



Royal College  
of Nursing

# Beyond breaking point?

*A survey report of RCN members on health,  
wellbeing and stress*





## Acknowledgements

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# Executive summary and recommendations

## Executive summary

The RCN regularly surveys its membership on many aspects of their working lives; their pay and rewards, workloads, training and development and how they feel about their job. Recent surveys have indicated worryingly high and increasing levels of stress among the nursing workforce who are dealing with heavy workloads, the impact of targets and the challenge of being asked to do more with fewer resources. Our *At breaking point survey* in 2005 was the last time we asked our membership specifically about stress in the workforce; this latest survey reveals what, if anything, has changed.

This *Beyond breaking point* 2012 survey of 2,008 RCN members working across the NHS, GP practice, the private sector, voluntary sector, universities and other public bodies examines the factors influencing health, wellbeing and stress, including management and peer support, sickness absence policies, bullying and harassment and occupational health service provision. It also details recommendations for UK governments, health departments, regulators, managers and union representatives to take forward in the promotion of health and wellbeing in the workplace.

### HSE management standards

The Health and Safety Executive's (HSE's) stress indicator tool provided the starting point for the 2012 RCN membership survey. Part of the HSE's management standards for work-related stress, the tool enables the measurement of stress against six primary stressors: demands, control, role, management support, peer support and change. As in 2005, the demands of the job and experience of change represent the biggest stress factors for nursing staff, but lower scores relating to work stressors indicate that things have significantly deteriorated in the intervening years since our previous survey.

The 2012 survey findings paint a picture of a nursing workforce struggling with both high workloads and the fast pace of work, while feeling unsupported and detached from the changes being implemented within their workplace. Respondents report working long hours, combined with unrealistic time pressures and unachievable deadlines.

Respondents are, however, much more confident about their own roles and how they fit with wider organisational objectives. While this is a welcome finding, jobs must also be rewarding and well designed. Ever increasing demands and workloads and uncertainties about organisational change will only negate any efforts to improve staff health and wellbeing.

Faced with work pressures, it is essential that staff motivation and engagement are developed and improved in order to support the workforce's contribution to delivering better and effective patient care. This must include creating a healthy workplace; it is essential to improving productivity, staff motivation, ensuring quality patient care and improving patient outcomes.

Healthy workplaces only come about through high quality employment practices and procedures that promote work-life balance, dignity at work, health and safety, and good job design where employees have autonomy, control and task discretion, access to training and development and fair pay and rewards.

### Stress in the workplace

We heard from nursing staff that they face a wide range of issues that get in the way of being able to provide the high level of care they wish to. As well as heavy workloads and staff shortages, nursing staff are often fatigued by shift working and very few manage to get the number or length of breaks they need. Others feel that pressure to do more and more work is testing their ability to their job well and some even feel pressured to work beyond their scope. Frustrations also come from paperwork, targets and a lack of resources such as equipment and IT.

Support from managers and team mates is important and most appreciate a simple 'thank you' or 'well done', while senior nurses get the 'middle management squeeze' and often feel under pressure from higher levels of managers as well as their team members.

Nursing staff across all sectors are worried about job security and cuts to terms and conditions and many are anxious about recent perceived challenges to the image of nursing and questions about levels of compassion in nursing.

We also heard from many respondents that they feel patient demands are increasing and that this can even mean verbal or physical violence. Meanwhile, bullying and harassment in the workplace is becoming a problem and is often seen as an indicator of organisational culture.

#### **Recommendation – safe staffing levels**

The RCN is clear that good nursing care starts with safe staffing levels. Insufficient staffing results in increased pressure, stress, burnout, lower job satisfaction and a greater inclination to leave among the workforce. A downward spiral often follows as morale declines and sickness absence increases, leaving fewer staff available to work and creating even more pressure on existing staff.

RCN members tell us that workload and safe staffing levels are the most pressing problems they face on a daily basis. Yet despite the evidence linking staff levels to patient outcomes, there has been a failure to act.

The RCN is clear that the time has come to for providers, regulators and commissioners of services to set clearly defined standards and adopt mandatory staffing levels. The RCN is committed to working with governments, health departments and key stakeholders on developing and implementing staffing level recommendations.

