At breaking point?
A survey of the wellbeing and working lives of nurses in 2005
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Employment Research Ltd
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Employment Research Ltd

Formed in 1994, Employment Research Ltd is a small independent research consultancy, undertaking a range of research and evaluation, much of which is focused on health sector human resource issues. For the last five years Employment Research Ltd has undertaken the RCN Annual Employment survey and conducted the RCN Working well survey.

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1. Introduction

Survey background

The RCN commissioned a survey of 6,000 members in 2000 to explore nurses’ wellbeing and working lives. The results\(^1\) subsequently helped shape RCN policy and materials for members on topics such as bullying and harassment, violence, needlestick injury and employee-friendly working practices.

Five years on, the RCN has commissioned a second survey looking at a similar range of issues. This report documents the findings of that survey, and describes differences between the 2000 and 2005 survey findings.

Context

At the time of the first survey in 2000, it was estimated that 22,000 whole time equivalent (WTE) posts were vacant in the NHS in England in March 2000. The ageing of the nursing workforce and the training deficits of the early 90s combined to produce shortages that were felt to “threaten to undermine the effective delivery of health care”\(^2\). At the end of the 90s and beginning of the new millennium concerted efforts were made to improve the recruitment and retention of nurses. This included government-supported initiatives to make nursing a more attractive profession.

July 1999 saw the launch of a £1m NHS campaign to Improve working lives (IWL) in England. The Improving working lives standard (October, 2000) stated that by April 2003 all NHS employees would be entitled to work for organisations that demonstrated commitment to flexible working arrangements. Key elements identified included: childcare support; support for carers; team-based self-scheduling; and flexi-time.

IWL and related initiatives indicate a more general move towards flexibility, and providing better work-life balance for employees. The Department of Trade and Industry (DTI) states that the ‘government is committed to encouraging the growth of flexible working and other work-life balance policies in the UK’.

The nursing workforce has also been gradually changing. The number of student nursing places has been increased over the last decade to reverse the reduction of the previous decade. Coupled with a large increase in the numbers of nurses recruited from outside the UK, there is an overall increase in the UK nursing workforce.

However, this has not been enough to end all staffing shortages\(^3\) because the volume and complexity of care delivered continues to grow. The Healthcare Commission noted: “In the past four years, the number of nurses has increased but recruiting and retaining nurses to work on inpatient wards remains a problem. In some areas, this has resulted in high level of vacancies and heavy reliance on temporary staff”\(^4\)."

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The increased reliance on internationally recruited nurses (IRNs) is one factor responsible for a shift in the demographic profile. IRNs now make up a larger proportion of the workforce, both in the NHS and independent sector. These nurses, described as saviours by some managers, have had mixed experiences in terms of how they are assimilated into the UK workforce. Research indicates that IRNs can face discrimination and poor management and employment practice in their workplaces. The influx of nurses from outside the UK has management implications for human resources (HR), which has to ensure that the skills and experience of new entrants are fully utilised.

The age profile of the nursing workforce is also shifting. The bulge of the workforce continues to grow older. Added to this there has also been a steady increase in the number of mature entrants to nursing.

Therefore, while the emphasis was more firmly on recruitment five years ago as employers attempted to deal with high vacancy rates, retention continues to be a concern. Recent RCN employment surveys have highlighted the relationship between working situations and age/stage of career. The results suggest that the quality of work-life and retention issues vary by stage in career:

- recent entrants – a large proportion of newly qualified nurses or IRNs are working intensively (full-time, often working shifts) in some of the most demanding environments, at the point in their careers when they have least experience.
- mid career – the RCN 2003 annual employment survey (AES) highlighted the average E grade nurse, and reported lower levels of morale among this group. Attracting staff back to nursing after career breaks is also an issue at this career stage. It is estimated that three-quarters of nurses will have had a career break/maternity leave by the time that they are 40.
- late career – as the average nurse becomes older, it is becoming increasingly important to ensure that the 50-plus age group (who account for 29% of working nurses) are retained.

Although three-quarters of respondents to the 2003 AES reported that they would consider delaying their retirement, the decision depends on their circumstances. Less stress and the chance to work reduced hours were both factors.

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6 Allan H and Aggergaard Larsen J (2003) We need respect - experiences of internationally recruited nurses in the UK. Report to the RCN by European Institute of Health and Medical Sciences, Guildford: University of Surrey.
A major theme running through the recent RCN employment survey is the level of change affecting nurses at individual, organisational, and national levels. For example, since the last survey NHS trusts have been dissolved and replaced with primary care trusts (PCTs) in England. Scotland now has area health boards, and Wales has local health boards. Northern Ireland has established four health and social services boards to commission health care services. April 2004 also saw the first hospitals winning NHS foundation hospital status. In the NHS there have been a huge number of mergers, dissolutions and reconfigurations over the last five years. At local level the range of work undertaken and configuration of roles is constantly evolving. This was highlighted when 62% of the nurses questioned in the 2005 RCN employment survey reported that their jobs had changed.

Nursing operates in a complex world, but:

- has the quality of nurses’ working lives actually improved since 2000?
- how do all these factors – changing demographics, changing modes of care delivery, change in doctors working hours, organisational restructuring, new workforce policies – interact?
- what is the net effect on the quality of working life for nurses in 2005?

To try and address these questions At breaking point? describes the 2005 survey findings on the quality of work-life and wellbeing of nurses, and contrasts them with the results from the 2000 Working well survey.

**Survey methodology**

**Sample**

The main sample consisted of 6,000 members selected from the RCN membership records. The sample was structured to include a disproportionately large number of nurses from Wales (14%), Scotland (14%), and Northern Ireland (12%). Within each strata of the sample members were selected at random. Before the mail-out, the demographic profile of each sample was checked against the entire RCN membership to ensure a representative gender/age mix.

In summary, the full samples comprised of 3,600 members from England, 720 from Northern Ireland, 840 from Scotland, and 840 from Wales. Further details of the sampling process and subsequent weighting applied are provided in the appendices.

**Questionnaire design**

The design for the survey questionnaire (see Appendix 4) followed discussions with the RCN and built on the previous survey. The questionnaire was piloted with several groups of nurses to ensure that it was relevant to their working lives. After the piloting, the questionnaire was amended to produce a 12-page A5 booklet.

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Note that the sample was drawn from full members (including newly qualified concessionary members), joint members and HCA members. The sample in 2000 did not include newly qualified concessionary members.
The areas covered in the survey were: employment situation; working time/hours; employee-friendly working; disability and sickness absence; needlestick injury; musculo-skeletal disorders (MSDs); stress; bullying and harassment; assault from patients/public; psychological wellbeing; and biographical information.

**Survey process and response**

The survey was mailed to 6,000 RCN members in July 2005. It was entirely anonymous and two blanket reminders were sent to the entire sample. In total 2,865 forms were returned, and 73 forms were sent back as Post Office returns. The overall response rate for the survey was 48%. Excluding the returns that were incomplete, the usable response rate was 47% (2,813 cases).

The additional cases from Northern Ireland, Scotland and Wales have been weighted so that every completed questionnaire can be included in the analysis. The distribution between countries is representative of the membership as a whole.

Not all RCN members responding to the survey were working in nursing. Retired nurses or those who were not in paid employment (2%) were excluded because the aim of the survey was to look at the employment conditions in nursing. The report does, however, include respondents who are employed in nursing, but who are on either sick (2%) or maternity leave (2%).

The total number of respondents reported on in this report is 2,790.

**Report structure**

**Chapter 2** examines the demographic profile of the nurses in 2005 before going on to look at their current employment situation.

**Chapter 3** looks at working time issues.

**Chapter 4** looks at employee–friendly working. It describes the data on the services and facilities provided by employers to support employees in their work, and the level of satisfaction with each.

**Chapter 5** covers workability and sickness absence.

**Chapter 6** reports on the findings to the new section on MSDs.

**Chapter 7** presents the findings on the level of bullying and harassment suffered by nurses in their workplaces.

**Chapter 8** looks at the incidence of verbal and physical assault at work.

**Chapter 9** reports on the level of needlestick/sharps injuries among nurses, and on the actions taken following injury.

**Chapter 10** explores stress levels, using the HSE stress measurement tool.

**Chapter 11** describes the psychological wellbeing of respondents, using the CORE index. This data was also collected in 2000 so the results can be contrasted.
2. Profile

This chapter reviews the demographic characteristics and employment situation of the nurses who responded to the 2005 *Working well* survey.

Demographic data is a key interest in its own right. For example, it can be used to monitor the ageing profile of the nursing workforce, and the relationship between demographic characteristics and work situation. This helps to make better sense of other survey findings.

Biographical profile

Gender

The nursing workforce remains predominantly female – 94% of respondents are women as was the case in the 2000 survey. The distribution of male nurses does vary according to work setting. For example, GP practice nurses are almost exclusively women (99%), while 9% of respondents working in independent sector care homes are men. Bigger differences still are found in the gender distribution between specialties, as figure 2.1 illustrates.

**Figure 2.1: Men by specialty – percentages**

![Graph showing men by specialty percentages](image)

Source: Employment Research, 2005
Age

The age distribution of respondents is presented in figure 2.2. Almost a third (29%) of respondents is over 50.

The RCN annual employment surveys have documented the steadily increasing average age of nurses in the UK. In the 1987 survey the average age of RCN members responding to the survey was 37, but by 2005 the average had gone up by five years to 42. One of the factors identified in the 2005 AES report as contributing to the rising age profile of nurses, is the fact that larger proportions of nurses are qualifying later in life. In the 1960s and 1970s the vast majority of nurses qualified when they were 20 or 21, but by the 2000s the average age of qualification is 29. This change, coupled with the nursing workforce bulge gradually ageing, accounts for the increased average age of the nursing workforce.

Figure 2.2 reflects the shift in the bulge, with an increase in the proportions of nurses who are over 40 compared with 2000 (from 57% to 65% in 2005). The increase in proportion of respondents in the youngest age bands reflects the exclusion of newly qualified nurses from the sample drawn in 2000 (11% aged under 30 compared to 7% in 2000).

Figure 2.2: Age distribution in 2005 and 2000 – percentages

Source: Employment Research, 2005


[12] The effects of this change in the age profiles are examined during the analysis underpinning each chapter.
Ethnicity

The ethnic composition of respondents to the Working well survey has also altered since the 2000 survey. The number of nurses from black or minority ethnic backgrounds has increased from 5% to 10% (4% are Asian, 5% Afro-Caribbean). Much of this growth is related to the international recruitment of nurses.

Respondents were asked where they first registered as a qualified nurse, and if outside of the UK, when they first started work in the UK. Nurses who trained outside the UK and started working in the UK since 1999 are likely to be IRNs. So, by combining the responses we have produced a figure for international nurse recruits working in the UK.

Table 2.1 shows the distribution of respondents between these categories. It demonstrates that half of the black and minority ethnic respondents qualified overseas and started working in the UK in the last six years (i.e. probably IRNs).

Table 2.1: Country of qualification/IRN by ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK-qualified white</td>
<td>2,429</td>
<td>89.0</td>
</tr>
<tr>
<td>UK-qualified minority ethnic</td>
<td>144</td>
<td>5.3</td>
</tr>
<tr>
<td>IRN minority ethnic</td>
<td>137</td>
<td>5.0</td>
</tr>
<tr>
<td>IRN white</td>
<td>18</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>2,728</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Disability

Nineteen per cent (514 cases) report that they have a long-term health problem or disability that has lasted, or that they expect to last, a year or more. In half of these cases (or 9% of the total 2,790 cases) respondents say that the health/disabilities they have affect the kind or amount of work that they can do. Asked if their employer does everything required to adapt or adjust the work environment to accommodate their health problems/disabilities, about a quarter (23%) of this group said that this did not apply to them. Of the nurses who say that they need an adapted work environment, equal numbers report that their employer has done so as say that their employer has not.

Employment profile

Years worked as a registered nurse

All but 18 respondents (1%) indicated that they are registered nurses. These respondents were asked when they first qualified as registered nurses. Figure 2.3 shows the time since qualification.

To give respondents greater anonymity the age on qualification cannot be calculated, so age band groups were used rather than exact ages.
Figure 2.3: Time since qualifying – percentages

Employer setting

Four-fifths (82%) of survey respondents work in the NHS. The remainder are split between the independent sector (11%), nursing bank (1%) or agency (1%) and other employers (4%). The most frequent other employers recorded are hospice/charity (30%) and university (19%).

Table 2.2 shows the breakdown between different settings in each employer category. NHS hospitals are the most typical work setting, and are the workplace for 53% of all respondents. Two per cent of respondents describe their main job as bank or agency work.

Table 2.2: Employer setting

<table>
<thead>
<tr>
<th>Employer Setting</th>
<th>Frequency</th>
<th>Valid per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS hospital</td>
<td>1,461</td>
<td>53</td>
</tr>
<tr>
<td>NHS community</td>
<td>412</td>
<td>15</td>
</tr>
<tr>
<td>NHS other</td>
<td>177</td>
<td>6</td>
</tr>
<tr>
<td>GP practice</td>
<td>209</td>
<td>8</td>
</tr>
<tr>
<td>Independent hospital</td>
<td>70</td>
<td>3</td>
</tr>
<tr>
<td>Independent care home</td>
<td>168</td>
<td>6</td>
</tr>
<tr>
<td>Other independent</td>
<td>49</td>
<td>2</td>
</tr>
<tr>
<td>Bank/agency</td>
<td>64</td>
<td>2</td>
</tr>
<tr>
<td>Hospice/charity</td>
<td>150</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>2,761</td>
<td>100</td>
</tr>
<tr>
<td>Unknown</td>
<td>29</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>2,790</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005
Table 2.3 looks at the specialty in which respondents work. Acute adult care accounts for 32% of respondents' specialties. Just under one in 10 (9%) work in older people’s nursing, although fewer men work in this field (6%). Relatively few men are also found in paediatrics, practice nursing, and district nursing. None of the male respondents worked in school nursing, health visiting, or midwifery.

However, relatively large proportions of men work in mental health (27% of male nurses compared to 5% of female respondents). In the 2000 survey, twice the proportion of men worked in management positions compared to women (8% compared to 4%). This gap appears to have reduced. Today 5% of men report that their field of practice is management compared to 4% of female nurses. Men account for 9% of all nurses working in management, but they make up 6% of all survey respondents. Just under a third (30%) of the nurses working in mental health are men.

### Table 2.3 Field of practice by gender - percentages

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Female</th>
<th>Male</th>
<th>All</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute adult care</td>
<td>32</td>
<td>29</td>
<td>32</td>
<td>865</td>
</tr>
<tr>
<td>Older people’s nursing</td>
<td>10</td>
<td>6</td>
<td>9</td>
<td>250</td>
</tr>
<tr>
<td>Mental health</td>
<td>5</td>
<td>27</td>
<td>6</td>
<td>161</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>195</td>
</tr>
<tr>
<td>Midwifery</td>
<td>&lt;1</td>
<td>0</td>
<td>&lt;1</td>
<td>11</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>57</td>
</tr>
<tr>
<td>Occupational health</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>School nursing</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Practice nursing</td>
<td>8</td>
<td>2</td>
<td>8</td>
<td>204</td>
</tr>
<tr>
<td>District nursing</td>
<td>7</td>
<td>2</td>
<td>7</td>
<td>177</td>
</tr>
<tr>
<td>Health visiting</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Long-term care</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Nurse education</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>Management</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>105</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>17</td>
<td>18</td>
<td>492</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,514</td>
<td>173</td>
<td>100</td>
<td>2,687</td>
</tr>
</tbody>
</table>

*Source: Employment Research, 2005*

**Grade**

Respondents were asked to indicate their current clinical grade, Agenda for Change (AfC) pay band, or its equivalent. The majority (88%) gave their grade or grade equivalent. The results by employment setting are shown in table 2.4.

Some respondents (285 cases, or 12% of those giving a clinical grade) also gave an AfC pay band as well as a clinical grade. A further 216 surveyed only gave an AfC pay band: 47% level 5; 32% level 6; 15% level 7; and 5% level 8. In total 18% of respondents gave an AfC pay band, but the figure is 21% of NHS nurses.
Table 2.4: Grade by employment setting - percentages

<table>
<thead>
<tr>
<th></th>
<th>NHS hospital</th>
<th>NHS community</th>
<th>NHS other practice</th>
<th>Indep hospital</th>
<th>Care home</th>
<th>Other indep</th>
<th>Bank/ agency</th>
<th>Hospice/ charity</th>
<th>All %</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-C</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>D</td>
<td>20</td>
<td>10</td>
<td>7</td>
<td>1</td>
<td>24</td>
<td>50</td>
<td>11</td>
<td>41</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>E</td>
<td>42</td>
<td>24</td>
<td>15</td>
<td>6</td>
<td>25</td>
<td>18</td>
<td>17</td>
<td>43</td>
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<td>32</td>
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<td>F</td>
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<td>20</td>
<td>33</td>
<td>27</td>
<td>12</td>
<td>17</td>
<td>11</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>G</td>
<td>14</td>
<td>33</td>
<td>25</td>
<td>42</td>
<td>16</td>
<td>8</td>
<td>33</td>
<td>5</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>H</td>
<td>5</td>
<td>14</td>
<td>25</td>
<td>14</td>
<td>6</td>
<td>6</td>
<td>17</td>
<td>-</td>
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<td>6</td>
<td>-</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>SMP</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| n=         | 1,309        | 354           | 152                | 198            | 63        | 129         | 36           | 61               | 117  | 2,419 | 2,419 |

Source: Employment Research, 2005

Compared to the 2000 survey, the grade mix is similar, but with slightly more H grades overall (9% as opposed to 6% in 2000). This is particularly noticeable in certain settings. For example, in 2005 14% of nurses working in GP practices are grade H, while in 2000 just 5% were. This means that the percentage graded H or I has gone from 6% to 17%. This may reflect an increase in the number of nurse practitioners working in GP practices. The big reduction in the differences between men and women in terms of the proportion on higher grades (see figure 2.4) may be explained by the dominance of female nurses in GP practices (99% of respondents in this setting are women).

Figure 2.4: Grade by gender – percentages

Source: Employment Research, 2005
In 2000 26% of men were on H grades or above, compared with 9% of women. Today the gender gap of nurses on H grade and above has disappeared, although the numbers of men are small (151 men gave a clinical grade). There are differences in the distribution between senior grades. The survey found more women are in H grade posts than men, and similar proportions of men and women are in I grade posts, but more men than women are paid on SMP grades.

Key points: chapter 2

- the proportion of female respondents is unchanged from 2000 at 94%

- more nurses in the 2005 Working well? survey are aged 40-plus than was the case in 2000 (64% compared to 57% in 2000). However, because there were no newly qualified nurses included in the 2000 survey the proportion aged under 30 is also higher in 2005 (11% compared to 7% in 2000)

- there has been a large increase in the proportion of respondents from minority ethnic origins (5% in 2000 to 10% today). This is chiefly because of international recruitment. Fifty per cent of minority ethnic respondents are classed as international recruits (qualified overseas but came to the UK since 1999)

- one in five (19%) respondents has a disability or health problem that is expected to last a year or more and in a half of these cases it affects the kind of work they can do

- more men work in mental health and management, but the mix has not changed significantly in the last five years

- the grade mix is very similar to that reported in 2000 although today more respondents are employed on H grades. In GP practices this figure has increased from 5% to 14%.
3. Working hours

In many cases nursing is a 24-hour service that necessitates some form of shift working to ensure constant staffing. The Health and Safety Laboratory\textsuperscript{13} notes that disrupted sleep patterns and inadequate sleep can result in fatigue. This in turn increases the risk of accidents and can lead to ill health. How many nurses working nights receive health assessments?

Aside from the specific potential hazards of working nights or rotating shifts, there are the more general issues of achieving a good work-life balance. This includes finding working hours that suit the individual, having control and choice over the length of time you work for and when you work. A major plank of becoming a \textit{model employer} has been to accommodate employee needs better by offering more flexible working hours, or by increasing employees’ control over their hours.

In this chapter we look at respondents’ current working patterns and their views about the way in which their working hours are organised. The following chapter goes on to look at the availability of flexible working opportunities and the range of initiatives and facilities on offer to enhance the quality of work-life balance.

Full or part-time working

Roughly six out of 10 (61\%) respondents work full-time, while 37\% describe their hours as part-time. A further 2\% of nurses work bank or agency and report that their working hours are occasional/various. The RCN AES data provides a good indicator of trends in part-time working in nursing over the last 20 years. For example, the 1989 AES survey found that only 29\% of all nurses worked part-time, while today it is just under 40\%. There have also been some recent changes in part-time working patterns:

- more men work part-time today than was the case even two years ago
- women with dependant children are less likely to work part-time compared to two years ago
- more women aged 50-plus are working full-time than was the case in 2003.

