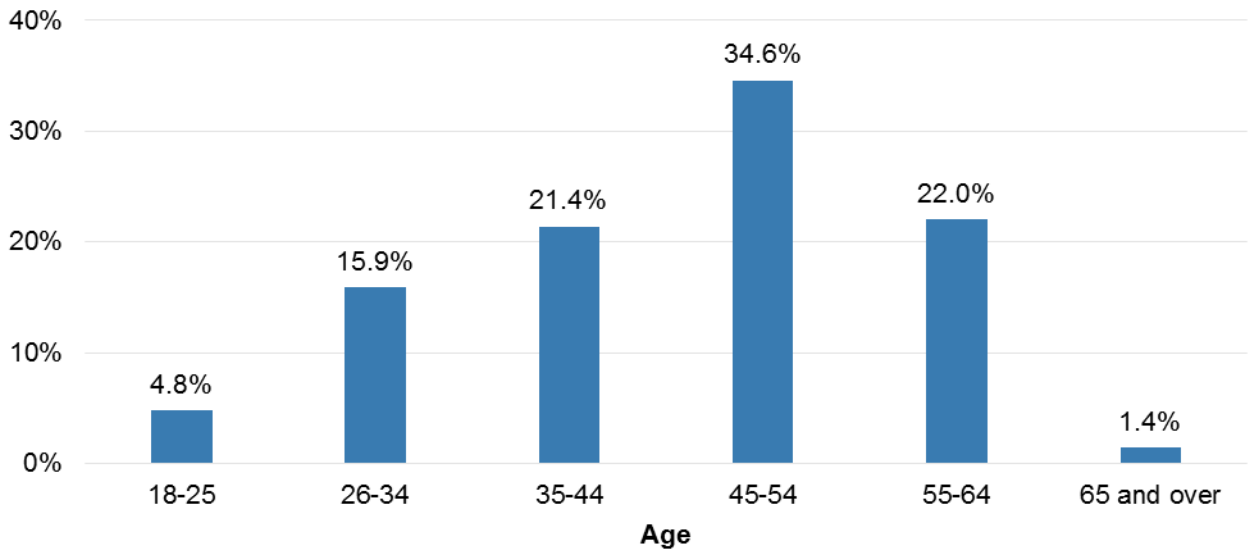
Source: IES/ERL/RCN, 2017

Demographic profile

Age, gender, disability and ethnicity

Eighty eight per cent of respondents are female and 12 per cent are male. The majority of respondents are aged 45 or over, with 35 per cent aged 45-54 and 22 per cent aged 55 or over (Figure B 2). In addition, nine per cent reported that they have a disability.

Figure B 2: Age breakdown of respondents



Source: IES/ERL/RCN, 2017

Most respondents (89%) identified their ethnic group as White, with four per cent identifying as Black African/Caribbean, three per cent as Asian/Asian British, and one per cent as mixed or multiple ethnic background (Table B 6).

Table B 6: Survey respondents by ethnic group

	No.	%
White	6,785	89.0
Black African/Caribbean	335	4.4
Asian/Asian British	220	2.9
Mixed/multiple ethnic groups	82	1.1
Prefer not to say	183	2.4
Other ethnic group	16	0.2
Total	7,621	100

Source: IES/ERL/RCN, 2017

Country of work

The majority of respondents (82%) work in England, 10 per cent work in Scotland, five per cent in Wales[36] and three per cent in Northern Ireland.

[36] Respondents in Wales were also asked about Welsh speaking. Of the 375 Wales-based respondents, 58 (15 per cent) said they speak Welsh to some extent and of those 58 (72 per cent) speak Welsh professionally in their role.

Respondents working in England were also asked to state their region of work and responses are presented in Table B 7 below. Out of 6,172 working in England, 16 per cent are in the South East, 15 per cent work in the South West and 14 per cent work in the North West.

Table B 7: Location of work by English region

	No.	%
South East	982	15.9
South West	940	15.2
North West	838	13.6
West Midlands	695	11.3
Greater London	622	10.1
East of England	559	9.1
East Midlands	604	9.8
Yorkshire and Humberside	601	9.7
North East	331	5.4
Total	6,172	100

Source: IES/ERL/RCN, 2017

Qualifications held

Survey respondents were asked about the types of registration and qualifications held (they were asked to tick all that applied.) A majority (52%) have completed their first-level registration nursing qualifications and eight per cent hold second level registration. In addition, 45 per cent hold a nursing degree, 36 per cent hold a diploma and 11 per cent hold a Masters or PhD. A small proportion (6%) hold a NVQ/SVQ at level 2, 3 or 4 (Table B 8).