#### **Recommendation – shift working**

A high proportion of nursing staff are working long hours without sufficient rest breaks. This can lead to exhaustion and fatigue and damages health and wellbeing. Employers have a duty to implement safe shift patterns compliant with the Working Time Regulations, and the RCN calls on employers and regulators to pay attention to the impact of working hours on health and wellbeing, and the importance of rest breaks.

There is a need for more research evidence to understand the impact of shift working on patient safety. In particular, the RCN believes more research is needed on the differential impact of working long (12 hour) shifts which are planned; working long hours through back to back shifts, overtime or additional jobs; and shorter shifts.

#### **Recommendation – workplace stress risk assessments**

The Management of Health and Safety at Work Regulations 1999 set out duties on organisations to carry out suitable and sufficient risk assessments on workplace stress. The HSE's management standards (available at [www.hse.org.uk](http://www.hse.org.uk)) provide a framework for organisations to use to prevent and reduce the risks of the work-related causes of stress. The RCN calls on all health care organisations to use the HSE framework to support staff and identify and manage sources of stress, including all NHS staff surveys, and for the HSE framework to be regularly updated so that it continues to be an effective benchmark in the measurement and management of stress.

The RCN would like to see the HSE take a robust approach to organisations that fail to meet the legal requirement to assess and manage the risk of work-related stress. In such cases, we call on the HSE to take enforcement action. Stress can damage individual health and wellbeing, team relationships and ultimately affect patient care.

#### **Recommendation – staff engagement and consultation**

Staff are anxious about the level of change and the lack of consultation and communication about changes made in their workplace. Poor staff engagement is linked to increased absenteeism, presenteeism, lower levels of performance and productivity. Health and social care organisations should consult and involve staff and trade unions around the management of change. In addition, they should also engage and consult with RCN and other trade union safety representatives to identify and address the possible health and safety impacts of any planned changes.

#### **Presenteeism**

In any work setting there are obvious risks to employees being at work when they are unfit or unwell – including risks to health and safety and to productivity. In a health care setting such risks become even more acute as these will impact heavily on patients, service users and their families. The pressure for nursing staff to attend work when unfit or unwell is often self-directed, as they are aware of the impact of being away from work on colleagues and patients/service users.

This survey found that in the previous 12 months the majority of nursing staff (82 per cent) had gone to work despite feeling ill and that presenteeism is widespread, regardless of where respondents worked or their job title. Many respondents told us that stringent use of sickness

absence policies was placing undue pressure on staff to attend work when unwell or unfit, and to return to work before they are ready. A description often used about the sickness management process was ‘intimidating.’ In addition, many nursing staff are fearful that poor absence records may be used against them when decisions about future staffing levels are made in relation to organisational change.

Respondents often feel they let down colleagues and patients/service users if they take sick leave. All too aware of tight staffing levels in their teams or departments, nursing staff are reluctant to be away from work even when they are ill or unfit. In some cases RCN members told us they were made to feel guilty by managers or colleagues if they were away from work through illness.

### **Recommendation – presenteeism**

Presenteeism should be given full recognition as a health and wellbeing issue; it can lead to negative health and wellbeing outcomes for staff and can impact on patient outcomes, particularly if staff members are infectious or suffer from fatigue. Staff surveys and other tools should be used to identify ‘hot spots’ of presenteeism and explore trends and drivers. We also urge organisations to follow the Acas guidance on absence and attendance management at work which states that ‘it is important to create a culture where people are able to inform their employer that they are unwell and take the necessary time off to recover.’

### **Working life and wellbeing**

A third (30 per cent) of respondents reported that work *often* or *always* has a negative impact on their health and wellbeing, with half stating it *sometimes* has an impact. Nursing can be a physically demanding job, with high levels of musculoskeletal stress and a high risk of infection. It can also be mentally demanding, thanks to the need to be constantly ‘on the ball’, as well as emotionally draining.

Work stressors and hazards can have an impact on health outcomes. Around half of the survey respondents stated they have felt unwell due to stress (55 per cent) or workload (46 per cent) over the previous 12 months, while a third (32 per cent) said they had felt unwell due to relationships with co-workers. One in nine (11.5 per cent) had been injured by moving and handling, and four per cent had experienced needlestick injuries.

### **Recommendation – managing sickness absence**

Effective management practices can reduce sickness absence. This includes the consistent use of appraisals, a supportive approach to staff and fast access to care and support.