Previous research has repeatedly demonstrated that the likelihood of working part-time hours is linked to several related factors: employment setting; age; stage of career; gender; and dependants. In general, more women work part-time than men, particularly if they have children or other dependants. Part-time working is also more prevalent in the employer settings that nurses move into later in their careers such as GP practice, community, or agency/bank nursing.

Figure 3.1 shows the relationship between survey respondents’ working hours and employer setting. A relationship also exists between grade and working hours, as illustrated in figure 3.2.

\textsuperscript{13} Available from: www.hsl.gov.uk/capabilities/shift_work.htm
Figure 3.1: Part-time working by employer setting – percentages

Source: Employment Research, 2005

Figure 3.2: Working full-time by grade – percentages

Source: Employment Research, 2005
Shift working

Sixty per cent of respondents work shifts, although this varies by place of work as figure 3.3 shows. While working in hospitals is typically associated with shift-working, other work environments also have large proportions of shift staff. For example, 82% of respondents nursing in care homes work shifts, and this applies to 79% of nurses in NHS hospitals. A smaller, but significant proportion of 15% of community NHS staff also work shifts.

Figure 3.3: Shift working by employer setting – percentages

The overall level of shift-working has not changed since 2000 when it was 60%. Of those that currently work shifts, 51% work a mixture of days and nights, 37% only work day shifts and 11% only work night shifts. Again the mix of shifts worked relates to the employer and work setting (table 3.1). While similar proportions of staff in independent and NHS hospitals work shifts, the mix of shifts differs. NHS hospital staff are much more likely to report that they work a mix of day and night shifts – 60% compared to 23% in independent hospitals. However, the patterns worked in independent hospitals and care homes are fairly similar to one another.

Direct comparison with the results from 2000 cannot be drawn because the question wording has been modified for the current survey. But a crude comparison of the overall results points to some changes in shift patterns over the last five years. Most strikingly, in 2000 41% of NHS hospital nurses working shifts reported working internal rotation (i.e. a mix of day and night shifts), and the proportion of this group working permanent nights was 15%. Today these figures are 60% and 10% respectively. The proportion of independent hospital nurses working permanent nights is the same in 2005 as it was in 2000 (19%). But, a larger proportion in 2005 (23%) work a mix of days and nights than reported working internal rotation in 2000 (5%).

Source Employment Research, 2005
Table 3.1: Pattern of shifts by employer setting - percentages

<table>
<thead>
<tr>
<th></th>
<th>Day shifts only</th>
<th>Mix day &amp; night shifts</th>
<th>Night shifts only</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS hospital</td>
<td>30</td>
<td>60</td>
<td>10</td>
<td>1,128</td>
</tr>
<tr>
<td>NHS community</td>
<td>71</td>
<td>20</td>
<td>8</td>
<td>59</td>
</tr>
<tr>
<td>NHS other</td>
<td>44</td>
<td>49</td>
<td>7</td>
<td>73</td>
</tr>
<tr>
<td>GP practice</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Independent hospital</td>
<td>58</td>
<td>23</td>
<td>19</td>
<td>57</td>
</tr>
<tr>
<td>Care home</td>
<td>61</td>
<td>21</td>
<td>18</td>
<td>134</td>
</tr>
<tr>
<td>Other independent</td>
<td>60</td>
<td>30</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Bank/agency</td>
<td>56</td>
<td>24</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Hospice/charity</td>
<td>41</td>
<td>53</td>
<td>5</td>
<td>75</td>
</tr>
<tr>
<td>Percentage of all</td>
<td>38</td>
<td>51</td>
<td>11</td>
<td>1,604</td>
</tr>
<tr>
<td>n=</td>
<td>606</td>
<td>820</td>
<td>178</td>
<td></td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Almost three-quarters (72%) of respondents working shifts say that they are happy with their current working pattern. One in five (19%) would like to work a different pattern of shifts, while one in 10 (9%) would prefer not to work shifts at all. Satisfaction with working patterns varied according to the mix of shifts worked. Respondents working either all nights or all days were most likely to be happy with their shift pattern (85% on nights, 82% working days only). On the other hand, significantly fewer staff who work a mix of day and night shifts are happy with their work pattern at just 62%. One in 10 (11%) of those working days and nights would prefer not to work shifts at all, and just over a quarter (27%) would like to work a different shift pattern.

Staff who work nights either permanently or on rotation were asked if they had received a health assessment to ensure that their health was not affected. The vast majority (87%) had not had an assessment. Significant differences exist between sectors. NHS staff are least likely to have had a health assessment (12%), compared to 23% of nurses working in the independent sector and 27% of agency nurses.

Roughly half (52%) of staff currently working shifts report that they would be unable to change their shift pattern if they wanted to. Staff doing bank or agency work are most likely to report that they could change their hours (80% of 50 respondents). However, NHS community staff working shifts are least likely to be able to change their hours (39% of 59 respondents). Being in a higher grade post does not guarantee any greater chances of being able to alter shift patterns. Of the D grade nurses interviewed 51% say that they would be able to. This compares with 41% of F grade staff, although higher proportions of H and I grades think that they could change their pattern of shifts if they wanted to (58% and 70% respectively).

Respondents were asked about the length of the shifts that they normally work, as well as being asked what length of shift they would like to work. The results are presented in figure 3.4.
In general, the proportion of people working each shift length is similar to the proportion wanting to work each, with the exception of those working long shifts. Eight hours was used as a cut-off to divide both current shifts worked and ideal shifts into two groups. Just over a quarter (27%) of respondents who currently work shifts of over eight hours would like to work shorter shifts.

**Figure 3.4: Shift length normally worked compared to preferred choice - percentages**

![Shift length comparison chart]

*Source: Employment Research, 2005*

**On-call/stand-by**

One in six (16%) sometimes work on-call, 4% on stand-by and 1% report that they sometimes sleep in. The majority (58%) of staff providing cover in one of these ways did not receive a rest period afterwards. Staff working on stand-by were slightly more likely to have a compensatory rest period than staff working other types of cover. In 30% of cases staff working stand-by received a rest before the next shift/work day, 8% within 72 hours and 14% at some later point.

**Nurses’ views of working hours**

The survey presented respondents with a series of statements about other aspects of working hours: control over hours; predictability; advanced notice; working unsocial hours; and choice. The results for all respondents are summarised in figure 3.5. The bars to the left of the figure represent dissatisfaction, the bars to the right satisfaction. Respondents who indicated neither are not represented in the figure.
Overall, the majority of staff agreed or strongly agreed with positive statements about these different aspects of work scheduling. The feature of working hours that they are most ambivalent about is the level of unsocial hours worked – just 52% said that this suited them well.

Perhaps unsurprisingly, one of the main factors that influences nurses’ views of their working hours is their current work pattern. Generally, nurses who work shifts are less satisfied with virtually all aspects of their working hours compared to those who do not. The differences between the two groups are marked, with differentials of between 12 and 35 percentage points in the proportions responding positively. For example, 84% of those who do not work shifts say that their working hours are predictable enough to allow them to plan their life outside of work, whereas only 49% of shift-workers felt this was the case. Staff working shifts also felt significantly less satisfied with their involvement in:

- planning their off-duty (59% compared to 82%)
- the advanced notice given of work schedules (66% compared to 86%)
- the extent to which employers respect their wishes about when and how they work (51% compared to 71%).

The only aspect of working hours where there is no difference between views on the basis of shift working was satisfaction with the level of unsocial hours.
The type of shift worked is also linked to different views. Nurses working internal rotation (a mix of day and night shifts) are significantly less satisfied with all features of their working hours. For example, only 35% of those working a mix of day and night shifts were satisfied with their ability to plan their life outside of work. This compares to 67% of those who work day shifts, and 63% of those who only work nights. Nurses who work days only are generally more satisfied than those just doing nights, except in relation to level of unsocial hours worked. Here we found that 75% of night staff are happy with their unsocial hours worked compared with 59% of day staff.

Part-time staff are also generally more satisfied than full-timers with the control and choice that they have over their hours. However, the differences are not as marked between those who work shifts and those who do not. Planning life outside work draws the biggest differences. The survey shows that 57% of full-time staff agree/strongly agree compared with 71% of part-time staff.

Four of the statements used (see figure 3.6) were also included in the 2000 survey. The results for the overall agreement with each (combining agree and strongly agree) in 2000 and 2005 are compared in figure 3.6. Respondents are more positive today than they were in 2000, particularly about the extent to which employers consider staff preferences about when and how they work, and choice given over the length of shift worked. Nurses responding to the current survey are more emphatically positive on these questions. For example, the number strongly agreeing that they are able to get the time-off they want has risen from 18% to 28%.

Figure 3.6: Views of working hours – percentage agree/strongly agree

![Figure 3.6: Views of working hours – percentage agree/strongly agree](source: Employment Research, 2005)
Key points: chapter 3

- four in 10 respondents work part-time, the same as the figure reported in the AES
- six in 10 respondents work shifts (the same as in 2000) although the mix of patterns appears slightly different with more respondents working a mix of day and night shifts rather than days or nights only
- only 13% of respondents working night shifts had received a health assessment
- just over half (52%) of respondents say that they would not be able to change their shift pattern if they wanted to. In the NHS community sector this figure reduced to 39%
- one in four respondents working shifts longer than eight hours would like to work a shorter shift length
- one in five nurses is on a form of on-call/stand-by, and of these 58% do not receive a compensatory rest period afterwards
- most nurses were satisfied with their working hours. However, there were big differences between those working shifts and those who don’t, and in terms of the type of shift worked. For example, 35% of nurses who work a mix of day and night shifts were satisfied with their ability to plan life outside work. This compares to 67% of nurses who don’t work shifts
- nurses are slightly more positive today about their working hours than was the case in 2000. Again, those working a mix of shifts are more negative in their views than other respondents.
4. Employee-friendly working

In July 1999 the NHS launched *Improving working lives* (IWL) in England. It stated that by April 2003 all NHS employees would be entitled to work for organisations that demonstrate commitment to flexible working arrangements. Key elements identified in this standard included: childcare support; support for carers; team-based self-scheduling; and flexi-time.

The NHS Childcare Strategy formed part of the IWL standard and NHS Plan. Its objective was to support the needs of staff with children and to encourage the recruitment, retention and return of parents to the NHS workforce. A research study to look at the impact of the strategy\(^{14}\) reported that it had made a big impact on helping to retain staff in the NHS by enabling parents to return from maternity leave, reducing sickness absence, and improving job satisfaction. However, the study also called into question the strength of support for the childcare strategy in many PCTs and trusts.

Since 2000 other changes have been made that affect all employees’ rights to flexible or part-time work. For example, under new legislation\(^{15}\), parents of children aged under six, or disabled children aged under 18, have the right to apply to work flexibly and their employers will have a duty to consider these requests seriously. The Government is also planning to increase and extend maternity leave and pay, and introduce rights to paid adoption and paternity leave. These rights, together with existing rights to parental leave and time off for dependants, are intended to provide parents with more opportunities to balance work and family life.

The 2000 *Working well?* survey was conducted only nine months after the IWL standard had been introduced, so any impact would have been negligible. However, it now provides a benchmark against which progress can be monitored through responses to the 2005 survey.

Chapter 4 looks at access to a series of employee-friendly working practices. It compares access to the 2000 survey and then examines respondents’ satisfaction with provision. We start by looking at practices/services related to working time, and initiatives aimed at achieving work-life balance, and then look at a wider range of facilities offered to employees.

**Working time practices**

Respondents were presented with a range of working patterns aimed at accommodating employees’ needs. They were asked to indicate if each of these is available where they work, and, if provided, their level of satisfaction with each. The proportion of respondents indicating that each initiative is provided by their employers is presented in table 4.1, alongside the results from the 2000 survey.

The biggest change in responses between 2000 and 2005 is in access to different working patterns/time. On the one hand there has been a reduction from 87% to 80% in the proportion reporting that they have access to part-time working and from 54% to 44% in members reporting access to job sharing. However, on the other hand there are increased numbers indicating that they have access to flexible working (46% in 2000 compared to 55% in 2005), access to term time/holiday contracts (12% to 24%), and opportunities to self-roster (35% compared to 42% in 2005). In addition to this, more nurses also report having access to out-of-hours play schemes, holiday play schemes and parental leave.

This increase in is in line with changes detected by other research, which have found that the proportion of workplaces in the UK offering flexible working arrangements and different types of parental leave had increased between 1998 and 2004. The report concludes that this increase is an indication that employers are taking on board the need to help employees balance their working and family lives. However, the research also found that employees themselves did not perceive this change in employer attitude, and were often unaware of what was available to them.

Opportunities to work part-time varied between employer setting. GP practices (84%), bank/agency work (82%) and NHS hospitals (82%) provide the highest levels of opportunity for part-time work. However, staff in hospices and independent hospitals report that they have the lowest levels of opportunity to work part-time (72% in both cases).

---

**Table 4.1: Work-life balance practices - percentages**

<table>
<thead>
<tr>
<th></th>
<th>Yes 2000</th>
<th>Yes 2005</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities to work part-time</td>
<td>87</td>
<td>80 ↓</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Breaks/rest times</td>
<td>84</td>
<td>76 ↓</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>Special leave</td>
<td>-</td>
<td>60 →</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Flexible working</td>
<td>46</td>
<td>55 ↑</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>Access to parental leave</td>
<td>48</td>
<td>53 ↑</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Opportunities to job share</td>
<td>54</td>
<td>44 ↓</td>
<td>32</td>
<td>24</td>
</tr>
<tr>
<td>Opportunities to self-roster</td>
<td>35</td>
<td>42 ↑</td>
<td>50</td>
<td>8</td>
</tr>
<tr>
<td>Dependent leave</td>
<td>37</td>
<td>39 ↑</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Career breaks</td>
<td>-</td>
<td>32 →</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Access to term time/school holiday contracts</td>
<td>12</td>
<td>24 ↑</td>
<td>47</td>
<td>29</td>
</tr>
<tr>
<td>Childcare vouchers or allowance</td>
<td>2</td>
<td>18 ↑</td>
<td>45</td>
<td>37</td>
</tr>
<tr>
<td>Holiday play scheme</td>
<td>11</td>
<td>16 ↑</td>
<td>50</td>
<td>34</td>
</tr>
<tr>
<td>Out-of-hours play scheme</td>
<td>3</td>
<td>9 ↑</td>
<td>55</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

---

Staff working shifts are as likely to have the opportunity to work part-time as those who do not. But, among shift-workers, nurses who work nights are most likely to report that they have the opportunity to work part-time (88% compared with 81% of those working day shifts, and 78% of those working rotating shifts).

Men are less likely to say that there are opportunities to work part-time (69% compared to 81% of women). More white British nurses say that they have the opportunity to work part-time (82%) compared with all other ethnic groups, but most notably Afro-Caribbean (64%).

One in 10 (11%) full-time staff are unaware whether part-time working is an option for them, while a further 18% report that it is not.

There has also been a reduction in the proportion of respondents saying that they have access to breaks/rest times (84% in 2000 compared to 76% in 2005). This is an indication of increased time pressures. Respondents were also asked to say to what extent they agreed that they ‘frequently work in excess of my contracted hours’. Over half of the nurses (58%) agreed or strongly agreed with this statement.

**Figure 4.1: Satisfaction with work-life balance practices - percentages**

Source: Employment Research, 2005
It is interesting that although the opportunity to self-roster, work flexibly or have term time only contracts has increased, satisfaction with these working practices has not. In fact, satisfaction has not increased for any of the working practices listed, apart from a slight improvement with the three benefits aimed at parents – parental leave, workplace nursery and holiday play schemes.

Similarly, while a higher percentage of respondents report childcare vouchers are available where they work (18% compared with 2% in 2000), satisfaction with their use has fallen since the 2000 survey.

Other research\(^\text{17}\) has pointed to what they term the ‘take-up gap’. While employers highlight the wide range of working practices available to staff, a sizeable proportion of the workforce is not able to take up these options because of the perceived effect it may have on career prospects. Organisational culture/unsupportive line management, heavy workloads, lack of supporting infrastructure, or concern about the possible impact on pay (e.g. of working part-time) also inhibits take-up. In other cases, staff simply do not have enough information about what is available and how they can make the most of the options available.

**Access to other employee-friendly practices**

This section looks at other facilities and services provided by employers, from catering facilities and staff transport through to clinical supervision and careers guidance.

The first point to note, which may again be a reflection of the ‘take up gap’, is the high percentage of nurses who do not know if they have access to some facilities/services or not. It seems in many cases that if a respondent has not tried to access a service they do not know if it is available to them or not.

In most areas of provision there has been little change from 2000 in the proportion of respondents reporting that they have access to the facility/service (table 4.2).

Table 4.2: Facilities/opportunities at work - percentages, n=2,759 in 2005

<table>
<thead>
<tr>
<th></th>
<th>Yes 2000</th>
<th>Yes 2005</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity for staff development and training</td>
<td>96</td>
<td>93</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Catering facilities in the day</td>
<td>78</td>
<td>74</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>70</td>
<td>70</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Staff rooms for taking breaks</td>
<td>70</td>
<td>67</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td>Counselling services</td>
<td>60</td>
<td>62</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Locker for belongings</td>
<td>-</td>
<td>57</td>
<td>41</td>
<td>2</td>
</tr>
<tr>
<td>(Free) car parking</td>
<td>90</td>
<td>55</td>
<td>44</td>
<td>1</td>
</tr>
<tr>
<td>Changing facilities</td>
<td>61</td>
<td>50</td>
<td>46</td>
<td>4</td>
</tr>
<tr>
<td>Showering facilities</td>
<td>-</td>
<td>39</td>
<td>57</td>
<td>4</td>
</tr>
<tr>
<td>Careers guidance</td>
<td>29</td>
<td>28</td>
<td>42</td>
<td>30</td>
</tr>
<tr>
<td>Catering facilities at night</td>
<td>34</td>
<td>26</td>
<td>63</td>
<td>11</td>
</tr>
<tr>
<td>Uniform laundering service</td>
<td>-</td>
<td>24</td>
<td>69</td>
<td>7</td>
</tr>
<tr>
<td>Staff transport</td>
<td>11</td>
<td>15</td>
<td>79</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Around nine in 10 respondents report that they have access to staff training and development.

Despite increased concern about MRSA, and other hospital-acquired infections, the proportion of nurses reporting that they have access to changing facilities has decreased since 2000 from 61% to 50% in 2005. This year to supplement this question, respondents were asked if they have access to showering facilities and a locker for belongings. Just four in 10 (39%) have access to showering facilities, and 57% have access to a locker.

The availability of catering facilities during the night has also reduced in the last five years (34% in 2000 to 26% in 2005) and, to a lesser extent, during the day.

There are some significant differences between employment settings, as table 4.3 shows.

---

18 In 2000 members were asked if they had access to car parking. In 2005 it was amended to free car parking.
In 2000 it was reported that relatively high proportions of NHS hospital nurses did not have access to even the most basic facilities. It would seem that this remains the case for many today.

Only 37% of NHS hospital nurses have access to free car parking compared to 70% of NHS community nurses, 87% of practice nurses, 77% of nurses in independent hospitals and 86% of care home/hospice nurses. In 2000 three-quarters of all NHS hospital respondents reported that they had changing facilities, today the equivalent figure has reduced to 60%. Three in 10 NHS hospital nurses do not have a staff room to take a break, a similar proportion to that found in care homes and hospices.

Around a third of hospital-based nurses (35% in NHS and 30% in the independent sector) have a uniform laundering service.

Counselling services are now available to twice as many care home/hospice and GP practice nurses than five years ago (42% compared to 22% in 2000). Also many more (65%) practice nurses have access to clinical supervision than was the case five years ago (45%).

In the independent hospital sector there has been a reduction in catering facilities, both during the day (83% from 98% in 2000) and night (25% from 45% in 2000).