Table B 8: Nursing qualifications held (respondents holding qualification)

	No.	%
First level registration (SRN/RN)	3,958	51.8
Nursing degree	3,397	44.5
Nursing diploma	2,755	36.1
Masters/PhD	828	10.8
Second level registration (ie SEN)	594	7.8
NVQ/SVQ level 2,3 or 4	456	6.0

Source: IES/ERL/RCN, 2017

Registered nurses

Country of registration

A total of 501 respondents (seven%) first registered as a qualified nurse outside of the UK, with 58 per cent of these qualifying outside the European Economic Area, mainly from African and Asian countries (particularly the Philippines, India, Nigeria and South Africa). Among those who first registered as a qualified nurse in the European Economic Area, the main countries of origin are Romania, Portugal and Italy.

Age at registration

The average age at which nurses first qualified as a registered nurse is 26, an increase from 23 in 2002, as more nurses qualify later in life than was traditionally the case. The 2017 Employment Survey suggests that 22 per cent of all respondents qualified at the age of 30 or older. This pattern is more prevalent among men, one-third (32%) of whom qualified aged 30 plus, compared to 20 per cent of women, with the mean age at first registration among men being 28, compared to 25 among women.

Highest nursing qualification

Nursing is now a degree-level entry profession, but it has not always been so. Ten years ago, 26 per cent of all respondents reported holding a degree as their highest level of qualification. Today, that figure is 40 per cent.

The changes in nurse education are reflected in the age profile by highest qualification held. Table B 9 below shows how the proportion of registered nurses holding nursing degrees increases inversely with age. Only one in four nurses aged 55 plus hold a nursing degree, compared to more than six in ten nurses aged under 35.

Table B 9: Highest nursing qualification held by age band[37] (percentage)

	18-25	26-34	35-44	45-54	55-64	65+	All
Degree	86.1	61.2	47.3	32.5	24.9	14.0	40.4
Diploma	5.4	24.3	36.4	22.9	20.5	18.3	24.7
Higher degree	3.1	10.3	10.9	13.5	11.3	10.8	11.4
Other qualification	0.7	0.5	0.7	2.7	5.7	9.7	2.6
Base N=100%	*294*	*1,107*	*1,546*	*2,513*	*1,589*	*93*	*7,142*

Source: IES/ERL/RCN, 2017

[37] Some students are included in the 18 to 25 age band, which distorts the figures slightly.

Appendix C: About the Survey

A key characteristic of the RCN Employment Surveys are that the methodology has evolved over time to ensure that there is some continuity in the data collected. Resources necessitated recent Employment Surveys (2013 and 2015) used an entirely online methodology among the whole membership, but weighting and careful consideration of the response patterns have ensured that some continuity in the analysis has been enabled. In particular, certain questions used have been included since the surveys started in the late 1980s. The survey achieved 7,720 usable responses and the respondent profile was sufficiently similar to the RCN membership that it can be said to be representative of the membership as a whole.

Questionnaire design

To ensure continuity and allow comparisons with previous years, the questionnaire covers core employment and biographical questions including: demographic details; pay and grading; working hours; job change; and various attitude items relating to nurses' experiences of working life.

The questionnaire design reflects input from the RCN Employment Relations Department, and builds on earlier surveys to enable longitudinal comparison. As a result of lower response rates in recent surveys of RCN members, reflecting both changes in the methodology and wider difficulties in maintaining response rates, the length of the questionnaire has shortened this year and has resulted in larger numbers completing the survey. A draft questionnaire was designed following discussion between IES/ERL and the RCN. The questionnaire was revised to ensure it was as user-friendly as possible while still meeting the requirement to supply reliable data that could be contrasted with previous surveys. A pdf copy of the online survey can be provided on request by the authors or the RCN.

Survey process, response and weighting

The online survey was emailed via the RCN membership database during June and early July, with two email reminders and a communications strategy that involved publicising the survey via social media.

By the time the survey closed on 12 July 2017, 7,720 usable responses had been submitted, representing a significant increase in the total response on previous years, vindicating the move to a shorter questionnaire and perhaps suggesting concern among the membership around workforce and employment-related issues and how they impact on the working lives of nurses.

When response rates are low, weighting the data can be essential to try and ensure that the response set, as far as possible, is representative of the population from which it is

drawn. The data were analysed and compared with the entire RCN membership to explore differences by region, gender and, based on previous experience, most importantly, age. In previous years it has been found that nurses in the early stages of their careers, in particular younger nurses, are less likely to respond than older nurses. This has the effect of introducing an unintentional bias whereby the views of nurses working, for example, in NHS hospitals (often younger nurses), in particular BAME and internationally recruited nurses, are under-represented, while conversely nurses working in GP practices, more often White, older and working part-time, are over-represented. These effects need redressing in the analysis.