### **Recommendation – staff with disabilities and long-term conditions**

The survey identified a number of difficulties encountered by staff with long-term health conditions and disabilities in managing their working life. Some problems are associated with punitive approaches to sickness absence management and it is therefore important that organisations are mindful of the Equality Act 2010 in relation to disabled employees and make appropriate adjustments to support employment.

The Equality Act states that it is against the law for employers to discriminate against anyone because of a disability, and that employers have to make ‘reasonable adjustments’ to avoid employees being put at a disadvantage compared to non-disabled people in the workplace. This could include adjusting working hours or providing a special piece of equipment to help people undertake their job.

Note: The RCN runs a [Peer Support service](#) for injured, ill and disabled RCN members to share experiences and knowledge. It is a membership group for members affected by physical or psychological injury, ill health or disability – whether work-related or not. The group exists to assist members in making connections with peers to give and receive support.

### **Recommendation – mental health**

A growing proportion of the working population have mental health conditions, highlighting the need for support and appropriate adjustments within the workplace. Health and social care organisations should be exemplar employers in this area; by demonstrating healthy work environments and successful employment policies they can then convince others to do the same.

### **Recommendation – emotional support**

Nursing staff are vulnerable to burnout but opportunities to talk through difficult issues can help. Formal supervision, mentorship or peer support can help staff cope with the emotional experiences and demands of the nursing work environment. It is important that employers and nursing staff themselves recognise the impact of emotional work.

### Recommendation – older workers

Older workers form a large part of the nursing workforce and a high physical workload means any reduced physical capacity can be a problem. Older workers should be supported with full risk assessments to evaluate individual differences between workers in terms of their capacities and health, and the redesign of work tasks to suit older workers – for example, through the reduction of physical workloads, or regular short breaks through the working day. Since the normal retirement age for all workers is set to increase and may be extended even further, it is vital that age-appropriate plans are put in place now in order to avoid difficulties in the future.

### Recommendation – physical hazards

Significant numbers of the nursing workforce continue to be exposed to risks from moving and handling activities, needlestick/sharps injuries, slips, trips and falls and exposure to harmful substances which could lead to dermatitis or asthma. Organisations must follow the appropriate legal frameworks to ensure risks are managed.

### Bullying, harassment and violence

Over the previous year well over half (56 per cent) of respondents have experienced verbal or physical violence from patients or service users and almost half (48 per cent) have done so from relatives of patients/service users. Around a fifth of respondents stated that they had experienced bullying from either a manager (23 per cent) or colleague (21 per cent).

Physical and verbal violence from patients, service users or their relatives is almost expected, especially in such settings as dementia care. While a significant proportion of respondents stated that they received good support from their managers and had been provided with training, others feel let down as physical or verbal violence is accepted as the norm.

RCN members described incidents of both overt bullying within their workplace, such as arguments and rudeness, and covert bullying which can include more subtle cases of excluding and ignoring people and their contribution, unacceptable criticisms and overloading people with work.

Many respondents referred to corporate bullying within their organisation, where bullying has become entrenched in the culture. This is often described as linked to organisational change, as well as an increased emphasis on performance within tight budgetary constraints.

Others described their inability to perform their job to the standard they would wish to achieve and their frustrations in a perceived lack of support from their managers. In many cases, nursing staff equated this to a form of bullying.

Responses from senior nurses, matron and sisters reveal the extent of pressure they feel from all sides – from members of their team and senior managers. This middle management squeeze can mean anxiety about passing on the pressure they feel from senior managers on to the members of their teams. We also heard about anxieties around managing bullying by colleagues within the team they lead or even feeling personally bullied by their team.

### Recommendation – violence and aggression

Violence and aggression should never be seen as part of the job for health and social care workers. The RCN regularly works with employers to ensure robust risk assessments are in place to address the underlying causes of violence and aggression, and has developed a tool to address risks and identify necessary changes to the physical environment, safe staffing levels and training.

In cases where staff are assaulted at work, we call on employers to fully support staff; this support should include effective liaison with the police. In turn, staff must be encouraged to report all instances of physical and verbal abuse, even where it is not appropriate to prosecute an individual with limited or no capacity.

### Recommendation – bullying and harassment

The RCN endorses an active approach to reducing bullying and harassment to encourage ‘a workplace culture in which everybody treats their colleagues with dignity and respect, and where all steps are taken to minimise the occurrence of bullying and harassment’ (RCN, 2005a).