**Table 4.3: Availability of working practices by employment setting for 2005 and (2000) - percentages**

<table>
<thead>
<tr>
<th>Practice</th>
<th>NHS hospital</th>
<th>NHS community</th>
<th>GP practice</th>
<th>Indep hospital</th>
<th>Care home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catering facilities in the day</td>
<td>89 (96)</td>
<td>35 (36)</td>
<td>41 (38)</td>
<td>83 (98)</td>
<td>78 (85)</td>
</tr>
<tr>
<td>Catering facilities at night</td>
<td>34 (42)</td>
<td>5 (10)</td>
<td>3 (3)</td>
<td>25 (45)</td>
<td>33 (50)</td>
</tr>
<tr>
<td>Staff rooms for taking breaks</td>
<td>71 (74)</td>
<td>47 (50)</td>
<td>76 (72)</td>
<td>58 (61)</td>
<td>70 (91)</td>
</tr>
<tr>
<td>Staff transport</td>
<td>20 (12)</td>
<td>11 (13)</td>
<td>2 (1)</td>
<td>3 (3)</td>
<td>10 (6)</td>
</tr>
<tr>
<td>Car parking</td>
<td>37 (94)</td>
<td>70 (82)</td>
<td>87 (81)</td>
<td>77 (87)</td>
<td>86 (97)</td>
</tr>
<tr>
<td>Counselling services</td>
<td>68 (68)</td>
<td>71 (74)</td>
<td>26 (11)</td>
<td>46 (47)</td>
<td>44 (22)</td>
</tr>
<tr>
<td>Careers guidance</td>
<td>30 (31)</td>
<td>26 (28)</td>
<td>17 (9)</td>
<td>20 (30)</td>
<td>32 (23)</td>
</tr>
<tr>
<td>Changing facilities</td>
<td>60 (74)</td>
<td>18 (22)</td>
<td>30 (36)</td>
<td>77 (84)</td>
<td>52 (71)</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>70 (76)</td>
<td>80 (81)</td>
<td>65 (45)</td>
<td>68 (60)</td>
<td>66 (53)</td>
</tr>
<tr>
<td>Opportunity for staff development and training</td>
<td>94 (97)</td>
<td>94 (97)</td>
<td>96 (98)</td>
<td>93 (98)</td>
<td>90 (92)</td>
</tr>
<tr>
<td>Showering facilities</td>
<td>44</td>
<td>17</td>
<td>22</td>
<td>61</td>
<td>44</td>
</tr>
<tr>
<td>Locker for belongings</td>
<td>75</td>
<td>12</td>
<td>22</td>
<td>84</td>
<td>60</td>
</tr>
<tr>
<td>Uniform laundering service</td>
<td>35</td>
<td>5</td>
<td>6</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td><strong>Base 2005 n=</strong></td>
<td><strong>1,456</strong></td>
<td><strong>412</strong></td>
<td><strong>209</strong></td>
<td><strong>68</strong></td>
<td><strong>309</strong></td>
</tr>
</tbody>
</table>

*Source: Employment Research, 2005*
Satisfaction with provision

Figure 4.1 below shows the percentage of respondents who report that they are either satisfied or very satisfied with each service. In most cases, where comparison with 2000 can be made, satisfaction levels have declined. For example, fewer respondents say that they have changing facilities (50% in 2005 compared to 61% in 2000). Also, of the staff who have changing facilities, fewer report being satisfied with the facilities (52% this year compared to 65% in 2000).

Figure 4.2: Satisfaction with employee-friendly working practices for 2000 and 2005 - percentages

![Bar chart showing satisfaction levels for various employee-friendly working practices for 2000 and 2005.](chart)

Source: Employment Research, 2005

Satisfaction levels are highest in relation to free car parking where it is available, staff training and development, lockers and staff rooms for taking breaks. More than 60% reported satisfaction.

There are fewer respondents who say that they are satisfied with staff transport, careers guidance and changing facilities. Only 20% of staff say that they are satisfied.

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19 The base here varies depending on how many respondents indicated access to the service/facility. The base (in some cases small) can be calculated from results in table 4.2. Note also that free car parking was worded as car parking in 2000. This will have resulted in more negative responses because one of the main criticisms of car parking in 2000 was that it was not free.
Table 4.4 summarises the results showing the percentage of nurses in each employer setting who say that they are satisfied and dissatisfied. More respondents in NHS hospitals report being dissatisfied than in other settings. This is particularly the case in relation to car parking (31%), changing (37%) and showering (35%) facilities, and catering facilities (30% during the day, 46% at night dissatisfied).

Table 4.4: Satisfaction with employee-friendly working practices by employer setting - percentages

<table>
<thead>
<tr>
<th></th>
<th>NHS hospital</th>
<th>NHS community</th>
<th>GP practice</th>
<th>Independent hospital</th>
<th>Care home/ hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catering facilities in the day</td>
<td>S: 55</td>
<td>D: 30</td>
<td>S: 64</td>
<td>D: 22</td>
<td>S: 8</td>
</tr>
<tr>
<td>Catering facilities at night</td>
<td>S: 37</td>
<td>D: 46</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Staff transport</td>
<td>S: 35</td>
<td>D: 28</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Counselling services</td>
<td>S: 42</td>
<td>D: 10</td>
<td>S: 46</td>
<td>D: 8</td>
<td>S: 38</td>
</tr>
<tr>
<td>Careers guidance</td>
<td>S: 44</td>
<td>D: 21</td>
<td>S: 58</td>
<td>D: 9</td>
<td>S: 65</td>
</tr>
<tr>
<td>Locker for belongings</td>
<td>S: 60</td>
<td>D: 26</td>
<td>S: 51</td>
<td>D: 38</td>
<td>S: 68</td>
</tr>
<tr>
<td>Uniform laundering service</td>
<td>S: 33</td>
<td>D: 43</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

S = satisfied  
D = dissatisfied

Source: Employment Research, 2005

Consultation

Less than a quarter (23%) of respondents say that their employer has consulted them about how best they can help balance their work-life needs. This figure is lower than reported in 2000 when nearly a third (30%) of respondents said that their employer had consulted them. Less than one in five NHS hospital nurses said that their employer had consulted them about work-life balance in 2000 (26%). Interestingly, the converse is true for NHS community nurses. Here we found an increase in respondents indicating that their employer has consulted them (22% in 2000 compared to 28% in 2005).

20 As previous footnote (19).
GP practice nurses remain the most consulted, but there has been a big reduction in the proportion from 52% in 2000 to 28% in 2005. Independent sector nurses are also less likely to report having been consulted about work-life balance.

Nurses who work shifts are more likely to be happy with their current working pattern, and to report that they have been consulted about work-life balance. One in four (23%) nurses is happy working shifts and says that they have been consulted. This compares to 8% of those who do not want to work shifts, and 10% of those who would like to work a different shift pattern.

Table 4.5: Consultation with nurses about balancing work-life needs and facilities 2005 (2000) - percentages

<table>
<thead>
<tr>
<th></th>
<th>NHS hospital</th>
<th>NHS community</th>
<th>GP practice</th>
<th>Indep hospital</th>
<th>Care home</th>
<th>All nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>About work and life</td>
<td>18 (26)</td>
<td>28 (22)</td>
<td>28 (52)</td>
<td>18 (38)</td>
<td>25 (39)</td>
<td>23 (29)</td>
</tr>
<tr>
<td>needs Base n=100%</td>
<td>1,393</td>
<td>389</td>
<td>190</td>
<td>68</td>
<td>290</td>
<td>2,594</td>
</tr>
<tr>
<td>About facilities</td>
<td>13 (19)</td>
<td>23 (16)</td>
<td>27 (47)</td>
<td>12 (33)</td>
<td>23 (34)</td>
<td>18 (23)</td>
</tr>
<tr>
<td>required Base n=100%</td>
<td>1,383</td>
<td>381</td>
<td>187</td>
<td>68</td>
<td>284</td>
<td>2,568</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

The results are similar to the responses given about consultation on the facilities that nurses say they require or want. Overall, 18% say that they have been consulted in this regard. However, just 13% of NHS hospital nurses say that they have been consulted about facilities. Again, independent sector and practice nurses are much less likely to report being consulted about facilities in 2005 than was the case in 2000.

Key points: chapter 4

- in NHS hospitals the proportion of respondents that say that they have access to changing facilities has reduced from 74% to 60%
- the number that say that they have access to catering facilities at night have also reduced in NHS hospitals and elsewhere
- only 37% of NHS hospital nurses have access to free car parking
- twice as many care home/hospice and GP practice nurses have access to counselling services than was the case five years ago. More of these nurses also have access to clinical supervision than five years ago
- nearly half of NHS hospital nurses (46%) say that they are dissatisfied with night time catering facilities
- less than a quarter (23%) of respondents say that their employer has consulted them about how best to help balance their work-life needs. This figure is lower than in 2000 (30%)
access to part-time working and job sharing has decreased since the 2000 survey, but access to flexible working and term time/holiday contracts have both increased in the last five years

there has been a reduction in the proportion of nurses who say that they have access to breaks/rest times. The figures are down from 84% in 2000 to 76% in 2005

although more respondents in 2005 indicate that they have access to flexible working practices than was the case in 2000, fewer are satisfied with the access they have.
5. Workability and sickness absence

This chapter of the report starts by looking at the number of respondents who have long-term health problem or disabilities, and how this impacts on their work life. In 2000 it was reported that 4% of nurses had a physical disability or impairment that affected their ability to work. But how many other nurses have long-term health problems or disabilities that they have successfully accommodated in their work, and what role have employers played?

Later in the chapter we examine the nature and volume of time off due to ill health taken by respondents to the survey. A review of ward staffing in 2005 found that sickness absence levels are higher among hospital nurses (an average of 7.5% of working time was lost a year) than they are for other public sector workers (5%). However, the National Audit Office (NAO) reported in 2003, that although the NHS had failed to meet the target of reducing absence by 30% by the end of 2003, there had been consistent reductions in the level of sickness absence reported in the NHS.

The current survey allows us to examine sickness absence in other settings. For example, do independent hospitals have similarly high levels of sickness absence? We also look at reasons for sickness absence.

Health problems and employer responses

Around one in five (19%) of respondents have health problems or disabilities that they expect to last more than a year. Long-term health problems are linked to age. Just 13% of nurses aged under 30 have health problems or disabilities that they expect to last more than a year, which compares to 27% of people aged 50-plus. Also, nurses who were recruited from overseas are less likely to have disabilities or health issues lasting for a year or more (10%).

A half (50%) of all respondents with disabilities or health problems report that their condition affects the kind or amount of work that they can do. Among respondents who say that their disability/health problem affects the type and volume of work they can do, 23% state that they need no adaptation of the work environment. Of those that do require some adjustment/adaptation to accommodate their health need or disability, half say that their employer does everything required, and the other half say that they do not.

Interestingly, more part-time respondents have a condition that affects their working life (59% compared to 44% of full-time). They are also more likely to say that their employer adapts or adjusts the working environment to accommodate their needs (56% compared to 44% of full-time respondents).

Table 5.1: Health problems and disabilities by employer setting – percentages

<table>
<thead>
<tr>
<th>Health problem/disability</th>
<th>Condition affects work</th>
<th>Adjustment required</th>
<th>Employer does everything to adjust</th>
<th>(n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS hospital</td>
<td>19</td>
<td>50</td>
<td>76</td>
<td>45</td>
</tr>
<tr>
<td>NHS community</td>
<td>18</td>
<td>51</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>GP practice</td>
<td>17</td>
<td>37</td>
<td>92</td>
<td>33</td>
</tr>
<tr>
<td>Independent hospital</td>
<td>22</td>
<td>57</td>
<td>83</td>
<td>38</td>
</tr>
<tr>
<td>Care home/hospice</td>
<td>20</td>
<td>47</td>
<td>100</td>
<td>49</td>
</tr>
<tr>
<td>All</td>
<td>19</td>
<td>50</td>
<td>77</td>
<td>48</td>
</tr>
</tbody>
</table>

(2,747) (497) (251) (188)

Source: Employment Research, 2005

The survey found that fewer nurses working in GP practices (33%) and independent hospitals (38%) say that their employers do all that they can to adapt the work environment to their health needs (see table 5.1 above). Nurses working in acute adult care, mental health, older people’s nursing and learning disabilities report a similar experience.

**Occupational health services**

Respondents were asked to indicate whether or not employers provide access to occupational health services (see figure 5.1). Approximately nine in 10 respondents (85%) say that their employer does provide access to occupational health services, which is more or less the same as the 2000 figure of 84%. Over two-thirds (69%) say that they can access the service without referral, but in 2000 the proportion (87%) was larger.25

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25 It is likely that the change in wording in 2005 to include a ‘don’t know’ option may have reduced this figure.
Among NHS nurses surveyed nearly all of them say that they have access to occupational health services (95% or more), and around 70% report direct access. Nurses in accident and emergency are most likely to say that they are able to access the service directly (79%). Care homes/hospices and GP practices are reported as the least likely to provide access to occupational health services (41%) to staff. But, where practices do provide the service, half (51%) of respondents say that they have direct access.

**Counselling services**

Counselling services are provided in the majority of cases. Just under six in 10 of all respondents (57%) say that their employer provides counselling, and 62% say that they can access the service without referral. In 2000, 64% of respondents reported that counselling was provided, and 79% said that they could self-refer to the service. This latter figure represents a significant drop. Access to counselling services varies by employment setting as figure 5.2 shows.
Many respondents (26% of all nurses surveyed and 28% of NHS staff) do not know if their employer provides a counselling service or not. This figure rises to 32% among independent sector nurses, and 29% of NHS hospital staff. However, it seems that grade is an important factor. Many more nurses in higher grade posts know if their employer provides counselling services. Nearly four in 10 D grades working in the NHS do not know if their employer provides counselling services. This compares to around one in 10 of H/I grade nurses.

In addition, many nurses who are aware that a counselling service is available at their workplace do not know whether or not it is accessible without referral. Again there is a strong correlation with grade (see table 5.2).

**Table 5.2: Employer provides access to counselling by grade (NHS only)**

<table>
<thead>
<tr>
<th>Access provided?</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>54</td>
<td>52</td>
<td>59</td>
<td>64</td>
<td>75</td>
<td>75</td>
<td>59</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>12</td>
<td>17</td>
<td>17</td>
<td>10</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Don’t know</td>
<td>37</td>
<td>36</td>
<td>24</td>
<td>18</td>
<td>15</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td><strong>Base n=100%</strong></td>
<td>319</td>
<td>673</td>
<td>348</td>
<td>423</td>
<td>183</td>
<td>40</td>
<td>2,014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can access directly?</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>54</td>
<td>54</td>
<td>61</td>
<td>66</td>
<td>66</td>
<td>90</td>
<td>61</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>7</td>
<td>9</td>
<td>13</td>
<td>9</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Don’t know</td>
<td>39</td>
<td>39</td>
<td>30</td>
<td>21</td>
<td>25</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td><strong>Base n=100%</strong></td>
<td>170</td>
<td>348</td>
<td>205</td>
<td>270</td>
<td>138</td>
<td>30</td>
<td>1,186</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005
When respondents were asked if they are receiving counselling, 2.5% said that they are. The survey found that all but two of the 68 cases (i.e. 97%) are UK-qualified white nurses. Nurses currently in counselling have very high CORE scores (see chapter 11): 15.4 compared to 7.0 for nurses not in counselling. A score in excess of 12 is described as ‘raised levels of psychological distress’.

Looking at other ways of treating psychological problems such as therapy, medication and other remedies, 7% of all survey respondents are having treatment. This is most strongly linked to age. Older nurses are more likely to be receiving treatment than younger nurses (see figure 5.3). Just over 10% of nurses aged 55-plus were receiving some treatment compared to 5% of those aged under 30.

**Figure 5.3: Receiving treatment, therapy, medication or remedy for psychological problems by age – percentages**

![Bar chart showing the percentage of nurses receiving treatment by age group, with the highest percentage among those aged 55+ and the lowest among those aged 20-24.](chart)

*Source: Employment Research, 2005*

**Incidence of sick leave**

In 2000, 26% of nurses took sick leave in the three months prior to the survey. This year the figure is just slightly higher at 28% (see figure 5.4).
As the 2000 survey found, the incidence of sick leave is higher in hospital settings than elsewhere. Taking sick leave is much more prevalent among younger nurses. Figures show that 40% of those aged under 35 had taken sick leave in the last three months, which compares to 21% of nurses aged 50-plus.

Therefore, full-time, younger nurses in acute hospital settings, and nurses who are new to the workplace are most likely to take sick leave. Nurses who work part-time were less likely to take sick leave in the three months prior to the survey. This partly reflects the working hours of the two groups above.

It is also worth noting that IRNs were more likely to have taken sick leave in the previous three months (45%) compared to (27%) UK qualified nurses. Some possible explanations for this might include the increased levels of stress associated with moving abroad and beginning work in an unfamiliar health setting. The latter might also include nurses being exposed to unfamiliar viruses and other pathogens to which they have not yet had the chance to build immunity.

Three-quarters (74%) of all those who took sick leave in the previous three months had done so on one occasion only, and 20% on two occasions. In 28% of those cases, the number of shifts taken is one, compared to 31% in 2000. The average is six shifts, which is slightly higher than the five reported in 2000. Across all respondents, including those who did not take any sick leave, the average number of shifts/days taken off sick is 1.5. In 2000 the figure was 1.3.
Nearly half of respondents (45%) say that ‘other physical infection/disease’ is the main reason for taking time off sick. While 20% report ‘other’ as the reason, which includes surgery. One in seven (14%) take sick leave because of bone/joint/muscle problems. Eight per cent say that stress, depression or anxiety causes them to take sick leave, while for 5% it is tiredness or exhaustion.

More than one in 20 says that they were not sick on the last occasion they took sick leave. They report that they took sick leave to tend to a child, other domestic crisis, or because they were unable to get the off-duty that they needed.

**Figure 5.5: Reasons given for taking sick leave (most recent occasion)**

![Graph showing reasons for taking sick leave]

Source: Employment Research, 2005

Nearly one in five respondents (19% in 2005 compared to 16% in 2000) say that they last took sick leave because of work-related injury/ill health. Many more IRNs (37%) say that their ill health is work-related compared to 18% of UK-qualified nurses.

Six in 10 nurses (60%) who took sick leave in last three months agree that their job is very stressful. This compares to 50% of nurses who have not taken sick leave in the previous three months.

In addition to work-related sick leave, ill health is more common among nurses who:

- work full-time (21%) compared to (15%) part-time nurses
• work in the independent hospital sector (31%)
• are working in older people’s nursing or longer term care (24%)
• who qualified in the last five years (24%).

It is worth noting, although more part-time nurses report an ongoing/long-term health problem that affects the work that they can do, fewer take time off sick.

**Key points: chapter 5**

• one in four (23%) respondents with a disability or health-related problem that affects their work say that no adjustment is necessary

• of the respondents who say that some adjustment/adaptation to accommodate their health need is necessary, a half report that their employer does everything required

• part-time respondents are more likely to have a health condition that affects their working life. They are more likely to say that their employer adapts or adjusts the working environment to accommodate their needs, and are less likely to take sick leave

• 85% of respondents say that their employer provides access to an occupational health service, and 69% say that they can access the service without referral

• six in 10 respondents say that their employer provides a counselling service, and 62% say that they can access this service without referral

• 28% of respondents had taken sick leave in the previous three months, compared with 26% in 2000. Six in 10 of the nurses who took sick leave in last three months say that their job is very stressful.
6. Musculo-skeletal disorders

The Health and Safety Executive (HSE)\textsuperscript{26} says that musculo-skeletal disorders are the most common occupational illness in Great Britain, and that they affect one million people a year. The problems include low back pain, joint injuries and repetitive strain injuries. In 1995/1996 it was estimated that MSDs cost the UK £5.7 billion. The HSE cites back pain as the leading cause of sickness absence from work in the UK that costs the NHS £481 million a year to treat\textsuperscript{27}.

A National Audit Office survey found that 24\% of NHS staff regularly experience back pain, and one in four nurses has taken time off work with a work-related back injury. Moving and handling is the most frequently reported cause\textsuperscript{28}.

Therefore, both the RCN\textsuperscript{29} and NHS Employers\textsuperscript{30} have launched campaigns and guidance about how to avoid back injury and other MSDs. In January 2003, Wales launched the All Wales NHS Manual Handling Training Passport and Information Scheme.

The previous chapter highlighted that one in seven nurses reported that when they last took sick leave it was because of a bone/joint/muscle problem. This chapter looks at the number of nurses that undertake moving and/or handling as part of their work. We then go on to describe the support offered by employers to prevent MSDs.

Moving/handling patients and equipment

More than eight in 10 respondents (84\%) move/handle patients or equipment as part of their work. A very large number 92\% (95\% of those whose jobs involved moving/handling) received health and safety training/guidance.

Table 6.1 below shows when respondents had last received training/guidance. In two-thirds of cases (66\%), training/guidance was received within the last year. Independent sector nurses were more likely to have received training recently, while only 40\% of GP practice nurses had received this training in the last year.

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\textsuperscript{26} See www.hse.gov.uk/msd
\textsuperscript{27} See www.hse.gov.uk/msd/backpain
\textsuperscript{28} National Audit Office (2003) \textit{A Safer Place to Work: improving the management of health and safety risks to staff in NHS trusts}, London: NAO.
\textsuperscript{29} Royal College of Nursing (2003) \textit{Safer staff, better care. RCN manual handling training guidance}, London: RCN.
\textsuperscript{30} NHS Employers launched a Back in Work campaign in 2002 to provide examples of innovation, problem solving and initiative.
Table 6.1: Time since received training/guidance on moving/handling – percentages

<table>
<thead>
<tr>
<th>Practice</th>
<th>NHS hospital</th>
<th>NHS community</th>
<th>GP practice</th>
<th>Indep hospital</th>
<th>Care home</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last month</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>2-6 months ago</td>
<td>28</td>
<td>21</td>
<td>11</td>
<td>37</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td>7-12 months ago</td>
<td>31</td>
<td>37</td>
<td>23</td>
<td>32</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td>More than a year ago</td>
<td>33</td>
<td>33</td>
<td>52</td>
<td>17</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td>Can’t recall</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Base n= 1,288 343 115 60 259 2,300

Source: Employment Research, 2005

Preventing MSDs

Employers have taken a variety of measures to prevent MSDs. Figure 6.1 summarises the data. It shows that two-thirds to three-quarters of respondents have received appropriate training (78%), or have been encouraged to use mechanical aids (68%). In just under 6 in 10 cases (59%), employers provided suitable mechanical aids. Information to reduce risk of MSDs has been given in more than half of all cases, and regular risk assessments were reported by 46% of respondents.