However, our analysis demonstrated that, this year, the respondent profile on these key variables was sufficiently similar to the RCN membership to not warrant further weighting and the data can be said to be representative of the membership.

Table C 1: Respondents by region

	Number of respondents	% of all respondents
Region		
East Midlands	555	9.1
Eastern	600	9.8
London	614	10.0
North West	330	5.4
Northern	836	13.7
South East	972	15.9
South West	933	15.2
West Midlands	690	11.3
York & Humberside	593	9.7
Other England	64	0.8
Total England	**6,207**	**81.6**
Northern Ireland	236	3.1
Scotland	788	10.4
Wales	370	4.9
Gender		
Female	6,595	87.7
Male	921	12.3
Age band[38]		
18-25	363	4.8
26-34	1,215	16.0
35-44	1,627	21.5
45-54	2,629	34.7
55-64	1,655	21.8
65 and over	96	1.3
All UK	**7,608**	**100**

Source: IES/ERL/RCN, 2017

[38] The 18 to 25 and 26 to 34 age bands required some estimation for the membership records as the categories were not the same as used in the Employment Survey.

Appendix D: Sample statistics and confidence for small sub samples

A key concern of the survey is to provide an accurate measure of nurses' experiences and views. Given that some of the statistics produced in the report are based on relatively small numbers of respondents, it is worth looking at the reliability of the estimates. For the most part, though, large samples are used and we can be very confident that the results are reliable estimates of the population of RCN members.

Here we try to give some indication as to the precision of the results given in the substantive parts of the report. The table below gives the approximate margin of error associated with percentage estimates for a 50/50 and 10/90 split for different sample sizes. The worst case in terms of precision of the estimate is for a 50/50 split in the sample.

Table D 1: Margin of error for estimating the population proportion to be 50/50 or 10/90 for different sample sizes and for a 95 per cent confidence interval

	Sample size				
	200	**500**	**1,000**	**2,000**	**5,000**
Standard error and (margin for 50% estimate)	3.5 (±7.0%)	2.2 (±4.4%)	1.6 (±3.2%)	1.1 (±2.2)	0.7 (±1.4)
Standard error and (margin for 10/90% estimate)	2.4 (±4.8%)	1.5 (±2.6%)	1.1 (±2.2%)	0.74 (±1.5%)	0.4 (±0.8%)

To put it into words, if we were estimating that 10 per cent of ethnic minority nurses hold a particular view and 500 responded to the question, the following applies:

> *We are 95 per cent confident that between 7.4 per cent and 12.6 per cent of ethnic minority nurses hold this view (10 per cent ± 2.6%).*

However, when we are looking at larger sub samples, for example all NHS nurses, a more precise estimate can be provided, say 10 per cent ± 1.5 per cent.

Knowledge of the margin of error allows us to specify the likely range of the estimate obtained from the survey data within which the population value lies with a certain level of probability/confidence. It also allows us to say, when two estimates differ by a certain amount, how confident we can be that they indicate different population values.

Clearly, with smaller sub samples, variation in the response increases and the level of precision of the data declines. As a result, reporting differences between groups of sub samples becomes more problematic and prone to error. However, we should also note that the main concern of most surveys is to estimate the magnitude of effects. This means that determining strength of opinion about key issues is as important as whether two results are significantly different from one another.

Additional data

Table D 2: Biographical profile by employer group: percentages (base cases maximum)

	% under 45	% aged 45 plus	% male	% qualified over 30	% BAME	% non-UK qualified	% diploma qualified	% degree/ higher qualified	*Number respondents*
NHS Hospital Ward	60	40	13	26	10	12	24	52	*1,935*
NHS Hospital unit	52	48	16	20	7	8	25	52	*1,025*
NHS Hospital outpatients	31	69	8	19	7	8	24	43	*417*
NHS Hospital other setting	37	63	12	15	5	7	21	57	*916*
GP Practice	25	75	3	17	1	3	22	45	*536*
NHS community	35	65	11	26	2	7	24	50	*1,414*
Other NHS	27	73	16	20	3	6	22	52	*372*
Independent Hospital	32	68	13	23	20	14	26	28	*170*
Independent Care Home	36	64	15	22	20	17	35	26	*210*
Agency/Bank	33	67	19	32	28	32	37	39	*70*
Hospice/Charity/Voluntary	26	74	7	20	6	1	20	38	*135*
Other public sector/education	27	73	14	11	3	7	14	68	*82*
Other private sector	39	61	14	20	14	15	20	40	*138*
Other	30	70	14	22	8	10	23	39	*235*
All respondents	42	58	12	22	7	9	24	49	*7,655*

Source: IES/ERL/RCN, 2017

Table D 3: Biographical profile by job title: percentages (base cases maximum)