The RCN calls on all health and social care organisations to ensure they regularly carry out suitable and sufficient risk assessments on workplace stress, as directed by the Management of Health and Safety at Work Regulations 1999. The HSE management standards provide a framework for health care organisations to use to prevent and reduce the risk of the work-related causes of stress.

### Bullying and harassment – black and minority ethnic nurses

A higher proportion of BME respondents reported having experienced bullying from managers and colleagues than white respondents. The research also revealed how some

BME nurses feel that they are not given support in career progression and in some cases feel marginalised among their own teams.

### **Recommendation – black and minority ethnic nurses**

The RCN calls for improved data collection on the employment experience of BME nursing staff as a basis for effective action and support, as well as investment in development and training which pays particular consideration to the needs of BME staff.

### **Occupational health**

The majority (86 per cent) of respondents stated they have access to services at work, yet just over half (54 per cent) felt confident these would be helpful. In addition, just under two-thirds (61 per cent) said that they could access occupational health (OH) services without a referral.

Where good quality services are provided these are evidently valued by RCN members, particularly when they can easily access local services. However, many described difficulties in accessing OH services either due to long waiting lists, services being in inconvenient locations or a lack of information on services provided. In some cases respondents stated that their employer offered no OH services at all.

Several described how they were unable to refer themselves to OH services, but had to go through their line manager. In some cases members did not feel they could ask their manager for help, while in others they were actively blocked from accessing services by the manager. Other concerns were expressed relating to a perception that services are not confidential and in some cases that using occupational health would be used against them.

### **Recommendation – occupational health services**

The reduction of working-age ill health can only be achieved through adequate resourcing of OH services; employers should ensure that they implement proactive measures and do not simply engage in attendance management and reactive services. Staff must be reassured that their use of OH services is confidential and independent of undue influence from employers.

The RCN supports the implementation of SEQOH – or Safe Effective Quality Occupational Health Service ([www.seqohs.org](http://www.seqohs.org)) – standards and a process of voluntary accreditation.

Investment in good OH support, which is valued by staff, will contribute to patient outcomes through its role in supporting the health of staff.

Health and social care staff should be able to self refer to OH services. Self referral provides an opportunity for staff to commence early interventions, as well as protecting confidentiality and promoting trust in OH services. And above all, it sends a clear message that staff are valued.

The RCN calls for the universal implementation of early intervention programmes for the nursing workforce. These programmes which allow prompt access to treatment and rehabilitation services ensure that staff absence (and time away from patient care) is minimised and the risk of conditions such as musculoskeletal disorders developing into long-term conditions is reduced.

### **Pre-registration students**

The research looked at the experience of pre-registration students on placement, which forms a major part of nursing courses. Student retention has been an issue for concern for many years, and since placements made up around half of the course, a positive experience for students can often make the difference to whether they leave or stay and whether they develop compassionate practice. While placements are vital for allowing students to develop clinical and interpersonal skills, organisational cultures within the workplace can also be highly influential in affecting both the quality of the placement, and learned behaviours of the students. It is important therefore that these cultures do not undermine efforts to provide high-quality learning experiences for the next generation of nurses.

### **Recommendations – students**

The RCN calls for improvements to the quality of many practice learning experiences so that students are supported in learning to care in real-life settings. Employers and universities must together identify positive practice environments in a wide range of settings, including community settings. We also call on employers to that ensure mentors have dedicated time for mentorship, and that universities actively train and update mentors.

### **Conclusions**

The 2012 survey findings highlight the high levels of stress among the nursing workforce. Stress can be a causal factor for health problems, physical injuries, psychological effects

and burnout. In addition to the high personal toll, stress is a major cause of both sickness absence and presenteeism and affects the ability of workers to be effective.

The survey reveals that the main causes of stress are high workloads, long hours, unrealistic expectations, lack of job control, conflicting roles, bullying and violence, poor working relationships and a lack of engagement in workplace change. Addressing these problems is an obvious way to improve nurses' working experience, and in turn improve the safety and quality of care for patients.

Issues of workload, stress and working life are, however, often symptomatic of systemic organisational problems. Poor work environments and working relationships damage the ability of nursing staff to provide safe care and there is a direct correlation between job satisfaction and patient satisfaction.

Nursing staff concerned about their inability to meet their professional standards of care must be able to raise their concerns in a safe and protected way.