Figure 6.1: Measures introduced by employers – percentages

Source: Employment Research, 2005

It is notable that regular risk assessments are more likely to be reported by nurses (60% to 65%) in the independent sector. This compares to around 40% in the NHS, and 25% of GP practice nurses. A wider range of measures are cited by nurses in the independent sector.
Table 6.2: Measures introduced by employers to prevent MSDs – percentages

<table>
<thead>
<tr>
<th>Practice</th>
<th>NHS hospital</th>
<th>NHS community</th>
<th>GP practice</th>
<th>Indep hospital</th>
<th>Care home</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information to reduce risk of MSDs</td>
<td>55</td>
<td>43</td>
<td>37</td>
<td>60</td>
<td>56</td>
<td>53</td>
</tr>
<tr>
<td>Appropriate training</td>
<td>82</td>
<td>73</td>
<td>44</td>
<td>83</td>
<td>82</td>
<td>78</td>
</tr>
<tr>
<td>Encouraging use of mechanical aids</td>
<td>74</td>
<td>54</td>
<td>14</td>
<td>73</td>
<td>80</td>
<td>67</td>
</tr>
<tr>
<td>Providing suitable mechanical aids</td>
<td>66</td>
<td>42</td>
<td>12</td>
<td>76</td>
<td>74</td>
<td>59</td>
</tr>
<tr>
<td>Changes to jobs/roles</td>
<td>9</td>
<td>7</td>
<td>2</td>
<td>17</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Reassigning tasks to other staff</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>14</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Regular health checks</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>16</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Regular risk assessments</td>
<td>43</td>
<td>42</td>
<td>25</td>
<td>65</td>
<td>60</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Do not know</td>
<td>8</td>
<td>15</td>
<td>32</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Base n=</td>
<td>1,377</td>
<td>384</td>
<td>131</td>
<td>66</td>
<td>274</td>
<td>2,489</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Key points: chapter 6

- Two-thirds of respondents have had health and safety training on moving/handling within the last year.
- Three-quarters of respondents have received appropriate training (78%), and two-thirds have been encouraged to use mechanical aids (68%) to prevent MSDs.
- Regular risk assessments are more likely to be reported by nurses in the independent sector than in the NHS, and a wider range of measures are also cited by nurses in the independent sector.
7. Bullying and harassment

Bullying and harassment is recognised as a serious issue in the workplace, and up until the 2000 Working well survey, little research had documented the extent to which this problem affected the working lives of nurses. That survey found that one in six (17%) of respondents had been bullied/harassed by another member of staff in the previous 12 months, and that bullying/harassment correlated with sickness levels and poor psychological health.

In 2000 bullying in the workplace was estimated to cause between a third and a half of all stress-related illness. However, in contrast with some other issues addressed in this survey, there is very little documented research evidence on the prevalence and nature of bullying in the workplace. In the NHS, the national staff surveys provide some indication of employee experience. In 2004 16% of staff surveyed reported that they had suffered bullying, harassment or abuse from other staff. This is the same percentage recorded in 2003.

The 2000 Working well report provides some baseline data against which change can be monitored by this year’s survey. First we look at the prevalence of bullying and harassment in the workplace before describing the perceived sources and perceptions as to why it took place.

The extent of bullying and harassment

Nearly a quarter (23%) of respondents say that they had been bullied or harassed by a member of staff in the previous 12 months. This is higher than the 17% figure reported in 2000.

Part of the increase could be attributed to the higher numbers and proportion of black and minority ethnic (BME) nurses and IRNs in membership compared to five years ago. In 2000 a higher incidence of bullying/harassment was reported among BME nurses. This remains the case in 2005. However, it is also the case that the proportions reporting bullying and harassment have increased among all ethnic groups and white nurses (16% to 21% of white respondents).


Figure 7.1: Bullied/harassed by a member of staff in previous 12 months by ethnic origin – percentages

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>30%</td>
</tr>
<tr>
<td>Afro Caribbean</td>
<td>45%</td>
</tr>
<tr>
<td>Mixed</td>
<td>30%</td>
</tr>
<tr>
<td>Other White (Irish)</td>
<td>27%</td>
</tr>
<tr>
<td>Asian</td>
<td>24%</td>
</tr>
<tr>
<td>White British</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Figure 7.1 shows that 45% of Afro-Caribbean nurses are most likely to report being bullied/harassed in the 12 months prior to the survey. A previous Policy Studies Institute survey found that more than a third of minority ethnic nurses had been racially harassed by colleagues.\(^{33}\)

It is also the case that a higher percentage of IRNs report having been bullied/harassed (36% compared to 22% of UK-qualified nurses).

Whether or not an individual has an ongoing health problem or disability also correlates with being bullied or harassed. A third of nurses with a long-term health problem/disability say that they had been bullied or harassed in the previous 12 months. This compares to just 20% of those without a disability.

It also seems that full-time nurses (26%) are more inclined to report being bullied or harassed than part-time nurses (19%). This is in addition to the two variables highlighted above. It may also be that full-time staff spend more time at work, so their exposure time is increased.

A third (33%) of respondents say that the problem is primarily bullying, 21% say that it is harassment and 46% say that it is mixture of the two. There is no discernible pattern in response between different settings and backgrounds.

Although over the last five years there has been an increase in the number of nurses who report experience of bullying and harassment in the 12 months prior to the survey, the frequency seems to be unchanged. *At breaking point?* found almost identical figures to the 2000 study: 16% of nurses indicate that bullying/harassment had happened once in the last year, 47% two to six times, 7% say that it occurs on a daily basis, and 6% say it is a weekly occurrence.

---

Source of bullying/harassment

Nursing colleagues are reported as the source of bullying/harassment in nearly a third (30%) of cases, although management is often perceived as the main source (see figure 7.2 below). Survey findings show that senior managers are the problem in one in five cases (21%), and the immediate supervisor/manager is the source for one in four (24%) respondents. Medical and other colleagues are mentioned by 9% of respondents. Managers can also be the victim of bullying/harassment by the staff that they manage, and 7% reported this.

Figure 7.2: Source of bullying and harassment – percentages

Source: Employment Research, 2005

Nurses early in their career (49%) and, by association, those working in hospitals (38%) are much more likely to mention nursing colleagues as the source of the bullying/harassment. Otherwise, the survey found little to separate groups of nurses in terms of the source of bullying/harassment.

However, it is interesting that when a respondent labels the incident(s) as harassment it is more likely to be linked to nursing colleagues. If the nurse says that it is bullying, then senior managers are more likely to be implicated.
Reasons for being bullied/harassed

In 2000 the options presented to respondents failed to pick up the reasons for bullying, and left a number of questions unanswered about its nature. The 2000 survey asked respondents: “What was the focus of bullying/harassment?” They were presented with a list of six factors: gender/sex; race; age; sexuality; personality clash; and other. The results indicated that relatively few (18% in total) considered that the bullying/harassment related to their sex, gender, age or race. The majority (64%) cited other factors, and a significant number (38%) referred to personality clash.

To address this, the questionnaire was revised for the 2005 survey. Respondents were first asked: “Why do you think that this person(s) has bullied/harassed you?” They were then asked to outline the nature of the bullying/harassment. Then the survey posed a question similar to the one used in 2000, but with more clearly defined categories. This question was: “Were any of the following characteristics (covered by current or planned legislation) relevant to the bullying/harassment you’ve experienced?” As in the 2000 survey the response categories included: gender; race; sex; and age. But, instead of personality clash and other, four new categories were added: nationality; religion; trade union membership; and disability.

Table 7.1 presents the results from the open question asking people about the reason for bullying/harassment. The responses primarily relate to characteristics of the bully as the source of the problems. It is either because of personality traits or their work situation that has led them to behave in this way. In many cases it is some aspect of the bully’s work position that is believed to be the reason for their behaviour. For example, the bully is unable cope with a position of seniority or responsibility, feels threatened by the victim’s capabilities, and cannot accept criticism or suggestions. One in 10 (9%) specifically refer to lack of management experience/training/skills as a contributing factor. Some (13%) feel that the bully is misusing the power/status of their position. In a few cases (3%), it is believed that the organisation itself is complicit – bullying is not being stamped out and the bully is ‘allowed to get away with it’.

The responses given depend on the source of the bullying. Most notably, respondents who have been bullied or harassed by a manager are much more likely to refer to work situations (abuse of position and power, and a lack of managerial/leadership skills) as the cause of the problem.

This echoes other research (based on a survey of 512 managers) that found that two-thirds of managers believed that lack of management skills was a factor contributing to bullying. This was the most frequently cited reason. Added to this, 60% of managers are reported to have had no training on how to tackle bullying34.

Relatively few of the responses relate to characteristics of the victim, although some see the bullying/harassment as a response to their situation. For example, it could be as a result of whistle blowing (4%), because the victim is new in post (5%), or because of specific actions such as taking leave (1%).

---

Table 7.1: Perceptions of why bullied/harassed – percentages by source of harassment

<table>
<thead>
<tr>
<th>Perception</th>
<th>Manager</th>
<th>Nursing colleague</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bully has work-related insecurities</td>
<td>14</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Bully has work-related stresses</td>
<td>14</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Abuse of their position/misusing their power/status</td>
<td>17</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Bully resents/is jealous of my grade/position/promotion/success</td>
<td>7</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Bully cannot handle people challenging/suggesting/criticising</td>
<td>12</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Egotistical/arrogant personality traits of bully</td>
<td>10</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Lack of managerial/leadership skills/experience</td>
<td>12</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Due to personal characteristics of victim</td>
<td>10</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Bully has personal/social insecurities</td>
<td>1</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Other/general personality of bully</td>
<td>7</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Bully just does not like me</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Because new in post</td>
<td>1</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Punishment for whistle blowing/disagreeing/challenging bully/speaking out</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Bullying is tolerated</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bully has personal stresses</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Work context politics</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Bully wants to make me leave job</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Because of taking leave</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Base n= 178 132 460

Source: Employment Research, 2005

As expected the largest category is other, and some of those perceptions have been explored in table 7.1.
Table 7.2: Main focus of bullying and harassment by ethnicity – percentages (2000)

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>BME</th>
<th>All nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>10 (4)</td>
<td>13 (11)</td>
<td>11 (5)</td>
</tr>
<tr>
<td>Race</td>
<td>4 (2)</td>
<td>61 (56)</td>
<td>13 (6)</td>
</tr>
<tr>
<td>Nationality</td>
<td>4 (-)</td>
<td>43 (-)</td>
<td>10 (-)</td>
</tr>
<tr>
<td>Religion</td>
<td>1 (-)</td>
<td>1 (-)</td>
<td>1 (-)</td>
</tr>
<tr>
<td>Age</td>
<td>9 (4)</td>
<td>11 (16)</td>
<td>9 (5)</td>
</tr>
<tr>
<td>Sexuality</td>
<td>3 (2)</td>
<td>4 (2)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Personality clash</td>
<td>- (38)</td>
<td>- (40)</td>
<td>- (38)</td>
</tr>
<tr>
<td>Trade union membership/role</td>
<td>2 (-)</td>
<td>3 (-)</td>
<td>2 (-)</td>
</tr>
<tr>
<td>Disability</td>
<td>2 (-)</td>
<td>1 (-)</td>
<td>2 (-)</td>
</tr>
<tr>
<td>Other factors/none of the</td>
<td>77 (67)</td>
<td>30 (36)</td>
<td>70 (64)</td>
</tr>
<tr>
<td>above</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Base n= (2005) 455 90 545

Source: Employment Research, 2005

Nearly two-thirds (61%) of black and minority ethnic nurses say that the bullying and harassment is racially influenced, and 43% think it is connected to nationality. White nurses are more than twice as likely to say that the incident(s) is not linked to any minority issue (77% compared to 30%).

One in four (24%) male nurses who experienced bullying and harassment in the previous 12 months report that it was linked to gender. This compares to 9% of female nurses. Male nurses are also more likely to report that the discrimination is linked to sexuality (9% compared to 3% of female).

Nurses aged under 30 (20%), or over 50 (13%), are more likely to report age-related harassment/bullying.

**Nature of the bullying**

Table 7.3 outlines the form the bullying/harassment took, based on a categorisation of the descriptions given by respondents.
Table 7.3: Perceptions of nature of bullying/harassment – percentages

<table>
<thead>
<tr>
<th>Perception</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimidation/belittling</td>
<td>45</td>
</tr>
<tr>
<td>Verbal aggression</td>
<td>27</td>
</tr>
<tr>
<td>Professional judgement/role discredited</td>
<td>22</td>
</tr>
<tr>
<td>Exclusion (no support)</td>
<td>15</td>
</tr>
<tr>
<td>Unfair treatment related to work/case/task allocation</td>
<td>12</td>
</tr>
<tr>
<td>Wrongfully accused about work issues</td>
<td>12</td>
</tr>
<tr>
<td>Criticism of work</td>
<td>9</td>
</tr>
<tr>
<td>Unfair treatment related to working hours/off duty/holiday/breaks</td>
<td>6</td>
</tr>
<tr>
<td>Deliberately making it difficult for me to do my job</td>
<td>6</td>
</tr>
<tr>
<td>Threatening/abusive letters/e-mails/phone calls</td>
<td>5</td>
</tr>
<tr>
<td>Misuse of power/status</td>
<td>4</td>
</tr>
<tr>
<td>Unfair treatment relating to training/development issues</td>
<td>2</td>
</tr>
<tr>
<td>Unfair treatment relating to pay/promotion/grade/benefits/transfers</td>
<td>2</td>
</tr>
<tr>
<td>Feel at risk of physical harm/aggression</td>
<td>2</td>
</tr>
<tr>
<td>Telling lies about me (personal issues)</td>
<td>2</td>
</tr>
<tr>
<td>Physical/sexual assault</td>
<td>1</td>
</tr>
</tbody>
</table>

*Base n* = 512

Source: Employment Research, 2005

There is considerable consistency in the reports of the nature of the bullying/harassment. Most instances involve some form of intimidation/verbal aggression. A range of work-related effects around unfair treatment, criticism of work and undermining of role are also given.

**Action taken**

The most frequent form of action taken by nurses in response to bullying and harassment situations in the workplace is to tell a colleague, and three-quarters (76%) of all respondents took this course. About half tell a manager (56%) or senior colleague (47%). In 12% of cases respondents left their job, and in 30% of cases they tried a change of work situation to get away from the person causing the problem. Both these approaches are most likely to bring about some improvement in the situation (see table 7.4).
Table 7.4: Action taken to deal with bullying/harassment and how situation changed as a result – percentages

<table>
<thead>
<tr>
<th>Action taken to deal with bullying/harassment</th>
<th>Action taken %</th>
<th>How situation changed - %</th>
<th>Base n= 588</th>
</tr>
</thead>
<tbody>
<tr>
<td>Told a colleague</td>
<td>76</td>
<td>81</td>
<td>5</td>
</tr>
<tr>
<td>Told manager</td>
<td>56</td>
<td>63</td>
<td>10</td>
</tr>
<tr>
<td>Told another more senior member of staff</td>
<td>47</td>
<td>64</td>
<td>8</td>
</tr>
<tr>
<td>Spoke to the bully/harasser about the problem</td>
<td>38</td>
<td>64</td>
<td>8</td>
</tr>
<tr>
<td>Sought help from the RCN</td>
<td>20</td>
<td>45</td>
<td>20</td>
</tr>
<tr>
<td>Made an informal complaint</td>
<td>29</td>
<td>59</td>
<td>15</td>
</tr>
<tr>
<td>Made a formal complaint</td>
<td>13</td>
<td>54</td>
<td>16</td>
</tr>
<tr>
<td>Sought a change in work situation to get away from person causing problem</td>
<td>30</td>
<td>34</td>
<td>11</td>
</tr>
<tr>
<td>Resigned/left my job</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Sought other support from employer</td>
<td>18</td>
<td>60</td>
<td>7</td>
</tr>
<tr>
<td>Sought other support from outside workplace</td>
<td>30</td>
<td>55</td>
<td>5</td>
</tr>
<tr>
<td>No action taken so far</td>
<td>25</td>
<td>75</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Speaking to the bully/harasser directly about the problem

This seems to have mixed results. For 35% the situation improves by speaking to the bully/harasser. But, for 20% it got worse – the latter is a higher percentage than for any other course of action. Making a complaint (either formal or informal) is also likely to change the situation, but not always for the better.

Seeking a change in work situation to get away from person causing problem

Creating change is most likely to improve the situation, and this occurs in 55% of cases. However, 12% of respondents resigned or left their job, and in 88% of those cases the situation improved from their perspective.

Seeking support from outside the workplace

Looking for support outside the workplace can be more beneficial, and for 40% of respondents this improved the situation. Speaking to work colleagues did not create an improvement for nearly two-thirds of cases.

More recently qualified nurses are less likely to tell their manager or make a formal complaint. The survey found that 44% of nurses with less than five years’ experience tell their manager compared to 58% of those with more than five years in post. Nurses on lower grades are also less likely to make an informal complaint or ask for support from their employer, and many take no action at all.

However, in most cases, regardless of the action taken, the situation remains the same.
Making the employer aware

Respondents who had been bullied or harassed by a member of staff were asked whether or not they had told their employer. Just under two-thirds (64%) of all respondents had done this. Employers of nurses who work full-time are more likely to be aware of the problem (66%), which compares to 58% of employers of part-time staff. Also, more employers of white nurses (67%) are aware of bullying/harassment problems than employers (51%) of black and minority ethnic nurses.

In most cases, the employer response (see table 7.5) is to have informal discussions about the incident (59%). However, in 36% of cases support is offered, but only a third (35%) of respondents is satisfied with the outcomes from this approach. Satisfaction among respondents is highest when employers offer support and take action to stop the bullying/harassment.

It is worth noting that respondents who make a formal complaint about the incident are more likely to be offered support (48%), compared to 33% of those who do not made a formal complaint.

Table 7.5 Employer response to bullying and harassment – percentages

<table>
<thead>
<tr>
<th>Employer response</th>
<th>Formal complaint</th>
<th>No formal complaint</th>
<th>All %</th>
<th>Employer response %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Satisfied</td>
</tr>
<tr>
<td>Offered support</td>
<td>48</td>
<td>33</td>
<td>36</td>
<td>61</td>
</tr>
<tr>
<td>Taken action to stop bullying/harassment</td>
<td>43</td>
<td>29</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>Informal discussions took place</td>
<td>72</td>
<td>55</td>
<td>59</td>
<td>35</td>
</tr>
<tr>
<td>A formal investigation was conducted</td>
<td>50</td>
<td>10</td>
<td>60</td>
<td>45</td>
</tr>
<tr>
<td>Disciplinary hearing held</td>
<td>19</td>
<td>3</td>
<td>5</td>
<td>36</td>
</tr>
<tr>
<td>Disciplinary action taken</td>
<td>16</td>
<td>3</td>
<td>5</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005

Overall, the survey found that one in five (19%) respondents, who indicated that their employer was aware of the problem, was satisfied with the outcome. One in four (26%) felt it was too early to say, and 54% were not satisfied. Disconcertingly, respondents who had made a formal complaint are less likely to be satisfied with the outcome (64% are not satisfied compared to 52% who have not made a formal complaint).

Respondents were also asked if they were satisfied with how the situation was handled by their employer regardless of the outcome. Again, one in five (19%) say that they are satisfied, 12% report that their case is still in progress, and 69% say that they are not satisfied.
These results are worse than those reported in the 2000 survey, when we found that 30% were satisfied compared to 57% who were not. Again, more nurses who had made a formal complaint were not satisfied with the way their employer handled the situation (83% compared to 65% of those who had not made a formal complaint).

**Figure 7.3: Satisfaction with employer handling by source of bullying/ harassment – percentages**

![Bar chart showing satisfaction levels by source of bullying/harassment](chart.png)

Source: Employment Research, 2005

Figure 7.3 shows that the source of the bullying influences how respondents feel the situation is handled by their employer. For example, where a senior manager or supervisor/manager is the reported source of the bullying/harassment, only 8% and 12% respectively are satisfied with how their employer handles the situation. If it is a nursing colleague, or someone managed by the respondent, then more than 30% are satisfied with the way their employer handles the problem.