	% under 45	% aged 45 plus	% male	% qualified over 30	% BAME	% non-UK qualified	% diploma qualified	% degree/ higher qualified	*Number respondents*
Staff nurse	52	48	11	28	11	11	44	47	*2,625*
Sister/charge nurse	40	60	13	17	8	10	37	43	*909*
Senior nurse/matron	36	64	14	18	7	10	43	61	*455*
Practice nurse	21	79	1	13	1	3	26	28	*260*
Advanced nurse practitioner	30	70	17	13	4	6	33	78	*286*
Assistant practitioner/health care assistant	42	58	21	33	0	7	2	3	*321*
Clinical nurse specialist	33	67	8	12	5	7	40	60	*670*
Commissioning/policy	29	71	16	19	0	3	56	71	*34*
Community psychiatric nurse	40	60	30	37	1	9	41	53	*181*
Consultant nurse	11	89	12	8	2	5	14	75	*44*
Deputy sister/charge nurse	48	52	7	22	8	11	35	38	*100*
District/community nurse	41	59	4	28	2	5	44	52	*411*
Divisional/clinical/directorate lead	19	81	18	8	5	10	28	73	*132*
Educator/trainer	25	75	11	10	1	5	29	62	*170*
Health visitor/SCPHN	46	54	1	14	0	8	65	92	*78*
Mental health nurse	57	43	23	35	3	11	45	52	*290*
Nurse practitioner	31	69	15	14	3	7	42	55	*190*
Public health nurse	42	58	12	9	0	8	46	69	*26*
Occupational health nurse	13	88	7	11	7	5	49	56	*58*
Researcher/lecturer/tutor	28	72	10	13	9	7	28	72	*74*
School nurse	31	69	3	11	2	5	36	44	*62*
Student	90	10	10	0	0	12	24	28	*127*
Other	11	89	22	13	4	4	19	32	*98*
Total	42	58	12	22	7	9	38	49	*7,601*

Source: IES/ERL/RCN, 2017

Table D 4: Biographical profile by field of practice: percentages (base cases maximum)

	% under 45	% aged 45 plus	% male	% qualified over 30	% BAME	% non-UK qualified	% diploma qualified	% degree/ higher qualified	*Number respondents*
Acute and urgent	53	47	15	23	9	11	23	55	*1,889*
Primary/community care	31	69	5	22	2	5	25	44	*1,324*
Surgical	50	50	11	23	14	13	26	46	*713*
Cancer care	40	60	7	19	6	4	14	64	*339*
Children and young people/young adults	52	48	8	13	3	5	24	57	*570*
Education and development	25	75	10	13	3	9	16	63	*130*
E-health/telecare	23	77	19	14	5	9	23	45	*22*
Learning disability	41	59	20	20	1	5	27	43	*150*
Management/leadership/policy	23	77	16	8	3	5	13	66	*154*
Mental health	46	54	29	37	3	11	28	49	*724*
Neonatal	47	53	3	14	9	8	19	61	*121*
Older people	38	62	9	25	9	9	24	35	*438*
Nursing home	39	61	14	23	24	20	34	26	*220*
Occupational/environmental health	13	87	13	11	6	4	20	52	*70*
Outpatients	31	69	7	17	9	7	26	36	*384*
Public health	32	68	8	19	5	5	17	62	*102*
Quality improvement/research	34	66	7	8	6	10	16	63	*94*
Other	31	69	17	17	2	5	18	37	*115*
Total	42	58	12	22	7	9	24	49	*7,559*

Source: IES/ERL/RCN, 2017

Table D 5: Biographical profile by region: means and percentages (base weighted cases max)

	% under 45	% aged 45 plus	% male	% qualified over 30	% BAME	% non-UK qualified	% diploma qualified	% degree/ higher qualified	*Number respondents*
East of England	41	59	13	19	8	10	35	45	*555*
East Midlands	47	53	11	22	6	8	33	45	*600*
Greater London	57	43	15	22	18	26	44	58	*614*
North East	38	62	12	22	4	5	42	53	*330*
North West	40	60	10	23	6	7	35	46	*836*
South East	42	58	11	20	10	12	36	47	*972*
South West	42	58	12	22	7	6	37	47	*933*
West Midlands	47	53	12	24	7	14	37	45	*690*
Yorkshire and Humberside	41	59	14	21	3	6	34	46	*593*
England	44	56	12	22	8	10	37	48	*6143*
Scotland	35	65	14	22	2	2	45	56	*788*
Wales	38	62	14	28	2	2	47	60	*370*
Northern Ireland	36	64	11	12	3	1	48	56	*236*
Total	42	58	12	22	7	9	38	49	*7,608*

Source: IES/ERL/RCN, 2017