The Francis Inquiry into care at the Mid Staffordshire Foundation Trust reinforced the importance of an open culture which enables concerns to be raised and disclosed freely without fear, and for questions to be answered. While this inquiry raises acute questions about whistle blowing and the importance of preventing and eliminating wrongdoing at work, the RCN believes that nursing staff should also be able to raise concerns about the issues raised in this survey – workload, staffing levels, bullying, violence and working relationships.

### Raising concerns

It is essential that organisations put in place effective mechanisms to enable staff to raise concerns on issues such as staffing levels and pressure of work, particularly when these get in the way of delivering patient care. Health and social care organisations should have policies in place outlining the processes to follow when raising concerns.

RCN members can also draw on resources for members and RCN representatives on raising concerns; RCN workplace representatives can play an important role in supporting members in raising concerns and highlight issues to

management. The RCN guidance encourages its members to raise matters or issues and ask the RCN to discuss and decide if these should be considered as a concern that requires a collective response. By raising concerns early, before there is any impact on patient care, unions can offer support in finding pragmatic and workable solutions.

### Checklist for representatives

1. Regularly monitor the NHS staff survey and compare findings across trusts/regions.
2. Jointly work with employers to undertake regular stress surveys, anchored on the legal obligation for employers to complete risk assessments on all health and safety hazards in the workplace, including stress.
3. Encourage members to monitor their hours and workload and to report stress-related issues to the RCN and their employer.
4. Identify where members are suffering from work-related stress. Work with employers to collect and present sickness absence figures to identify 'hot spots' and analyse causes.
5. Undertake accurate recording of reasons for absence, including 'work-related stress' or 'stress-related illness'.

## 1

# Introduction

This survey of the health and wellbeing of RCN members and the factors at work impacting on their health and wellbeing was conducted in the autumn of 2012. In one sense, the outlook could not appear bleaker; efficiency measures in the private and public sectors mean there are fewer people in the workplace doing more work, working longer hours, feeling less secure and under tighter management.

However, there have been positive and mitigating developments in recent years which have pushed employee health and wellbeing further up the management and employment relations agenda. One of the most important drivers has been the Dame Carol Black review which in 2008 looked at the health of working age people with a 'concern to remedy the human, social and economic costs of impaired health and wellbeing in relation to working life in Britain.'

This was followed by the Boorman review which in 2009 undertook a detailed study of the health and wellbeing of the NHS workforce. This study was the first to identify a clear link between staff health and wellbeing and service quality.

While conducted for the NHS, the findings of the Boorman reviews are transferable to any organisation operating in a health care setting. The study demonstrated the relationship between staff health and wellbeing and performance, and set out a strong business case for investing in staff health and wellbeing. It called on NHS bodies and other public sector organisations to lead the way in improving staff health – to show leadership on health improvement and promoting healthy lifestyles amongst staff.

Even in times of economic uncertainty, managers in any workplace cannot afford to take their eye off staff health and wellbeing. Maintaining and improving engagement and wellbeing is crucial for meeting the increasing demand for safe, high quality patient care.

## 1.1 Current workforce indicators

A review of recent health and wellbeing indicators paints a complex and worrying picture of the UK workforce. Starting with sickness absence figures, the Chartered Institute of Personnel and Development (CIPD) *Absence management 2012* survey showed an annual fall in absence levels from 7.7 days to 6.8 per employee a year. This good news is tempered by the additional finding that almost a third of employers reported an increase in the number of people going to work ill, also known as 'presenteeism.' The main reasons for this are the threat of redundancy and concerns over job security. Stress-related absence had also increased, with two-fifths of employers reporting a rise over the previous year. Stress is the number one cause of workplace absence and is accompanied by a rise in mental health problems such as anxiety and depression. In 2009, a fifth (21 per cent) of employers reported a rise in mental health problems – by 2012 this figure had doubled to 44 per cent.

The most common cause of stress is workload. Other major causes of stress at work include management style, non-work factors such as relationships and family, relationships at work and considerable organisational change/restructuring.

The CIPD *Employee outlook: summer 2012* survey found that 51 per cent of all employees and 65 per cent of employees in the public sector reported that the economic downturn has resulted in increased stress among employees.