**Key points: chapter 7**

- 23% of respondents say that they have been bullied or harassed by a member of staff in the previous 12 months. This is higher than in 2000 (17%)
- minority ethnic nurses are more likely to report being harassed/bullied by a member of staff than white nurses
nursing colleagues are reported as the source of bullying/harassment in 30% of cases, although management is often perceived as the main source. Senior managers are the problem in one in five cases (21%), and the immediate supervisor/manager is the source for one in four (24%)

nearly two-thirds (61%) of black and minority ethnic nurses say that the bullying and harassment is racially influenced

a wide range of factors is identified by respondents as the cause of bullying/harassment mainly associated with issues connected with the bully (personality traits/jealousy etc.) such as poor management skills

most instances of bullying/harassment involve some form of intimidation/verbal aggression

64% of all respondents who have experienced bullying/harassment have made their employer aware of the problem. Of these, 19% say that they are satisfied, 12% say the case is still in progress and 69% are not satisfied. These results are worse than those reported in 2000 when 30% were satisfied and 57% were not

respondents who have made a formal complaint about the incident are less likely to be satisfied with the outcome, and are less likely to be satisfied with the way the situation is handled by their employer.
8. Assault from patients/public

This chapter looks at incidents of harassment and assault carried out by patients and members of the public. In 2000, a third of respondents to the survey said that they had been harassed or assaulted in the previous 12 months. This year the survey has been constructed to allow more detailed exploration of both verbal and physical assault on nurses.

In 2003 the National Audit Office conducted surveys of NHS trusts in England to establish information about a range of health and safety issues. The results of this, and previous surveys, show a year-on-year increase in reported incidents of violence and aggression between 1998 to 1999, 2000 to 2001, and 2001 to 2002\(^{35}\). The NAO estimates that violence and aggression have a direct cost to the NHS in England of at least £69 million a year.

In the five years since the last survey, the NHS has adopted a number of new policies/initiatives aimed at addressing the safety of staff at work, such as:

- in 1999 the campaign to stop violence against staff working in the NHS was launched (NHS zero tolerance zone). A poster campaign was re-launched in March 2001

- *Working together, securing a quality workforce for the NHS* required NHS trusts and health authorities to have systems for recording incidents, and set targets to reduce violence and aggression by 30% by 2003

- the Security Management Service\(^{36}\) was launched in 2003. It has operational and policy responsibility for reducing violence and improving security in the NHS in England. Part of the organisation’s strategy is the establishment of a Legal Protection Unit to take forward successful private prosecutions in conjunction with trusts

- in Wales, the All Wales NHS Violence and Aggression Training Passport and Information Scheme\(^{37}\) has been developed by the Welsh Assembly to provide a framework for the delivery of violence and aggression training in the NHS in Wales

- in Scotland new legislation, the Emergency Workers’ Act, 2005\(^{38}\), identifies a specific offence of assault of emergency workers, including nurses

- in February 2005 the National Institute of Clinical Excellence (NICE) issued guidelines on the management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments\(^{39}\).

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36 The SMS is part of the Counter Fraud and Security Management Service (CFSMS), a Special Health Authority with responsibility for the prevention, detection and investigation of fraud and corruption and the management of security in the NHS. See: www.cfsms.nhs.uk

37 See: www.wales.nhs.uk/documents/AllWales_viol_agg_passport-e.pdf


The extent of assault and harassment

Four in 10 (40%) respondents report that they have been harassed or assaulted by patients or their relatives in the last 12 months. This figure is higher than reported in 2000 (34%). Nurses working in different settings experience different levels of assault. Nearly eight in every 10 nurses (79%) working in accident and emergency (A&E) report that they have been assaulted in the previous 12 months. Hospital wards (52%) and care homes (48%) are the next most frequent sites of assault.

Figure 8.1: Harassment/assault by patients/relatives in previous 12 months by location – percentages

Source: Employment Research, 2005

The fields of practice that have a higher than average incidence of assault by patients and their relatives are: learning disabilities (71%); long-term care (67%); mental health (59%); older people’s nursing (48%); and acute adult care (47%).

The following sections explore the nature of assault in a little more detail, and examine employer responses.
Verbal abuse from patients and the public

Two-thirds (67%) of all nurses have experienced some form of verbal abuse at some stage in their careers. This has happened to almost all nurses in A&E (95%), and the majority (73%) of those working in hospital wards. A similar pattern of response is also apparent by field of practice (see figure 8.2). More nurses in mental health (84%), learning disabilities (84%) and adult acute care report that they have experienced verbal abuse from a patient or their relative.

**Figure 8.2: Verbal abuse at work by patients/public by field of practice – percentages**

![Figure 8.2: Verbal abuse at work by patients/public by field of practice – percentages](image)

Source: Employment Research, 2005

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40 It is not possible to compare results to this question with the 2000 survey because the 2005 question format has been altered to elicit more detail on each type of abuse.
It is worth noting that black and minority ethnic nurses, particularly IRNs, are less likely to report being verbally abused (53% compared to 69% of white nurses). This is interesting because more minority ethnic nurses work in specialties where there is a high incidence of verbal abuse i.e. mental health and learning difficulties.

Mainly, the frequency of verbal abuse reported by respondents is an occasional occurrence. Figure 8.3 shows that 28% of those who experienced verbal abuse from patients say that it happened once in the last year, and 43% say it happened two to six times. However, 29% of A&E nurses say that it happens at least weekly, and 9% say that it occurs daily. This compares to 12% of all nurses who say that it happens at least weekly. Nurses working in mental health and learning disabilities experience high levels of verbal abuse, similar in scale to A&E colleagues.

**Figure 8.3: Frequency of verbal abuse at work – percentages**

![Figure 8.3: Frequency of verbal abuse at work – percentages](image)

Source: Employment Research, 2005

Nearly a third (31%) of all verbal abuse incidents on nurses committed by patients and the public go unreported. Nearly a fifth (19%) of nurses reports them occasionally, 21% sometimes and 29% always reports them.

**Physical assault by patients/public**

More than one in four (27%) say that they have been physically assaulted at work at some stage in their career. Partly related to the nursing specialty, physical assault is almost twice as high among men as women (49% compared to 25%).
Looking at the respondents who have been assaulted at some stage in their career, on average it is just under five years since they were last assaulted. But, 25% have been assaulted in the last six months and 50% in the last two years. Nurses on lower grades have been assaulted more recently, which is partly due to age and length of career: D grades have been assaulted in last two years, and H grades more than 10 years ago (see figure 8.4).

**Figure 8.4: Time since last physical assault – mean years**

![Time since last physical assault – mean years](image)

*Source: Employment Research, 2005*

Nurses working in older people’s nursing and in independent care homes have been assaulted most recently, and on average the last occasion happened within the last two years.

Nearly a half (45%) of respondents, who say that they have been physically assaulted at some stage of their career, had been assaulted in the last year. Accident forms were completed in 38% of cases. Across all nurses, the mean average number of assaults they were subjected to in the previous 12 months was 1.6. However, D grade nurses had been assaulted 2.7 times, and E grade 1.9 times. Minority ethnic nurses also experienced more assaults - 3.3 assaults compared to 1.5 for white nurses.

One in nine nurses (11%) who have been physically attacked at some stage in their careers had to take time off as a result. Two-thirds (65%) of respondents completed an accident report form when they were last assaulted, a half told a senior member of staff, and just under 40% told a colleague. One in eight (12%) nurses did nothing in response to the incident (see figure 8.5).

D grade nurses are most likely to tell a colleague (50%) about an assault. More full-time respondents complete an accident report form (70%) compared to part-time (55%) colleagues. A higher proportion of men say that they report the incident to the police (19%) and make a claim to the Criminal Injuries Compensation Authority (8%).

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Respondents were also asked how their employers responded when they reported an assault. Nearly half (45%) says that their employer offered immediate support, 15% report that counselling/debriefing was available, and 13% say that their employers issued a verbal warning to the assailant.

**Figure 8.5: Action taken as a result of last assault – percentages**

- Completed an accident form
- Reported it to a more senior member of staff
- Told a colleague
- Reported it to the police
- Sought help from the RCN
- Made a claim to the criminal injury compensation authority
- No action taken

**Source:** Employment Research, 2005

**Figure 8.6: Employer responses to the assault – percentages**

- Offered immediate support
- Offered counselling/debriefing
- Verbal warning issued to assailant
- Involved police
- Written warning sent to assailant
- Care discontinued
- Supported private prosecution

**Source:** Employment Research, 2005
In almost all cases (91%) there was no outcome from any intervention taken by the individual or their employer. In 6% of cases the incident was reported to the police, and in 1% an injunction was taken out. Despite the lack of any definite outcome from their employer’s support/intervention, 60% of respondents are happy with the way that the incident was handled, and 60% say that they are satisfied with the outcome.

However, only 21% of IRNs are satisfied with how their employer handled the situation, compared to 60% of UK-qualified nurses. Perhaps this reflects the lack of employer support that IRNs report. In addition, 60% are satisfied with the eventual outcome, despite the fact that, in most cases, there is no formal outcome from the incident. In this case, black and minority ethnic nurses are less likely to be satisfied with the outcome (30% compared to 62% of white nurses).

Finally, nurses were also asked to respond to the statement: *I am confident that my manager would support me if I were physically assaulted at work.* Overall, 80% agreed with the statement, but this figure was lower for IRNs.

**Key points: chapter 8**

- 40% respondents report that they had been harassed or assaulted by patients or their relatives in the last 12 months, more than in 2000 (34%)
- eight in 10 A&E nurses have been harassed or assaulted in the last 12 months. Nurses working in learning disabilities, mental health and longer term care are also more likely to have experienced harassment or assault from patients or their relatives over this period
- two-thirds of all nurses have experienced verbal assault at some stage in their careers. Mostly it is an occasional occurrence, 71% say it happens no more than once every couple of months. However, one in 10 report verbal abuse as a daily occurrence
- black and minority ethnic nurses are less likely to report verbal abuse, this is despite the fact that more work in specialties where the incidence is higher i.e. mental health/learning disabilities
- one in four nurses say that they have been physically abused at some stage in their careers. This is twice as likely to happen to men as to women, and 11% of respondents who have been physically assaulted have had to take time off as a result
- in just under a half of cases employers offered immediate support, but in 91% of cases there was no outcome of any intervention from the employer or the individual. However, most (60%) are satisfied with the way that their employer handled the situation.
9. Needlestick injuries

As reported in the 2000 survey, sharps (needlestick) injuries pose a serious occupational hazard to nurses, although at the time there was a lack of UK-based data and evidence about the prevalence of sharps injuries. Most of the available research evidence had been gathered in the USA, and information on occupational exposure to blood and body fluids in the UK has been scant. USA research\textsuperscript{41} estimates that between 600,000 and one million health care workers sustain sharps injuries every year, and that 1,000 per year are estimated to contract a blood-borne infection.

The April 2003 NAO report revealed that needlestick injuries are the second most prevalent cause of accidents to NHS staff, and account for 17\% of reported incidents.

In 2005 \textsuperscript{42} the Health Protection Agency (HPA) reported that there had been nine hepatitis C (HCV) sero-conversions following significant exposure over a seven-year period. Six of the incidents were reported in the 12 months between July 2003 and June 2004.

The NHS Employers blue book\textsuperscript{42} on health, safety and welfare issues offers guidance about how to reduce needlestick injuries by training, risk assessment and the use of new technology such as safety mechanisms.

This chapter starts by looking at the prevalence of needlestick or sharps injuries among nurses, and then goes on to describe the nature of the injuries and action taken.

**Prevalence of needlestick injuries**

Nine in 10 respondents (90\%) use needles or sharps as part of their job, and of these 97\% say that there is a procedure in their workplace for dealing with needlestick or sharps injuries.

Just over one in three (35\%) of all respondents say that at some point in their careers they have been stuck by a needle or sharp that has been used on a patient. This figure is slightly lower than reported in 2000 (37\%).


\textsuperscript{42} NHS Employers (2005) The management of health, safety and welfare issues for NHS staff, London: NHS Employers. This is also known as the blue book. See: www.nhsemployers.org

\textsuperscript{43} Health Protection Agency (2005) Eye of the needle - surveillance of significant occupational exposure to blood-borne viruses in healthcare workers, London: HPA.
As one might expect, the likelihood of being stuck by a needlestick or sharp is linked to a nurses’ length of service. One in five (22%) who qualified in the last five years have been injured in this way. This figure compares to 36% of those with five to 10 years’ experience and 38% of respondents with more than 10 years’ experience. The link between length of service and employment setting/field of practice, described in the last two RCN annual employment surveys\textsuperscript{43}, means that more practice nurses have been injured by sharps/needlesticks than those working on NHS hospital wards.

To get a clearer idea of the incidence of needlestick/sharps injuries respondents were asked to indicate the number of times that they were injured in the last 12 months.

Across all respondents who use needles/sharps, fewer than 7% have had an injury in the last year. This figure is almost identical to that reported in 2000. Nurses in the early years of their careers are less likely to have had a needlestick/sharp injury due to less exposure. However, they are almost three times as likely to have had one in the previous 12 months as more experienced nurses (17% of those in the first three years compared to 5.7% of those with more than three years’ experience).

Also, although the numbers are small it seems that needlestick injuries are more prevalent among IRNs, particularly those in the first three years of their careers.

**Figure 9.1: Injured by needlestick/sharp in last 12 months IRN/UK-qualified by experience – percentages**

![Figure 9.1: Injured by needlestick/sharp in last 12 months IRN/UK-qualified by experience – percentages](image)

Source: Employment Research, 2005

Acute adult care, older people’s nursing and practice nursing have slightly higher than average rates of injury – around 8% compared to 6.5% overall.

At the time of the survey it was just over an average of five years (5.5 years) since respondents had been last stuck/cut. Nurses in mental health and older people’s nursing have been cut/stuck on average slightly more recently. The average figure for IRNs injured in this way is just 3.1 years previously, and for nurses who have qualified in the last three years it is within the last 14 months.

**Last time respondents had been stuck/cut**

In 80% of cases the incident drew blood, and in 11% the respondent did not know which patient the needle/sharp had been used for. Interestingly, black and minority ethnic nurses are much less likely to report that the incident drew blood (62%), or know who the patient is (22%).

In just over half (51%) of the cases where the source patient is known, the source patient was blood-tested. But, 40% say that no blood test was taken, and in 9% of cases the respondent did not know. Incidents in A&E are most likely to result in blood testing the patient (62%). But, blood tests are much less likely to happen in care homes/hospice settings (25%), and GP practices (32%) as show in figure 9.2.

**Figure 9.2: Patients blood-tested where patient identity known – percentages**

![Bar chart showing percentages of patients blood-tested in different settings](image_url)

*Source: Employment Research, 2005*
In nearly nine out of 10 cases (88%) the respondent reported the incident. Again, nurses in care home/hospice settings are less likely to do so (68%), but otherwise there was little difference by workplace. What is of concern is that IRNs are much less likely to report the incident than UK-qualified nurses (60% compared to 89%), although the numbers are relatively small (37 applicable IRN cases).

**Risk and advice**

Nearly a half (48%) of all respondents says that they were given advice about the risk of blood-borne disease immediately after a sharps incident. A further 16% report that advice came within 24-hours, and 7% say they received support within 48-hours. One in four (28%) say that they never received any advice.

In most cases (69%) where a respondent has been stuck with a needle or sharp the level of risk of contracting a blood-borne disease is perceived as low. While in 19% of cases the risk is regarded as medium, for 12% of all such injuries the risk level is considered high.

There is a significant difference in the response to this question between minority ethnic nurses and white nurses. Only 10% of white nurses see the risk of contracting a blood-borne disease as high, but nearly five times as many (46%) black and minority nurses do (see figure 9.3).

**Figure 9.3: Perceived risk of blood-borne disease – percentages by ethnicity**

![Bar chart showing perceived risk of blood-borne disease by ethnicity](chart)

*Source: Employment Research, 2005*
Respondents working in paediatrics are more likely to perceive that cut/needlestick injuries (80%) are a low risk. Fewer nurses in mental health (56%) and adult acute care (60%) perceive these injuries as a low risk, but both sectors employ a higher proportion of black and minority ethnic nurses.

A third of respondents (33%) did not have a blood test after an incident. Not surprisingly, more respondents who perceived the risk to be high had a blood test (77%), compared to (73%) where the risk was perceived as medium or (57%) or seen as low. However, it is a concern that more than one in five nurses who perceived the risk of blood-borne disease as high did not have their blood tested after a sharps injury.

There is some correlation with age. For example, younger nurses are slightly more likely to have blood tests after this type of incident than older nurses (75% of the under 30s compared to 57% of those aged 50-plus).

Just six in 10 respondents who had blood tests following an injury attended the follow up. Although younger nurses are more likely to have had their blood tested after a cut/needlestick incident, they are also less likely to attend the follow up blood test (51% of the under 30s compared to 65% of respondents aged 50-plus) as shown in figure 9.4.

**Figure 9.4a: Percentages receiving blood test by age**

![Figure 9.4a: Percentages receiving blood test by age](image)

*Source: Employment Research, 2005*
Seventeen per cent of respondents were offered prophylactic treatment following their blood test, and 13% received this treatment (76% were not offered it, and 80% did not receive it). Among black and minority ethnic nurses these proportions rise to 39% who are offered prophylactic treatment and 31% who decide to take it. Most respondents feel that their employer offers adequate support (78%), but newly-qualified nurses (within last three years) are less inclined to agree (61%). There was little variation by employer in response to this question.

**Key points: chapter 9**

- nine in 10 nurses use needles or sharps as part of their job and almost all report that there is procedure for dealing with sharps/needlestick injuries
- seven per cent of nurses have been injured by a sharp/needle in the last 12 months (same proportion as in 2000). Nurses in the first five years of their careers are three times as likely to be injured in this way as nurses later in their careers
- a third of nurses did not have a blood test after the injury, and one in five nurses who perceived the risk of blood-borne disease to be high did not have their blood tested after the incident
- only six in 10 respondents who had blood tests following injury attended the follow up
• most respondents feel that their employer offers adequate support, but fewer nurses early in their careers are positive about the support provided by their employer

• older nurses are more likely to have a follow up.
10. HSE stress indicator

It is estimated\textsuperscript{44} that around half a million individuals in Britain believe that they have been experiencing work-related stress at a level that is making them ill. The Stress and Health at Work Study (SHAW) indicates that nearly one in five of all working individuals think that their job is very or extremely stressful\textsuperscript{45}.

The Health and Safety Executive (HSE) reports that nursing in the public sector has one of the highest prevalence rates of work-related stress. The THOR\textsuperscript{46} (The Health and Occupation Reporting Network) statistics also show high incident rates of work-related mental illness for nurses, teachers, and medical practitioners. People working in public sector security-based jobs such as police officers, prison officers, and UK armed forces personnel are also in this group.

An NAO\textsuperscript{47} survey conducted in 2002 found that two-thirds of NHS trusts believe that work-related stress has increased over the last three years.

The HSE has developed a set of six Stress Management Standards to identify and tackle work-related stress. Six dimensions of work design are identified by the standards, and if they are not properly managed they may become sources of workplace stress. They are:

- **demands** – workload, working patterns and the working environment
- **control** – the extent to which individuals can control the way they do their work
- **support** – level of support from the organisation, line managers and colleagues in terms of encouragement, sponsorship and resources. The items on this theme produce two scales – one related to peer support and the other management support
- **relationships** – promoting positive working to avoid conflict and dealing with unacceptable behaviour
- **role** – understanding role in the organisation and avoidance of role conflict
- **change** – management and communication of organisational changes (both big and small).

The HSE has devised a stress indicator tool to support the standards. It covers 35 statements, which relate to the six primary stressors listed above (also see appendices). By using the tool the HSE has compiled substantial data against which the performance of specific groups of staff can be contrasted\textsuperscript{48}.

\textsuperscript{44} Health and Safety Executive (2005) *Self-reported work-related illness in 2004/05*, London: HSE (SWI04/05).
\textsuperscript{45} See: www.hse.gov.uk/statistics/causdis/stress.htm
\textsuperscript{46} The Health and Occupation Reporting Network known as THOR. See: www.coeh.man.ac.uk/thor
\textsuperscript{47} National Audit Office (2003) *A safer place to work: improving the management of health and safety risks to staff in NHS trusts*, London: NAO.
\textsuperscript{48} Health and Safety Executive (2004) *Psychosocial working conditions in Great Britain in 2004*, London: HSE.
The stress indicator tool is included in this survey, and the results are reviewed. Firstly, we look at how the nurses in the survey compare to the HSE benchmark data. We then go on to explore variations between nurses according to their biographical and employment situations on the six different scales. We look at which nurses’ experience causes most stress. The data is analysed to identify the relationship between negative work experiences, such as bullying and harassment or assault, and stress of different kinds. The relationship between the HSE scales and job satisfaction and intention to leave are also examined. Finally, we consider a model that looks at the relationship between stressors, and perceptions of stress.