The CIPD reports that organisations that have noted an increase in presenteeism over the past year are more likely to report an increase in stress-related absence over the same period. The World Health Organization (WHO) has found that UK workers are the most depressed in Europe, with just over a quarter having been diagnosed with a condition. Meanwhile, a [survey](#) conducted by Ipsos MORI on behalf of the European Depression Association in October 2012 found that one in ten UK employees has taken time off work at some point suffering from depression; one in four of those suffering from depression chose not to tell their employer, with a third reporting they were worried it could put their job at risk.

Stress has consistently been one of the most commonly reported types of work-related illness, cited in the national Labour Force Survey (LFS) conducted by the Office for

National Statistics (ONS). The occupations that reported the highest prevalence of work-related stress (three-year average) were health professionals (in particular nurses), teaching and educational professionals and caring personal services.

The human cost of stress is huge. Since the recession began in 2008 there has been a 47 per cent increase in hospital admissions in England due to stress. According to the Health and Social Care Information Centre, hospitals in England dealt with 6,370 admissions for stress in the 12 months to May 2012. In 2012 alone, the increase was seven per cent but this does not include those diagnosed with depression, anxiety and a range of other physical conditions linked to stress. Nor does it take into account people turning up at GP surgeries for help.

## 1.2 The impact of wellbeing on patient care

Research led by Professor Jill Maben for the National Institute for Health Research (NIHR, 2012) demonstrated that there is a clear relationship between staff wellbeing and patient care performance. In short, where patient experience is good, staff wellbeing is good. The report explains that ‘individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance; seeking to enhance staff wellbeing is not only important in its own right but also the quality of patient experiences.’

The research also showed that the effect of staff wellbeing on performance depends on the climate for patient care and that a strong climate at local or team level can help reinforce some of the positive effects of individual wellbeing on patient care. The researchers state that the local climate can act as a substitute for individual wellbeing, ‘making up’ for the absence of high levels of wellbeing.

The independent inquiry into care provided at the Mid Staffordshire NHS Foundation Trust led by Robert Francis ([www.midstaffsinquiry.com](http://www.midstaffsinquiry.com)) highlighted the fact that nursing is demanding and difficult work requiring emotional investment. When nursing staff no longer feel able to do the job properly they can withdraw and behave in negative and defensive ways, leading to poor practice. This phenomenon was described by the psychoanalyst Isabel Menzies Lyth (1960) who stated that that organisations as social systems can create anxiety and feelings of

fragmentation for nurses working within them, and this can lead to failures of care. Robert Francis also described this process as a ‘loss of a moral compass’ aggravating the distress associated with low job satisfaction.

## 1.3 The working environment for nursing staff

Nursing staff work in a wide range of different environments. In addition to the NHS, many work for private and independent sector health care providers, charity and voluntary sector organisations, hospices, as well as criminal justice organisations, universities and the armed forces. Others work in industry as occupational health advisers, and in many other settings.

The NHS is the main employer for nursing staff, and is also the largest employer in the UK. Commitment to the health and wellbeing of the NHS workforce in itself is therefore important as it represents a large proportion of the working population; a healthy and resilient workforce is necessary to look after the overall health and wellbeing of the UK. As an employer the NHS also plays an important role in setting a good example for other employers.

Worries about living standards, job security, staffing levels and the future direction of the NHS is driving anxiety and uncertainty among the NHS workforce. Over recent years the NHS has undergone a myriad organisational changes, the latest resulting from the Health and Social Care Act 2012 in England. The outcome of this seemingly endless restructuring is ‘change fatigue’ among many members of the NHS workforce. This comes on top of a two-year pay freeze for all public sector staff lasting from 2010 to 2012, followed by ongoing pay restraint set against high inflation. Nursing numbers in the NHS have been falling steadily since 2010, while commissioned places for students are also being reduced.

Research conducted for the NHS trade unions (IDS, 2012) involved a comprehensive survey of NHS employees across all Agenda for Change occupations, exploring their working hours, job satisfaction and levels of morale and motivation. The survey paints a picture of a workforce badly affected by staff shortages, high levels of stress, long working hours and low levels of morale, with around two-thirds considering leaving their job.

The RCN's *Views from the frontline* 2011 employment survey (RCN, 2011b) provides further insight into the state of morale and motivation of nursing staff across the nursing workforce both within the NHS and other organisations in public, private and voluntary sectors. In common with the previously mentioned research conducted on behalf of the NHS trade unions, nursing staff across all sectors reported extensive unpaid overtime working, high levels of stress, anxiety about both their job and their financial security and declining levels of morale. In addition, the report revealed worryingly high and increasing levels of bullying from managers and colleagues and violence and harassment from patients or service users and/or their families.