Overview of stress factors

The HSE stress factors were presented in the questionnaire on two separate pages – the first set with agreement scales and the second set with frequency scales from never to always. The scores of negative statements have been reversed so that all the scores indicate how positive respondents are. The data is then compared with the HSE benchmarking statistics - the higher the mean score, the lower the level of stress.

The mean scores of the statements relating to each factor were compared to seven scales that relate to the HSE Stress Management Standards. We split support between manager and peer support.

The average scale scores for the RCN members surveyed (n=2754-2769) are contrasted with the averages from the HSE benchmark data (n=887-945)\(^49\). Figure 10.1 shows that on the control scale, the average for nurse respondents is the same as the cross section of employees covered by HSE. For all other stress factors, the mean scores for nurses are worse than the HSE average, particularly on the demands, role and relationship scales.

The demands of the job and experience of change represent the biggest stress factors for nursing respondents.

Figure 10.1: Stress scale scores of RCN respondents compared to HSE standards

Biographical differences

This section examines some of the variation between nurses in relation to biographical differences. There is no significant variation between male and female nurses in their responses to the HSE Stress Management Standards. However, there is some variation by age, ethnicity and decade in which respondents first qualified (see table 10.1).

Table 10.1: HSE benchmark and target standards by ethnicity, age and decade in which first qualified

<table>
<thead>
<tr>
<th></th>
<th>Ethnicity</th>
<th>Age</th>
<th>Decade in which qualified</th>
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<td>3.4 3.7</td>
<td>3.7</td>
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<td>3.3</td>
<td>3.3 3.5</td>
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<td>3.7 3.9</td>
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<td>3.2</td>
<td>3.1 3.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Base n= 2,447 281 2,360 373 193 619 824 602 428 2,730

Source: Employment Research, 2005

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Ethnicity here is closely linked to whether or not nurses were recruited from overseas and first qualified in another country. So, although we have identified the variable as ethnicity, it is possible it may be more related to a UK-qualified/IRN dimension. There are interesting differences between BME and white respondents. Black and minority ethnic nurses are more positive on some scales and less so on others. So, for example, in relation to demands of their work, 22% of minority ethnic nurses say that they never have to neglect some tasks because they have too much to do. However, just 5% of white nurses say this. Conversely, 21% of black and minority ethnic nurses say that they always have to work very fast compared to 10% of white nurses.

In terms of relationships at work though, minority ethnic nurses respond less positively than white nurses. For example, 52% say that they are at least sometimes subjected to bullying at work compared to 36% of white nurses.

Looking at age-related differences, there was little obvious difference between age bands. The exception is between those aged 55-plus and nurses under 30 years. Older nurses tend to respond more positively on all the scales than their younger colleagues, and in relation to control over their work. For example, nearly three times as many nurses aged 55-plus (29%) say that they always have control over the way they work as those aged under 30 (10%). Control over work and working patterns is a function to a degree of experience, which is shown by the gradual decline in the control mean by decade in which nurses qualified (see figure 10.2).

**Figure 10.2: HSE Management Standards – control statements by percentage, indicating often/always by decade in which first qualified**

![Graph showing control statements by percentage, indicating often/always by decade in which first qualified.](source: Employment Research, 2005)
One in five respondents indicate that they have health problems or disabilities that they expect to last more than a year. These nurses are more likely to respond negatively on the HSE Stress Management Standards in relation to demands, manager support, peer support, relationships at work, and change. In particular, this is the case for manager support. For example, only 37% of respondents think that their manager supports them through emotionally demanding work, compared to 50% of nurses without health problems/disabilities.

**Employer setting**

Nurses’ perception of how much control they have over their work and employment situation is shown in table 10.2 above. Grade accounts for much of this variation. Figure 10.3 highlights the relationship between experience and decade in which respondents qualified. Higher grade nurses have much higher levels of control over various aspects of their working life.

<table>
<thead>
<tr>
<th>Table 10.2: HSE Management Standards by employer group</th>
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<td><strong>NHS hospital</strong></td>
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<td>Demands</td>
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<tr>
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</tr>
<tr>
<td>Change</td>
</tr>
<tr>
<td><strong>Base n=</strong></td>
</tr>
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</table>

*Source: Employment Research, 2005*
Figure 10.3: HSE Management Standards – statements about control over work by percentage, indicating often/always by grade

Source: Employment Research, 2005

GP practice nurses have the least stressful work environments and respond most positively to the HSE stress standards. Nurses working in A&E departments respond most negatively. Community and hospice nurses report higher levels of control over their work, while care home nurses respond more positively in relation to their role – i.e. being clear about what is expected of them in their work. Respondents working in adult acute care and learning disabilities are more negative than nurses in other specialties, notably practice nursing and occupational health.

Nurses working full-time have greater work demands than part-time colleagues, otherwise there is little to separate them in their responses to the stress standards. For example, 70% of full-time nurses say that they have to work very intensively in their job, compared to 57% of part-time nurses. This is partly a function of what stage the nurse has reached in their career, their field of practice and employer. GP practices and community settings have higher proportions of older nurses, and those working part-time, not on shifts. Younger nurses tend to work in hospital-based acute care, working on full-time contracts.
Table 10.3: HSE Management Standards by work pattern

<table>
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<th>Type of shift</th>
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<td>Demands</td>
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<td>3.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Control</td>
<td>3.5</td>
<td>3.4</td>
<td>3.3</td>
</tr>
<tr>
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<td>3.3</td>
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</tr>
</tbody>
</table>

Base n = 1,686 1,073 1,642 1,110 819 834 196 2,790

Source: Employment Research, 2005

There is greater variation in the responses between nurses who do or who don’t work shifts. For example, 69% of respondents who do not work shifts say that they are never subjected to bullying at work, compared to 57% of those who do. Relationships are strained for 31% of shift workers compared to 24% who don’t work shifts. Similarly, 34% of shift workers say that staff are always consulted about change at work, compared to 45% of nurses not working shifts.

These differences are even greater between nurses who are able to change their current shift and those who can’t. For example, 57% of nurses working shifts who can change their shift pattern say that their working time is flexible. This compares to 26% of nurses who are not able to change their shift pattern.

Stress indicators and negative experiences at work

This section looks at the links between the HSE Management Standards and negative working experiences.

Inappropriate grade

As reported earlier in the report, 44% of respondents think that their grade is not appropriate to their role and responsibilities. Previous RCN annual employment surveys highlighted the connection between this variable and negative views of work and nursing. Figure 10.4 below shows how this variable is related to the seven scales. In all cases the differences are statistically significant. The largest differences are in response to items concerning change and manager support. For example, 55% of nurses who consider that their grade is appropriate to their role and responsibilities say that their manager supports them through emotionally demanding work. This compares to 38% of those who say that they are not appropriately graded. Also, two-thirds (65%) of those who feel appropriately graded say that they have opportunities to question managers about change at work, compared to 50% of those who do not.
Physical and verbal abuse

Four in 10 of all the nurses who responded to the survey have been harassed or assaulted by patients or their relatives in the last 12 months. Although there is a significant relationship to other scales (see table 10.4), physical and verbal abuse at work is most strongly linked to demands. So, nurses who have been harassed or assaulted at work in the last 12 months are much more inclined to say that they, at least sometimes, have unachievable deadlines: 66% compared to 48% of respondents who have not had this experience. All demands statements are significantly linked to whether or not nurses have been harassed or assaulted by patients or their relatives (see figure 10.5).

Table 10.4: HSE Management Standards by type of assault

<table>
<thead>
<tr>
<th>Harassed/assaulted (patients) last 12 months</th>
<th>Verbal abuse (patients) ever</th>
<th>Bullied/harassed (staff) last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Demands</td>
<td>2.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Control</td>
<td>3.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Manager support</td>
<td>3.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Peer support</td>
<td>3.7</td>
<td>3.9</td>
</tr>
<tr>
<td>Relationships</td>
<td>3.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Role</td>
<td>4.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Change</td>
<td>2.9</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Base n= 1,091 1,614 1,784 881 623 2,112 2,790

Source: Employment Research, 2005
A similar pattern of response emerges separately for whether or not respondents have ever been verbally and physically assaulted. Taken together the data suggests that this type of experience impacts significantly on work life satisfaction. In particular, it impacts on perceptions of the demands that are placed on nurses and the intensity with which they feel they have to work.

**Figure 10.5: Demands on work life – percentages indicating often/always by whether or not harassed/assaulted in previous 12 months**

![Diagram showing the percentage of nurses experiencing various demands on work life, broken down by whether they have been harassed or assaulted in the previous 12 months.]

Source: Employment Research, 2005

**Bullying and harassment**

One in four (23%) of all the nurses, who responded to the survey, have been bullied or harassed by a member of staff in the last 12 months. Using the HSE Management Standards similar differences in work life stress emerge when contrasting respondents. However, the differences between those who have been bullied or harassed at work and those that have not are much greater (see table 10.4).

In particular, work relationships are most adversely affected by this experience. Figure 10.6 shows the difference in responses between those who have been bullied and those who have not on each of the items on the relationships scale. Nearly a half (47%) of the respondents who have been bullied/harassed say that ‘relationships at work are strained’. This compares to 21% of nurses who had not experienced this in the 12 months prior to the survey.
Respondents who say that they have been bullied/harassed are also more likely to report that they do not receive the managerial support they would like. Twice as many say that they are not supported through emotionally demanding work (51% compared to 25% not bullied/harassed). Only 33% report that they can rely on their manager to help them with a work-related problem compared to 54% of those who have not been bullied/harassed.

**Figure 10.6: Relationships at work – percentages indicating often/always by whether or not been bullied/harassed by member of staff in last 12 months**

![Graph showing relationships at work](image)

Source: Employment Research, 2005

It is also worth noting that the frequency of bullying/harassment influences views of working relationships, as does whether or not respondents are satisfied with outcomes when incidents have been reported to employers.

**HSE stress indicators and views of work**

This section takes the analysis of stress indicators a step further by comparing the stress scores for nurses with different views of their work.

As expected, nurses who intend to leave their current nursing position in the next year have higher stress scores on all variables (see figure 10.7). The variable that is most strongly linked with intention to leave is *relationships* at work. Where these are more strained respondents are much more likely to say they want to leave within 12 months.
This is particularly true for respondents who have been subjected to bullying at work. For these nurses nearly twice as many plan to leave within 12 months. The survey found that 41% of those who say that they have been bullied/harassed by a member of staff in previous 12 months say that they plan to leave their current position within 12 months. This compares to 21% of nurses who have not been bullied/harassed.

Figure 10.7: HSE Management Standards – mean scores by plans to leave current nursing job

![Graph showing mean scores by plans to leave current nursing job]

Source: Employment Research, 2005

Nurses who are satisfied with their present job are much less likely to have plans to leave their current position within 12 months (15% compared to 59% of those who are not satisfied with their current job). Looking at the relationship between the HSE stress indicators and job satisfaction, manager support is the scale that is most strongly associated to job satisfaction. On this scale, ‘support during emotionally demanding work’ is the strongest link. For example, of those who say that they are not supported during emotionally demanding work, 43% are not satisfied with their job. But, for nurses who report that they are supported during emotionally demanding work, just 4% are not satisfied with their current job.
In addition to manager support, responses to the management of change statements are also strongly linked to job satisfaction. For example, of respondents who do not think that they have sufficient opportunities to question managers about change at work, 41% are not satisfied with their present job. Conversely, nurses who are satisfied with their opportunities to question management about change just 8% are not satisfied with their present job.

**Stress model**

Throughout this chapter we have seen a large number of relationships between variables. It is clear that the prevalence of different stressors at work varies between workplaces. It has also been demonstrated that a relationship exists between the exposure to stressors (as measured by the seven HSE scales) and the likelihood of respondents being satisfied with their jobs or whether they are considering leaving.

It should be noted however that the HSE scales identify exposure to stressors, rather than level of stress experienced. That said it is likely that those who report higher levels of exposure to stressors will suffer the most stress. This can be tested for the RCN members surveyed. An additional item was included alongside the HSE items, asking respondents the extent to which they agreed or disagreed with the assertion: ‘I find my job very stressful’. Figure 10.9 shows distribution of responses.
Nurses exposed to higher levels of stressors in their jobs are also likely to report that they find their job stressful. This was particularly the case in relation to the work ‘demands’ scale. Regression analysis suggests that work demands, control over work and workplace relationships can each affect levels of stress independently of one another. Taken together (by calculating a mean HSE stressor score across all 35 items) there is also strong association between the stressors and reported stress among nurses.

Regression analysis was also used to explore which factors contribute most to nurses’ stress and to find out if exposure to stressors relates directly to job satisfaction or likelihood to leave. Each of the following variables accounts for some of nurses’ perceived stress levels: total HSE score; experience of bullying; assault; employer facilities (computed as total number of facilities/services offered); and shift-working.

Analysis earlier in the report has shown that many of these variables are significantly and substantially linked to one another. But regression shows that all five of these variables have a separate and unique effect in terms of predicting stress.

It was also found that perceived stress is itself a predictor of job satisfaction, and that both stress and job satisfaction (separately and together) are predictors of nurses’ desire to leave their current jobs. Thus the five factors described above contribute to nurses’ perceived levels of stress, which is the key to predicting how people feel about their jobs and their intention to stay or leave. Note that these five variables when taken together can affect job satisfaction, although they do not individually. Perceptions of stress are the link between job satisfaction and bullying, assault, shift-working and facilities.
These relationships are shown in figure 10.10. The arrows indicate independent relationships between variables. Outside of their relationships with each other, all five of the variables on the left (HSE, bullying, assault, facilities, and shift working) explain some of the variation in reported stress. But the HSE stressor scale also has a direct link to job satisfaction and desire to leave (‘I would leave my job if I could’). Although the other four variables have a relationship with job satisfaction and desire to leave, it is primarily because they predict stress levels, and stress in turn is related to overall job satisfaction, which predicts likelihood of wanting to leave their job.

Stress not only explains variation in job satisfaction, but also has a direct relationship with desire to leave – people who are more stressed are more likely to want to leave, regardless of their overall job satisfaction.

**Figure 10.10 Predictors of stress, job satisfaction and wanting to leave**

Stress caused by workplace conditions and events may be a key contributor to general psychological ill health. By using CORE to measure (see chapter 11) stress we can also reveal nurses’ psychological wellbeing. The HSE stressor tool explains variation in terms of both psychological wellbeing and stress. However, it seems highly likely that the stress resulting from HSE stressors/bullying/assault is a precursor to general psychological ill health. In other words, stress caused by workplace conditions and events may be a key contributor to general psychological ill-health.
Key points: chapter 10

- nurses score more poorly than the HSE average, showing that they are exposed to higher levels of stressors in their jobs, particularly in terms of demands and change
- black and ethnic minority nurses, particularly those who first qualified abroad, experience a different mix of stressors. They score more positively on some scales such as demands, but more negatively on others, most notably relationships
- on the HSE stressor scales nurses working in the NHS, particularly in hospitals, generally experience higher levels of stress than those working outside
- GP practice nurses indicate lower levels of exposure to stress in their work
- lower grade nurses, often at earlier stages in their careers, experience less control over their working lives
- inappropriate grade is linked to variations in the manager support and change scales
- unsurprisingly, the HSE stressors scales are related to negative experiences at work. Nurses who have been bullied, harassed or assaulted score more poorly on the scales than those who have not
- low scores on the HSE stressors scales are associated with lower levels of job satisfaction and greater desire/intention to leave current position.
11. Psychological health and wellbeing

This section explores the use of the CORE Outcome Measure (CORE-OM, CORE System Group, 1998) to profile the psychological wellbeing of nurses responding to the 2005 *Working well* survey\(^{50}\) (see the appendix for a detailed description of the CORE-OM).

The aims of this chapter are to:

- examine the psychological health of nurses in 2005, compare this with the 2000 survey results, and benchmark the nurses against the general population
- identify any group differences in psychological wellbeing (e.g. demographic groups and employment situations)
- examine the association between psychological wellbeing and negative experiences at work
- explore associations between CORE scores and views of current jobs in terms of job satisfaction, plans to leave and perceptions of work stress.

**Psychological health of the nursing population**

**CORE-OM scores**

The CORE-OM is a series of 34 questions concerning psychological health and wellbeing. By using this it is possible to calculate the CORE mean score across the 34 questions\(^{51}\). All of the questions in the measure are scored on a scale of 0 to 4, with 0 indicating the healthiest state and 4 indicating the least healthy state. The mean score is multiplied by 10. This figure represents the CORE clinical score, which has a range from 0 to 40 with low scores indicating positive wellbeing.

Table 11.1 compares the CORE clinical scores for nurses responding to the 2005 *Working well* survey with the general population, and with those responding to the 2000 survey. It shows that there has been a reduction in wellbeing among respondents since 2000 from a mean score of 6.3 to 7.2 today. Both these scores are markedly higher than the mean score among the general population at 4.8.

The results from the 2000 survey showed that on average nurses’ psychological wellbeing was better than that of the general population. However, since then further work has been carried out on deriving general population scores. This has resulted in evidence suggesting that the mean CORE score for the general population is lower, therefore more positive, than originally calculated\(^{52}\).

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\(^{50}\) Note that the layout of the scale was different in 2005 – the 2000 survey used tick boxes, and the 2005 survey asked respondents to circle a number on a scale. The headings above the tick boxes/column were consistent in both surveys.

\(^{51}\) Scores for positively framed questions are reversed.

\(^{52}\) Connell J, Barkham M, Stiles W, Twigg E, Singleton N, Evans O and Miles J. Distribution of CORE-OM scores in a general population, clinical cut-off points, and comparison with the CIS-R. Submitted June 2005.
Table 11.1: CORE clinical scores

| CORE clinical scores | Working Well survey 2000 (n=4049) | Working Well survey 2005 (n=2675) | General population (n=535)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.3</td>
<td>7.2</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005/PTRC, University of Leeds

In summary, the psychological wellbeing of nurses responding to the survey is slightly poorer than that recorded in 2000, and considerably poorer than that of the general population.

Psychological cut-offs

CORE scores need to be contextualised and banded so that we have some understanding of what constitutes psychological ill health in the population under scrutiny. The data suggests that a population can be grouped into four defined bands. These are described in table 11.2, which shows the scores that indicate each level of psychological health/ill health. The table shows the percentage of nurses responding to the surveys in 2000 and 2005 that fall into each group.

Table 11.2: Percentage of respondents falling into defined groups

<table>
<thead>
<tr>
<th>CORE clinical score</th>
<th>Group 1 Healthy</th>
<th>Group 2 Minimal difficulties</th>
<th>Group 3 Moderate difficulties</th>
<th>Group 4 Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Well 2005</td>
<td>60</td>
<td>14</td>
<td>12</td>
<td>14</td>
</tr>
</tbody>
</table>

Group 1: psychologically healthy
Group 2: psychologically healthy but experiencing some difficulties
Group 3: experiencing a broader range of difficulties or more intense problems in particular areas
Group 4: raised levels of psychological distress, some action may be required.

Source: Employment Research, 2005/PTRC, University of Leeds

Table 11.2 shows that 60% of nurses in 2005 are categorised as healthy, but 40% show signs of psychological ill health, 14% exhibit minimal difficulties, 12% moderate difficulties and 14% are classified as in distress.

CORE statements profile for 2005

Table 11.3 presents responses to individual statements on the questionnaire in a hierarchical list. This gives a snapshot of what troubled the nurses in the week before they completed the questionnaire.