The Boorman review provided expert evidence on the health and wellbeing of NHS staff and showed that almost half of all NHS staff absence is accounted for by musculoskeletal disorders such as back pain and more than a quarter by stress, depression and anxiety. These findings are likely to be similar for nursing staff in other health and social care environments.

## 1.4 The importance of employee engagement

The Boorman review recommended a range of policies to improve health and wellbeing including line management, counselling and occupational health services. However, it is vital that health and wellbeing is allied to staff role engagement; the failure of staff to engage with their role can affect employee attitudes, absence and turnover levels.

A lack of engagement has been linked to increased absenteeism and presenteeism and lower levels of performance and productivity. Conversely, strong engagement can enable individuals to invest themselves fully in their work and a positive impact upon their health and wellbeing, which in turn induces increased employee support for the organisation. Moreover, staff engagement and involvement can help build sustainability for any health and wellbeing initiatives. In fact, many organisations try to merge their staff engagement and health and wellbeing work streams together.

## 1.5 The importance of trade union engagement

The contribution of union representatives to health and safety has been well documented and well acknowledged as significantly reducing the likelihood of workers experiencing an accident or suffering an occupational illness. Trade union representatives also facilitate dialogue between workers and employers about ways to address concerns and improve working conditions. Increasingly union representatives are taking the lead on promoting broader health and wellbeing in the workplace, raising awareness and working with employers and employees to improve health and wellbeing.

## 1.6 The RCN health and wellbeing survey

Given the highly complex environment described above, in 2005 the RCN decided to undertake a survey of the state of members' health and wellbeing; the findings of the 2005 *At breaking point* survey revealed that nurses' psychological wellbeing was lower than the general working population. This survey updates this previous work.

While there is more awareness of the need to improve staff health and wellbeing, all the indicators suggest increasing levels of stress, depression and presenteeism. We regularly survey our members about their opinions and their working conditions, but this latest research concentrates on how members feel about their own health and stress levels, and how this impacts on their ability to do their job and how well they are supported at work.

## 1.7 How do we measure good health and wellbeing at work?

While it is relatively straightforward to measure the occurrence of accidents at work, the number of work-related illnesses and injuries and levels of sickness absence, preventative action can only be taken by understanding and measuring causal factors – particularly if these are related to job characteristics or work environment.

## 2

## Methodology

Sir Michael Marmot has led seminal research on the link between social class and health, including the Whitehall studies which examines the health of civil servants. This identified the key workplace factors that predict employees' health outcomes and clearly sets out what constitutes a good job:

- employment security
- autonomy, control and task discretion
- appropriate balance between effort and rewards (beyond financial rewards)
- appropriate match between skills and work demands
- procedural fairness at work
- strength of workplace relationships (social capital).

These factors align with measurements in the HSE management standards indicator, which forms a major part of this 2012 RCN research. The indicator was designed to help employers identify and manage the causes of work-related stress in six areas of work that can have a negative impact on employee health if not properly managed. These are factors over which managers have some degree of influence; in other words, it is important that these are measured, monitored and acted on.

### The six HSE management standards

**Demands** – includes workload, work patterns and the work environment.

**Control** – how much say a person has in the way they do their work.

**Support** – includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

**Role** – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles.

**Change** – how organisational change is managed and communicated in the organisation.

**Relationships** – promoting positive working to avoid conflict and dealing with unacceptable behaviour.

In September 2012, approximately 28,000 RCN members were sent an email asking them to respond to an online survey on health, wellbeing and stress. A total of 2,008 members responded, indicating a response rate of around 7.2 per cent.

At three distinct survey stages respondents were given the opportunity to provide comments on their experiences of: working when unfit or unwell; violence, bullying or harassment in the workplace; and occupational health services.

Where possible, these comments have been grouped into themes, and particular comments have been selected that illustrate these themes. Most respondents were keen to give at least a short description of their experiences or concerns. While several respondents had positive stories to tell about good management practice and good working relationships, these were far outweighed by the number of negative comments. It is acknowledged that some degree of self-selection bias may be at play, leading to over-representation of those who have strong opinions. However, comparisons with other RCN surveys suggest that these comments broadly reflect the experiences and opinions of the nursing workforce.