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53 As previous footnote (52).
54 This represents a combined male and female cut-off, but the actual percentages are calculated on the gender specific cut-offs.
Table 11.3: Individual CORE-OM questions ordered by mean score

<table>
<thead>
<tr>
<th>Negatively framed items</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have felt I have someone to turn to for support when needed</td>
<td>1.49*</td>
</tr>
<tr>
<td>I have felt optimistic about my future</td>
<td>1.47*</td>
</tr>
<tr>
<td>I have been troubled by aches, pains or other physical problems</td>
<td>1.40</td>
</tr>
<tr>
<td>I have achieved the things I wanted to</td>
<td>1.37*</td>
</tr>
<tr>
<td>I have felt warmth or affection for someone</td>
<td>1.29*</td>
</tr>
<tr>
<td>I have felt tense, anxious or nervous</td>
<td>1.26</td>
</tr>
<tr>
<td>I have felt able to cope when things go wrong</td>
<td>1.09*</td>
</tr>
<tr>
<td>I have had difficulty getting to sleep or staying asleep</td>
<td>1.07</td>
</tr>
<tr>
<td>I have felt OK about myself</td>
<td>1.06*</td>
</tr>
<tr>
<td>I have been able to do most things I needed to</td>
<td>1.01*</td>
</tr>
<tr>
<td>I have been happy with the things I have done</td>
<td>0.96*</td>
</tr>
<tr>
<td>I have felt unhappy</td>
<td>0.83</td>
</tr>
<tr>
<td>I have felt like crying</td>
<td>0.81</td>
</tr>
<tr>
<td>I have felt terribly alone and isolated</td>
<td>0.81</td>
</tr>
<tr>
<td>I have felt criticised by other people</td>
<td>0.78</td>
</tr>
<tr>
<td>I have been irritable when with other people</td>
<td>0.77</td>
</tr>
<tr>
<td>My problems have been impossible to put to one side</td>
<td>0.77</td>
</tr>
<tr>
<td>I have thought I am to blame for my problems and difficulties</td>
<td>0.67</td>
</tr>
<tr>
<td>Tension and anxiety have prevented me doing important things</td>
<td>0.52</td>
</tr>
<tr>
<td>Talking to people has felt too much for me</td>
<td>0.51</td>
</tr>
<tr>
<td>I have been disturbed by unwanted thoughts and feelings</td>
<td>0.44</td>
</tr>
<tr>
<td>I have felt overwhelmed by my problems</td>
<td>0.43</td>
</tr>
<tr>
<td>I have felt humiliated or shamed by other people</td>
<td>0.39</td>
</tr>
<tr>
<td>I have thought I have no friends</td>
<td>0.34</td>
</tr>
<tr>
<td>I have felt despairing or hopeless</td>
<td>0.33</td>
</tr>
<tr>
<td>Unwanted images or memories have been distressing me</td>
<td>0.32</td>
</tr>
<tr>
<td>I have felt panic or terror</td>
<td>0.30</td>
</tr>
<tr>
<td>I have threatened or intimidated another person</td>
<td>0.16</td>
</tr>
<tr>
<td>I have thought it would be better if I were dead</td>
<td>0.09</td>
</tr>
<tr>
<td>I have thought of hurting myself</td>
<td>0.07</td>
</tr>
<tr>
<td>I have hurt myself physically or taken dangerous risks with my health</td>
<td>0.06</td>
</tr>
<tr>
<td>I made plans to end my life</td>
<td>0.05</td>
</tr>
<tr>
<td>I have been physically violent to others</td>
<td>0.03</td>
</tr>
</tbody>
</table>

* Scores reversed on statements that were positively framed

Source: Employment Research, 2005/PTRC, University of Leeds
Over half the responses are above the level (more than 0.75) at which this kind of stress is evident to a relatively serious degree in the population. They broadly cluster around common symptoms for depression and anxiety.

**Group differences in psychological health and wellbeing**

This section explores differences in the CORE mean scores by different groups of respondents. The first section looks at variations when comparing different biographical groups of respondents. The second section focuses on their employer settings and work patterns.

**Biographical differences**

Analysis of the core data found that there were no differences in levels of wellbeing between men and women. Likewise there is no discernible difference between nurses in relation to their ethnic origin. It is noticeable, though, that older nurses (i.e. those aged 55 and over) show slightly better psychological wellbeing (mean score 6.0 compared to 7.2 across the population). However, this may be related to the different workplaces that older nurses tend to be in.

**Differences by employer setting**

Respondents who were on long-term sick leave at the time of the survey had considerably poorer psychological health than those who were employed and working, and those who were on maternity leave. This is indicated by a CORE score that is more than twice as high as those respondents who were employed and working at the time of the survey, and three times as high as those of maternity leave.

This result is not surprising. People on long-term sickness are much more likely to be receiving counselling (32% compared with 2% of the rest of the sample), and receiving treatment for psychological problems (56% compared with 7% of the rest of the sample). Also, 47% of those off sick had a psychological problem.

Employer type accounts for much of the variation in clinical scores between groups of nurses. Figure 11.1 below highlights this. It shows that NHS settings all have significantly higher CORE scores than other settings, which demonstrates poorer psychological health and wellbeing. In NHS hospitals, A&E nurses have poorer psychological health/wellbeing scores (mean of 8.4), compared with those working on wards, in outpatients, day care, or in other hospital settings.
Finally, it is worth highlighting the variation in wellbeing within different fields of practice (see figure 11.2).
Working hours also explains some of the variation in CORE scores. Part-time respondents show higher levels of wellbeing than full-time respondents (6.8 compared to 7.4).

Whether or not respondents work shifts and the degree of control that they have over their shift patterns is also strongly associated with their wellbeing. Nurses working shifts have a CORE score of 7.7, while those not working shifts have a score of 6.4. The average CORE score for all nurses is 7.1, and 4.8 is the average for the whole population. However, nurses who work shifts, but do not want to, have a score of 10.4. Those respondents who work shifts, but would prefer a different pattern, have a mean score of 9.5. This variable is strongly linked to psychological wellbeing, and suggests that enforced shift work contributes significantly to a poorer psychological wellbeing.

This relationship is underscored by a link between CORE scores and the extent to which respondents feel that their employer respects their wishes about when, and how they wish to work.

Respondents working shifts who are unable to change their current shift pattern have a score of 8.6 (compared with a mean of 6.6 for those who are able to change their shift pattern).
Grade is also associated with the wellbeing measure. D and E grades show lower levels of wellbeing than respondents on other grades, but they are also more likely to work shifts than other grades. Whether or not respondents consider their grade is appropriate to their role and responsibilities, it is also linked to psychological wellbeing. This is particularly true for E grades. At this level the average CORE mean score is 6.4 for nurses who consider themselves appropriately graded, and 8.6 for those that do not. However, the biggest difference, albeit with lower numbers of cases, is for H grades. Here the CORE mean is 5.5 (n=141) for appropriately graded respondents, and 9.2 (n=72) for those that do not consider their grade appropriate to their role.

Some employee-friendly working patterns are also linked to the CORE mean score. In order of strength of association, they include: opportunity for staff training and development; clinical supervision; flexible working; and opportunities to work part-time. However, whether or not respondents feel that they have been consulted by their employer about how they can help best balance work and life needs is of more importance. Where respondents say that they have been consulted by their employers the CORE mean score is 5.6, and where they have not it rises to 7.7. There is a similar difference in relation to responses concerning employer consultation about staff facilities.

**Explaining variation in CORE scores**

The analysis presented above shows that a number of biographical and employment factors are significantly related to variations in CORE scores. They are: age; employer setting; working hours; shift working; and grade. But analysis earlier in the report has shown that many of these variables are inter-related. For example, fewer older nurses work in hospitals, are less likely to work shifts, and are more likely to be on higher grades. So which of these factors is most important in explaining variation in CORE scores?

To answer this we undertook regression analysis to see which of the following has a unique relationship with CORE scores beyond the relationship that they have with each other: age; NHS/non-NHS; hospital/not hospital; full-time/part-time; shift working; happy with current working pattern; grade; and perceived appropriateness of grade. Only three of these have independent relationships with psychological wellbeing. We found that the relationship exists even once the following has been taken into account: whether work for the NHS or not; whether happy with current shift pattern; and whether respondents perceive the grade they are paid on is appropriate.

**Wellbeing and negative work experiences**

The questionnaire asked about negative work experiences such as assault and bullying and harassment, and they are reported in detail in previous chapters of the report. These experiences have been used to examine CORE clinical scores for nurses with negative work life experiences.
Physical and verbal abuse

Nurses who had experienced physical or verbal abuse (or both) in their job had lower levels of wellbeing than those who had not. Respondents who had experienced physical abuse had a CORE clinical score of 8.3, whereas those who had not been assaulted had a score of 6.8. Nurses who had experienced verbal abuse had a CORE clinical score of 7.8, compared with 6.00 for those who had not. Respondents who had experienced both physical and verbal assault had a CORE clinical score of 8.00, where as those who experienced neither had a CORE clinical score of 6.00.

Bullying and harassment

Nurses who had experienced bullying or harassment in the last year had substantially poorer psychological wellbeing than those who had not. Wellbeing also deteriorated with frequency of the experience (see figure 11.3, which shows that a higher CORE score corresponds to poorer wellbeing/psychological health). Nurses who had experienced bullying several times a month or more had an average CORE clinical score of 12.7. This places the nurses in group 4, which is characterised by ‘raised levels of psychological distress, some action may be required’.

Figure 11.3: CORE clinical scores and experience of bullying – mean scores

![CORE clinical scores and experience of bullying – mean scores](image)

Source: Employment Research, 2005/PTRC, University of Leeds

Wellbeing and views of own job

This section addresses the association between psychological health and wellbeing and respondent views of their work. It also shows the relationship between psychological wellbeing and intentions to leave current employment, job satisfaction and job-related stress.
Nurses who say that they want to leave their current position have much higher CORE clinical scores at greater than 9.00, which compares to 6.4 among those who have no plans to leave. There is no difference in the scores between nurses who intend to leave within six months (9.6) and those who want to leave in one year (9.3).

In addition, respondents were asked to indicate the extent to which they agree or disagree with the statement *I would leave my current job if I could*. Nurses who strongly agree with the statement fall into the group with most acute psychological distress, and have a CORE score of more than 12.00.

**Figure 11.4: Mean CORE scores by negative views of current job**

Nurses who are satisfied with their job had substantially more positive psychological wellbeing than those who are not. This relationship is stronger than desire to leave current job. Respondents who are most dissatisfied with their current job show significantly worse scores on the CORE clinical scale.

Stress is also linked to job satisfaction, or the lack of it. Respondents were asked to indicate the extent to which they agree with the statement *I find my job stressful*. Those who strongly agree with the statement show high CORE scores (11.7). However, this link is not as strong as the association between CORE scores and job satisfaction. Figure 11.4 illustrates these findings.

*Source: Employment Research, 2005/PTRC, University of Leeds*
Key points: chapter 11

- Nurses’ levels of psychological wellbeing have lowered since the survey conducted in 2000.
- Nurses’ psychological wellbeing is lower than the general population.
- Sixty per cent of nurses are psychologically healthy; 14% are psychologically healthy but experiencing some difficulties; 12% are experiencing a broader range of difficulties, or more intense problems in particular areas; and 14% are experiencing raised levels of distress, where some action may be required.
- Nurses’ psychological wellbeing varies according to employer setting. Those working in the NHS, particularly A&E, have poorer psychological wellbeing. This effect is not due to the different age profiles in different sectors.
- Feeling appropriately graded relates to psychological wellbeing.
- Wellbeing varies between different specialties. Nurses working in learning disabilities or school nursing have scores over 8.00 (i.e. poorest wellbeing), while those in occupational health and practice nursing score under 6.00 (i.e. better wellbeing).
- Working shifts when this is not the preferred pattern of work is associated with poorer psychological wellbeing and is a key factor in explaining variation in CORE scores.
- Respondents who had experienced bullying or harassment in the last year had substantially lower levels of wellbeing than those who had not.
- Nurses with poorer levels of wellbeing are more likely to be thinking of leaving their jobs.
- Job satisfaction is strongly linked to psychological wellbeing.
- Nurses who report that they find their job very stressful have poorer psychological wellbeing than those who do not.
Appendices: Survey administration

Appendix 1: Sampling and weighting

A sample of 6,000 RCN members living in the UK was taken from the following membership groups:

- full
- full newly-qualified
- full concessionary
- health care assistant
- health care assistant concessionary (included this year, not included in the past).

The sample included:

- 3,600 members living in England
- 840 members living in Scotland
- 840 members living in Wales
- 720 members living in Northern Ireland.

The survey was mailed on 20 July 2005 with two reminders. The initial pack consisted of a letter from RCN Employment Relations Department, the questionnaire and a reply-paid envelope. The survey was anonymous so all members in the sample were sent two reminders, which consisted of a second questionnaire and reply-paid envelope. They were mailed in two week intervals.

Response rates

An overall response rate of 48% was achieved. This was slightly lower than expected. It is likely that nurses are experiencing some survey fatigue after several surveys from their employer as part of Healthy Working Lives. In addition, the questionnaire was longer than the previous survey, and it is possible that this reduced response rates too.

Table A.1 Overall response rates

<table>
<thead>
<tr>
<th></th>
<th>Total mailed</th>
<th>Post Office returns</th>
<th>Inappropriate</th>
<th>Number usable responses</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main sample</td>
<td>6,000</td>
<td>73</td>
<td>41</td>
<td>2,865</td>
<td>48%</td>
</tr>
</tbody>
</table>

Source: Employment Research, 2005
The sample contained disproportionate numbers from Scotland, Wales and Northern Ireland so a weighting procedure was used to ensure the data set reflected the actual distribution of nurses living in each of the four UK countries.

**Sample statistics and confidence for 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 some relatively small numbers of respondents it is worth giving some discussion to 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 split 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 A.2 Margin of error for estimating the population proportion to be 50/50 or 10/90 for different sample sizes and for a 95% confidence interval**

<table>
<thead>
<tr>
<th>Sample size</th>
<th>200</th>
<th>500</th>
<th>1,000</th>
<th>2,000</th>
<th>5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard error and (margin for 50% estimate)</td>
<td>3.5</td>
<td>2.2</td>
<td>1.6</td>
<td>1.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Standard error and (margin for 10/90% estimate)</td>
<td>2.4</td>
<td>1.5</td>
<td>1.1</td>
<td>0.74</td>
<td>0.4</td>
</tr>
</tbody>
</table>

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

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

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

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 that, 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 to whether two results are significantly different from one another.
Appendix 2: CORE Outcome Measure - structure and profile

The CORE Outcome Measure (CORE-OM) is a single-sheet, 34-statement client self-report questionnaire. It assesses the psychosocial areas of subjective wellbeing (self-confidence/esteem), symptoms (common problems), life, social and relational functioning. It also contains four statements on risk to self, and two on risk to others. The individual CORE-OM questions and the psychosocial areas they assess are provided in table B1.

The structure of the CORE questionnaire was informed by a large-scale survey of psychological therapists\textsuperscript{55}. That survey sought to quantify the life aspects which therapists routinely assessed in determining the type and extent of their patients’ psychosocial difficulties and subsequent post-therapy improvement. The four most common aspects assessed are now reflected in the four questionnaire domains.

The CORE measure shows the level of problems the respondent might be experiencing, from mild depression through to severe anxiety and even harm to self or others. Coincidentally, these mirror the phase model theory of Howard et al\textsuperscript{56} in their descriptions of the affects of adverse life events on psychosocial functioning.

By measuring subjective wellbeing, symptoms, functioning and risk, the CORE-OM, is able to help assess if a person is psychosocially unwell. It can also reveal the extent and severity of that illness relative to a population of psychosocially well individuals. As a consequence, when used in psychological therapy practice, the measure is administered immediately prior to first contact (e.g. assessment or first therapy session), and again at the last therapy session in order to determine levels of illness post-therapy compared with pre-therapy.


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

The psychometric properties of the CORE-OM have been detailed elsewhere (Evans et al., 200057, and Barkham et al., 200158). In brief, highly significant differences have been found between clinical and non-clinical population samples for CORE-OM dimensions. Alpha coefficients for dimensions and statement totals have been calculated for clinical and non-clinical samples, and test-retest stability has been demonstrated. Convergent validity has been established with a range of well-validated psychometric measures, giving CORE-OM clinical and academic credibility. A sample of correlations with other well established measurement questionnaires in common use in UK clinical and research practice are summarised in table B2.

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

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


The rationale for including CORE-OM

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

1. identify the proportion of nurses who may be in need of counselling interventions or support, but who are not currently attending a psychological therapy service, or alternatively receiving prescribed appropriate medication

2. establish some occupation-specific norms for the nursing population. In the development of CORE-OM, the normative population used to establish the non-clinical group norms were largely (and traditionally) made-up of students and a sample of convenience drawn from the general public. The RCN Counselling Service was interested to establish population-specific norms that would enhance their use of CORE-OM in exploring the effectiveness of counselling for problems presented by nurse clients

3. profile response to CORE-OM at an individual statement level to help the RCN Counselling Service understand the types of subjective wellbeing, symptoms and functioning impairments that are commonly experienced in the nursing environment

4. explore whether there are identifiable occupational stressors that impact on the psychosocial wellbeing of nurses.


### Appendix 3: HSE stress indicator tool

<table>
<thead>
<tr>
<th>Scale</th>
<th>Themes</th>
<th>HSE standard</th>
<th>Aim/state to be achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demands</td>
<td>Workload</td>
<td>▪ employees indicate that they are able to cope with the demands of their jobs&lt;br&gt;▪ systems are in place locally to respond to any individual concerns.</td>
<td>▪ organisation provides employees with adequate and achievable demands in relation to the agreed hours of work&lt;br&gt;▪ people’s skills and abilities are matched to the job demands&lt;br&gt;▪ jobs are designed to be within the capabilities of employees&lt;br&gt;▪ employees’ concerns about their work environment are addressed.</td>
</tr>
<tr>
<td></td>
<td>Work patterns</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>How much say a person has in the way they do their work</td>
<td>▪ employees indicate that they are able to have a say about the way they do their work&lt;br&gt;▪ systems are in place locally to respond to any individual concerns.</td>
<td>▪ where possible, employees have control over their pace of work&lt;br&gt;▪ employees are encouraged to use their skills and initiative to do their work&lt;br&gt;▪ where possible, employees are encouraged to develop new skills to help them undertake new and challenging pieces of work&lt;br&gt;▪ organisation encourages employees to develop their skills&lt;br&gt;▪ employees have a say over when breaks can be taken&lt;br&gt;▪ employees are consulted over their work patterns.</td>
</tr>
<tr>
<td>Support</td>
<td>Encouragement, sponsorship and resources provided by the organisation, line management and colleagues</td>
<td>▪ employees indicate that they receive adequate information and support from their colleagues and superiors; and&lt;br&gt;▪ systems are in place locally to respond to any individual concerns.</td>
<td>▪ organisation has policies and procedures to adequately support employees&lt;br&gt;▪ systems are in place to enable and encourage managers to support their staff&lt;br&gt;▪ systems are in place to enable and encourage employees to support their colleagues&lt;br&gt;▪ employees know what support is available and how and when to access it&lt;br&gt;▪ employees know how to access the required resources to do their job&lt;br&gt;▪ employees receive regular and constructive feedback.</td>
</tr>
<tr>
<td>Relationship</td>
<td>Promoting positive working to avoid conflict and dealing with unacceptable behaviour</td>
<td>▪ employees indicate that they are not subjected to unacceptable behaviours, e.g. bullying at work&lt;br&gt;▪ systems are in place locally to respond to any individual concerns.</td>
<td>▪ organisation promotes positive behaviours at work to avoid conflict and ensure fairness&lt;br&gt;▪ employees share information relevant to their work&lt;br&gt;▪ organisation has agreed policies and procedures to prevent or resolve unacceptable behaviour&lt;br&gt;▪ systems are in place to enable and encourage managers to deal with unacceptable behaviour&lt;br&gt;▪ systems are in place to enable and encourage employees to report unacceptable behaviour.</td>
</tr>
<tr>
<td>Role</td>
<td>Role clarity</td>
<td>Role conflict</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>employees indicate that they understand their role and responsibilities</td>
<td>organisation ensures that, as far as possible, the different requirements it places upon employees are compatible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>systems are in place locally to respond to any individual concerns.</td>
<td>organisation provides information to enable employees to understand their role and responsibilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>organisation ensures that, as far as possible, the requirements it places upon employees are clear</td>
<td>organisation ensures that, as far as possible, the requirements it places upon employees are clear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have in their role and responsibilities.</td>
<td>systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have in their role and responsibilities.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change</th>
<th>Management and communication of organisational change (large or small)</th>
<th>organisation provides employees with timely information to enable them to understand the reasons for proposed changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>employees indicate that the organisation engages them frequently when undergoing an organisational change</td>
<td>organisation ensures adequate employee consultation on changes and provides opportunities for employees to influence proposals;</td>
</tr>
<tr>
<td></td>
<td>systems are in place locally to respond to any individual concerns.</td>
<td>employees are aware of the probable impact of any changes to their jobs. If necessary, employees are given training to support any changes in their jobs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>employees are aware of timetables for changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>employees have access to relevant support during changes.</td>
</tr>
</tbody>
</table>
HSE stress indicator – questionnaire statements

Scale: never, seldom, sometimes, often, always
1 I am clear what is expected of me at work
2 I can decide when to take a break
3 Different groups at work demand things from me that are hard to combine
4 I know how to go about getting my job done
5 I am subject to personal harassment in the form of unkind words or behaviour
6 I have unachievable deadlines
7 If work gets difficult, my colleagues will help me
8 I am given supportive feedback on the work I do
9 I have to work very intensively
10 I have a say in my own work speed
11 I am clear what my duties and responsibilities are
12 I have to neglect some tasks because I have too much to do
13 I am clear about the goals and objectives for my department
14 There is friction or anger between colleagues
15 I have a choice in deciding how I do my work
16 I am unable to take sufficient breaks
17 I understand how my work fits into the overall aim of the organization
18 I am pressured to work long hours
19 I have a choice in deciding what I do at work
20 I have to work very fast
21 I am subject to bullying at work
22 I have unrealistic time pressures
23 I can rely on my line manager to help me out with a work problem

Scale: strongly disagree, disagree, neutral, agree, strongly agree
24 I get help and support I need from colleagues
25 I have some say over the way I work
26 I have sufficient opportunities to question managers about change at work
27 I receive the respect at work I deserve from my colleagues
28 Staff are always consulted about change at work
29 I can talk to my line manager about something that has upset or annoyed me about work
30 My working time can be flexible
31 My colleagues are willing to listen to my work related problems
32 When changes are made at work, I am clear how they will work out in practice
33 I am supported through emotionally demanding work
34 Relationships at work are strained
35 My line manager encourages me at work
Appendix 4: Survey questionnaire

A. EMPLOYMENT SITUATION

A1 Are you currently: (Please circle one number)
1 Employed, and working
2 Employed, on maternity leave
3 Employed, on long term sick leave
4 Not in paid employment
5 Retired
6 Other (Please specify)

________________________________________________________________________

If you are not in paid employment please go to Section L

A2 In your main nursing job, do you work:
(Please circle one number)
1 Full-time
2 Part-time
3 Occasional/Various

A3 Who is your employer for your main nursing job?
(Please circle one number)
1 NHS (including GP practices)
2 Non-NHS/Independent Sector
3 Nursing bank
4 Nursing agency
5 Other (Please specify)

________________________________________________________________________

If you are not currently working in nursing at all, please go to Section L

A4 Which of the following best describes the field of practice of your main nursing job?
(Please circle one number)
1 Acute adult care
2 Older people’s nursing
3 Mental health
4 Paediatrics
5 Midwifery
6 Learning disabilities
7 Occupational health
8 School nursing
9 Practice nursing
10 District nursing
11 Health visiting
12 Long term care
13 Nurse education
14 Management
15 Other (Please specify)

________________________________________________________________________

A5 Where do you spend most of your time in your main nursing job? (Please circle one number)
1 Hospital ward
2 Hospital outpatients/day care
3 Accident & emergency
4 Other hospital setting
5 Community
6 GP practice
7 Care home
8 Hospice
9 Other (Please specify)

________________________________________________________________________

A6 Please indicate your current clinical grade or AFC pay band (or its equivalent)
(Please give one answer)
A B C D E F G H I

SMP

OR

AFC pay band level ______

A7 Do you consider your current grade/pay-band to be appropriate given your role and responsibilities?
1 Yes  2 No

A8 Do you plan to leave your present nursing position? (Please circle one number)
1 Yes, within 6 months
2 Yes, within 12 months
3 No plans to leave in the next year

A9 Do you have an RCN role as:
(Please circle all that apply)
1 Steward
2 Safety representative
3 Learning representative
4 None of the above

Administered confidentially by Employment Research
B. WORKING TIME

B1 Do you work shifts?
1 Yes 2 No If No, please go to question B7

B2 In your main nursing job, which of the following shift patterns do you work?
(Please circle one number)
1 Day shifts only (e.g. early, late, long days or evenings)
2 Mix of day & night shifts (e.g. internal rotation)
3 Night shifts only

B3 Are you happy with your current working pattern? (Please circle one number)
1 Yes 2 No, I'd like a different shift pattern 3 No, I don't want to work shifts

B4 In your current job, would you be able to change your shift pattern if you wanted to?
1 Yes 2 No

B5 a) What length of shifts do you normally work?
_______No. hours

B6 If you work nights/rotating shifts have you had a health assessment (to ensure that your health is not affected)?
1 Yes 2 No

B7 a) Do you work any of the following?
(Please circle all that apply)
1 On call (i.e. available to come in to work from home if you are needed)
2 Stand by (i.e. available to work if needed but remain in workplace)
3 Sleep in

b) If YES, after what period of time are you given a compensatory rest period?
(Please circle one number)
1 Before the next shift/day worked 2 Within 72 hours 3 Later 4 No compensatory rest period offered

B8 Below are a number of statements about working hours. Please indicate the extent to which you agree with each by circling one answer on each row.

a) I am generally able to get the off-duty/time-off I want

b) I am satisfied with the length of time my work schedule is planned in advance

c) I find it hard to plan life outside of work because my working hours vary so much

d) My employer respects my wishes about when and how I wish to work

e) I am given sufficient notice of changes to the off-duty rota

f) I frequently work in excess of my contracted hours

g) I am satisfied with the choice I am given over the length of shifts I work

h) I am satisfied with the level of input I have in planning my own off-duty/time off

i) I generally get to work the shifts/times that I want

j) The amount of unsocial hours I work suits me well

Administered confidentially by Employment Research
### C. EMPLOYEE FRIENDLY WORKING

**C1 a)** Which of the following services/facilities does your employer provide?  
Please circle YES, NO, or Don’t Know for each

<table>
<thead>
<tr>
<th>Service/Facility</th>
<th>Yes</th>
<th>No</th>
<th>dk</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Catering facilities in the day</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Catering facilities at night</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Staff rooms for taking breaks</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Breaks/rest-times</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Staff transport</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Free car parking</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Access to parental leave</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) Opportunities to work part-time</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Opportunities to job-share</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) Opportunities to self-roster</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) Flexible working</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12) Access to term-time or school holiday contracts</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
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<tr>
<td>13) Child-care vouchers or allowance</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14) Out of hours play scheme</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
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<tr>
<td>15) Holiday play scheme</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>16) Workplace nursery or crèche</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>17) Counselling services</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>18) Careers guidance</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>19) Clinical supervision</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>20) Opportunity for staff training and development</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
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<tr>
<td>21) Career breaks</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>22) Changing facilities</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>23) Showering facilities</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24) Locker for belongings</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25) Uniform laundering service</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>26) Dependent leave</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>27) Special leave</td>
<td>Yes</td>
<td>No</td>
<td>dk</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**C2** Has your employer consulted with you about how best they can help you balance your work and life needs?  
1 Yes  2 No

**C3** Has your employer consulted with you to find out which facilities you need or want?  
1 Yes  2 No

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D. WORKABILITY & WELL-BEING

D1  Do you have any health problems or disabilities that you expect will last more than a year?  
1  Yes  2  No  If No, please go to D4

D2  Do these problems/disabilities affect the kind or amount of work that you can do?  
1  Yes  2  No

D3  Does your employer do everything required to adapt or adjust the work environment to accommodate your health problems/disabilities?  
1  Yes  2  No  3  Not applicable (no adjustments are needed)

D4  Does your employer provide you with access to an occupational health service?  
1  Yes  2  No  3  Don’t know

D5  Can you access the service directly (without referral)?  
1  Yes  2  No  3  Don’t know

D6  Does your employer provide you with access to a counselling service?  
1  Yes  2  No  3  Don’t know

D7  Can you access the counselling service directly (without referral)?  
1  Yes  2  No  3  Don’t know

D8  Are you currently receiving counselling?  
1  Yes  2  No

D9  Are you receiving any other form of treatment, therapy, medication or remedy for psychological problems?  
1  Yes  2  No

D10  How long is it since you took sick leave?  
_______ (yrs) _______ (months) ago

D11  On the last occasion you were off sick, what was the main reason? (Please choose one response)  
1  Bone, joint, muscle problems  2  Other physical illness/infectious disease  
3  Other injury  4  Stress, depression or anxiety  5  Tiredness/exhaustion  
6  Sick child/dependant  7  Other domestic crisis  8  Unable to get off-duty needed  
9  Other

D12  Was your injury or ill-health work related?  
1  Yes  2  No

D13  On how many separate occasions in the last 3 months have you taken sick leave?  
_____ No. times If none, please go to Section E

D14  In total, how many working days/ nights have you taken off sick in the last 3 months?  
_____ No. shifts
E. NEEDLE STICK INJURIES

E1 Do you use needles or sharps as part of your job?
1 Yes  2 No  If No, please go to Section F

E2 Is there a procedure in your work-place for dealing with needle stick or sharps injuries?
1 Yes  2 No

E3 Have you ever been stuck with a needle or sharp that has been used on a patient?
1 Yes  2 No  If No, please go to Section F

E4 How many times has this happened in the last 12 months? (If none, please enter "0")

_______No. times in last 12 months

E5 How long ago were you LAST stuck/cut:

_______ (years) _______ (months) ago

E6 On this LAST occasion:

a) Did it draw blood?
1 Yes  2 No

b) Did you know which patient the needle/sharp had been used for?
1 Yes  2 No

c) If Yes, was the source patient blood tested?
1 Yes  2 No  3 Don’t know

d) Did you report the incident?
1 Yes  2 No  3 Can’t remember

e) At what point (if at all) were you given advice about the risk of blood borne disease?
1 Never (no advice of risk was given)  2 Immediately  3 Within 24 hours  4 Within 48 hours  5 More than 48 hours later

f) How did you perceive the level of risk of you contracting a blood borne disease?
1 High  2 Medium  3 Low

g) Did you have your blood tested following the incident?
1 Yes  2 No  3 Can’t remember

h) If Yes, did you attend the blood test follow up?
1 Yes  2 No  3 Can’t remember

i) Were you offered any prophylactic treatment?
1 Yes  2 No  3 Can’t remember

j) Did you receive prophylactic treatment following the incident?
1 Yes  2 No  3 Can’t remember

k) Overall, did you feel that your employer offered adequate support to you?
1 Yes  2 No
Below are a series of statements describing feelings towards work. Please circle one number on each line to indicate the extent to which you agree or disagree with each.

a) I get help and support I need from colleagues
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

b) I have some say over the way I work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

c) I have sufficient opportunities to question managers about change at work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

d) I receive the respect at work I deserve from my colleagues
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

e) Staff are always consulted about change at work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

f) I can talk to my line manager about something that has upset or annoyed me about work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

g) My working time can be flexible
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

h) My colleagues are willing to listen to my work related problems
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

i) When changes are made at work, I am clear how they will work out in practice
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

j) I am supported through emotionally demanding work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

k) Relationships at work are strained
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

l) My line manager encourages me at work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

m) Overall I am satisfied with my job
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

n) I am confident that my manager would support me if I were physically assaulted at work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

o) I am satisfied with the quality of care provided where I work
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

p) I would leave my current job if I could
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

q) I find my job very stressful
   1 Strongly Disagree  2 Disagree  3 Neither  4 Agree  5 Strongly Agree

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‘Bullying’ is defined as: offensive, intimidating behaviour, an abuse/misuse of power intended to undermine, humiliate or injure the recipient.

‘Harassment’ is defined as: any unwanted conduct affecting a person’s dignity, which is considered demeaning and unacceptable to the recipient.

H1 Have you been bullied/harassed by a member of staff in the last 12 months?
1 Yes 2 No Please go to Section I

H2 Which of the following best describes the problem: Please circle one answer only
1 Bullying
2 Harassment
3 Mixture of bullying and harassment

H3 Who was the main source of bullying/harassment?
Please circle one answer only
1 A senior manager
2 Your supervisor/manager
3 Nursing colleague
4 Medical colleague
5 Other colleague
6 Staff managed by you

H4 Why do you think that this person(s) has bullied/harassed you?

H5 Please outline the nature of bullying/harassment that you have experienced:

H6 Were any of the following characteristics (covered by current or planned legislation) relevant to the bullying/harassment you’ve experienced? Please circle all that apply
1 Gender
2 Race
3 Nationality
4 Religion
5 Age
6 Sexuality
7 Trade union membership/role
8 Disability
9 None of the above

H7 How often would you estimate that you have been bullied/harassed by staff over the last 12 months? Please circle one answer only
1 Once in last 12 months
2 2 – 6 times in last 12 months
3 7 – 12 times in last 12 months
4 Several times a month
5 About once a week
6 Daily

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**H8**  
**i)** What action have you taken/are you taking?  
(Please circle YES or No for each)  
**ii)** How did the situation change as a result?  
(Please circle an answer for each action taken)

<table>
<thead>
<tr>
<th>Action Taken</th>
<th>Got worse</th>
<th>Stayed the same</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I told a colleague</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) I told my manager</td>
<td></td>
<td></td>
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<tr>
<td>c) I told another more senior member of staff</td>
<td></td>
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<tr>
<td>d) I spoke to the bully/harasser about the problem</td>
<td></td>
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<tr>
<td>e) I sought help from the RCN</td>
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<tr>
<td>f) I made an informal complaint</td>
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<tr>
<td>g) I made a formal complaint</td>
<td></td>
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<tr>
<td>h) I sought a change in my work situation to get way from person causing problem</td>
<td></td>
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</tr>
<tr>
<td>i) I resigned/left my job</td>
<td></td>
<td></td>
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<tr>
<td>j) I sought other support from employer</td>
<td></td>
<td></td>
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<tr>
<td>k) I sought other support from outside workplace</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>l) I have not taken any action so far</td>
<td></td>
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</tbody>
</table>

**H9**  
Is your employer aware of the problem?  
1 Yes  
2 No  
If No, go to Section I

**H10**  
**i)** What has been the response from your employer?  
(Please circle YES or No for each)  
**ii)** Were you satisfied with the response?  
(Please circle an answer for each response)

<table>
<thead>
<tr>
<th>Response</th>
<th>Got worse</th>
<th>Stayed the same</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) My employer has not responded</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b) I have been offered support</td>
<td></td>
<td></td>
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<tr>
<td>c) Employer has taken action to stop the bullying/harassment</td>
<td></td>
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<tr>
<td>d) Informal discussions took place</td>
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<tr>
<td>e) A formal investigation was conducted</td>
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<td></td>
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<tr>
<td>f) Disciplinary hearing held</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Disciplinary action taken</td>
<td></td>
<td></td>
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</tbody>
</table>

**H11**  
Overall, were you satisfied with the outcome?  
1 Yes  
2 No  
3 Too early to say

**H12**  
Regardless of the outcome, are you satisfied with how the situation was handled by your employer?  
1 Yes  
2 No  
3 Still in progress

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## I. PHYSICAL AND VERBAL ASSAULT FROM PATIENTS/PUBLIC

### I1. Have you been harassed or assaulted by patients/clients or their relatives in the last 12 months?
- **1 Yes**
- **2 No**

### VERBAL ABUSE

#### I2. Have you ever been verbally abused by patients/public at work?
- **1 Yes**
- **2 No** (If no, please go to I5)

#### I3. How often would you estimate that you have been verbally abused by patients/public in the last 12 months?
- **1 Once in last 12 months**
- **2 2-6 times in last 12 months**
- **3 7-12 times in last 12 months**
- **4 Several times a month**
- **5 About once a week**
- **6 At least daily**

#### I4. How often have you formally reported the verbal abuse?
- **1 Every time**
- **2 Sometimes**
- **3 Occasionally**
- **4 Never**

### PHYSICAL ASSAULT

#### I5. Have you ever been physically assaulted by patients/public at work?
- **1 Yes**
- **2 No** (If no, please go to Section J)

#### I6. How long ago were you LAST physically assaulted at work?
- ________ (years) ________ (months) ago

#### I7. Did you take time off work as a result of this incident?
- **1 Yes**
- **2 No**

#### I8. What did you do about the assault?
- Please circle all that apply
  - **1 Nothing**
  - **2 I told a colleague**
  - **3 I completed an accident form**
  - **4 I sought help from the RCN**
  - **5 I reported it to a more senior member of staff**
  - **6 I reported it to the police**
  - **7 I made a claim to the criminal injury compensation authority**

#### I9. How did your employer respond?
- Please circle all that apply
  - **1 Offered immediate support**
  - **2 Offered counselling/debriefing**
  - **3 Verbal warning issued to assailant**
  - **4 Written warning sent to assailant**
  - **5 Care discontinued**
  - **6 Involved police**
  - **7 Supported private prosecution**

#### I10. What was the outcome? Please circle all that apply
- **1 None**
- **2 Injunction taken out**
- **3 Reported to police**
- **4 Anti-Social Behaviour Order (ASBO) issued**
- **5 Assailant prosecuted**
- **6 Awaiting outcome**

#### I11. Were you satisfied with how the incident was handled by your employer?
- **1 Yes**
- **2 No**

#### I12. Were you satisfied with the outcome?
- **1 Yes**
- **2 No**

#### I13. How many times have you been physically assaulted in the last 12 months?

- ____________ No of times in last 12 months

#### I14. Please estimate the number of times you have completed an accident form for physical assault in the last 12 months

- ____________ No of times in last 12 months
Below are a series of statements describing feelings towards work. Please circle one number on each line to indicate how often you feel each applies to you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I am clear what is expected of me at work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) I can decide when to take a break</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c) Different groups at work demand things from me that are hard to combine</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d) I know how to go about getting my job done</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e) I am subject to personal harassment in the form of unkind words or behaviour</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f) I have unachievable deadlines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g) If work gets difficult, my colleagues will help me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h) I am given supportive feedback on the work I do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i) I have to work very intensively</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>j) I have a say in my own work speed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>k) I am clear what my duties and responsibilities are</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>l) I have to neglect some tasks because I have too much to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>m) I am clear about the goals and objectives for my department</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>n) There is friction or anger between colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>o) I have a choice in deciding how I do my work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>p) I am unable to take sufficient breaks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>q) I understand how my work fits into the overall aim of the organisation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>r) I am pressured to work long hours</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>s) I have a choice in deciding what I do at work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>t) I have to work very fast</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>u) I am subject to bullying at work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>v) I have unrealistic time pressures</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>w) I can rely on my line manager to help me out with a work problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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K. YOUR FEELINGS OVER THE LAST WEEK

This section has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week, then circle the number that is closest to this, using 0 for not at all to 4 for most or all of the time.

<table>
<thead>
<tr>
<th>OVER THE LAST WEEK…</th>
<th>Not at all</th>
<th>Only occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most or all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I have felt terribly alone and isolated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2) I have felt tense, anxious or nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3) I have felt I have someone to turn to for support when needed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4) I have felt OK about myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5) I have felt totally lacking in energy and enthusiasm</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6) I have been physically violent to others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7) I have felt able to cope when things go wrong</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8) I have been troubled by aches, pains or other physical problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9) I have thought of hurting myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10) Talking to people has felt too much for me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11) Tension and anxiety have prevented me doing important things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12) I have been happy with the things I have done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13) I have been disturbed by unwanted thoughts and feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14) I have felt like crying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15) I have felt panic or terror</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16) I have made plans to end my life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17) I have felt overwhelmed by my problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18) I have had difficulty getting to sleep or staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19) I have felt warmth or affection for someone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20) My problems have been impossible to put to one side</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21) I have been able to do most things I needed to</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22) I have threatened or intimidated another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23) I have felt despairing or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24) I have thought it would be better if I were dead</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25) I have felt criticised by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26) I have thought I have no friends</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27) I have felt unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28) Unwanted images or memories have been distressing me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29) I have been irritable when with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30) I have thought I am to blame for my problems and difficulties</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31) I have felt optimistic about my future</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32) I have achieved the things I wanted to</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33) I have felt humiliated or shamed by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34) I have hurt myself physically or taken dangerous risks with my health</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Thank you very much for taking the time to complete this form. Please return it in the freepost envelope provided or send it to: Employment Research, SEA 1044, FREEPOST, PO Box 2106, Hove, BN3 5ZB. If you have queries about the survey itself you can contact the researcher, Jane Ball, at Employment Research on 01273 299 719.

L. ABOUT YOU

L1 Are you:
1 Female 2 Male

L2 What is your ethnic group? Please circle one number to indicate your cultural background.
White
1 British
2 Irish
3 Any other white background

Mixed
4 White and Black Caribbean
5 White and Black African
Asian or Asian British
6 White and Asian
7 Any other mixed background

Asian
8 Indian
9 Pakistani
10 Bangladeshi
11 Any other Asian background

Black or Black British
12 Caribbean
13 African
14 Any other Black background

Chinese or other ethnic group
15 Chinese
16 Other ethnic group

L3 What is your age:
1 20-24 5 40-44
2 25-29 6 45-49
3 30-34 7 50-54
4 35-39 8 55+

L4 In which country do you work?
(Please circle one number)
1 England
2 Wales
3 Scotland
4 Northern Ireland
5 Other

L5 If you work in England, in which county do you mainly work?
____________________________County

L6 Are you a registered nurse?
1 Yes 2 No

L7 If yes, when did you first register as a qualified nurse?
_______Year

L8 Where did you first register as a qualified nurse?
1 UK 2 Other country

L9 If other country, in what year did you start working as a registered nurse in the UK?
_______Year

If you have become aware of concerns about areas of your life whilst completing this questionnaire you may like to contact one of the following:

- Your local RCN representative
- The counselling service provided by your employer/institution
- The RCN Counselling Service on 0845 7697064
- Or you can contact RCN Direct on 0845 772 6100.
At breaking point?
A survey of the wellbeing and working lives of nurses in 2005