Respondents were asked whether they would be prepared to take part in further research, in the form of a telephone interview, to follow up some of the issues raised in the survey. Respondents were assured that the interviews would be confidential and that all details from the research would be anonymised. A sample group of those willing to participate in this additional research stage was created and contained a reflective cross-section in terms of place of work and biographical details. 'Pen pictures' of each interview conducted can be found in [Appendix 1](#); details and quotes are also included within the main report to illustrate key themes and findings.

## 3

## Demographics

In total 2,008 RCN members completed the 2012 survey. This section presents the key demographic data for all respondents with the exception of nursing students (which can be found at [Section 12](#)).

- Around two-thirds (68 per cent) work full-time; just less than a third (30 per cent) work part-time; the remainder work occasional or various hours or do not currently work.
- Around 40 per cent describe themselves as a staff nurse, with others working in various occupations, including senior nurses, community and district nurses, practice nurses and clinical nurse specialists.
- The majority of respondents work in the NHS and in hospital settings.
- The largest group of respondents are between 45-54 years of age.
- 143 respondents (7.2 per cent) reported that they have a disability.

	n	%
Full-time	1,334	68.3
Part-time	578	29.6
Occasional/various hours	29	1.5
Not currently working/retired	11	0.6
<b>Total</b>	<b>1,952</b>	<b>100</b>

	n	%
Staff nurse	775	39.7
Sister/charge nurse/ward manager	240	12.3
Clinical nurse specialist	188	9.6
Community nurse	168	8.6
Senior nurse/matron/nurse manager	118	6.0
Practice nurse	77	3.9
Nurse practitioner	75	3.8
District nurse	56	2.9
Occupational health nurse	43	2.2
Manager/director/owner	36	1.8
Health care assistant/health care support worker	34	1.7
Researcher	27	1.4
Educator	23	1.2
Health visitor/SCPHN	16	0.8
School nurse	16	0.8
Non-nursing role	14	0.7
Public health practitioner	13	0.7
Not currently working/retired	11	0.6
Consultant nurse	9	0.5
Lecturer/tutor	9	0.5
Midwife	5	0.3
<b>Total</b>	<b>1,952</b>	<b>100</b>

	n	%
NHS (excluding GP practice)	1,448	74.2
Independent/private sector	170	8.7
GP practice	115	5.9
Charity/voluntary sector group	55	2.8
NHS Bank/nursing agency	35	1.8
Social enterprise	27	1.4
Local authority/other public sector	21	1.1
Other NHS employer	18	0.9
University/research	18	0.9
Not currently working/retired	11	0.6
NHS Direct/NHS24/helpline	8	0.4
School/education	8	0.4
Criminal justice	6	0.3
Care/nursing home	6	0.3
Self employed	3	0.2
Occupational health	3	0.2
<b>Total</b>	<b>1,952</b>	<b>100</b>

	n	%
Hospital ward	562	29.2
Hospital unit	305	15.8
Hospital outpatients or daycare	136	7.1
Other hospital setting	113	5.9
<b>All NHS hospital settings</b>	<b>1,116</b>	<b>58.0</b>
Community	429	22.3
GP practice	107	5.6
Care home	95	4.9
Office	37	1.9
Hospice	31	1.6
Private clinic or hospital	28	1.5
Across different sites/settings	28	1.5
Workplace	21	1.1
University	16	0.8
School	11	0.6
Not currently working	8	0.4
<b>Total</b>	<b>1,927</b>	<b>100</b>

	n	%
Acute/urgent care	385	19.8
Primary/community care	375	19.3
Adult general/medical/surgical	193	9.9
Mental health	172	8.8
Older people	156	8.0
Children and young people	131	6.7
Surgery	79	4.1
Outpatients	61	3.1
Long-term conditions	57	2.9
Cancer care	56	2.9
Palliative care	48	2.5
Workplace/environmental health	44	2.3
Women's health	31	1.6
Learning disabilities	31	1.6
Quality improvement/research	25	1.3
Management/leadership	24	1.2
Education	21	1.1
Public health	17	0.9
School nursing	17	0.9
Not currently working	11	0.6
e-health/telecare	7	0.4
Various areas	7	0.4
<b>Total</b>	<b>1,948</b>	<b>100</b>

	n	%
25 or under	98	4.9
26-34	196	9.8
35-44	487	24.3
45-54	852	42.4
55-64	354	17.6
65 or over	16	0.8
Prefer not to say	5	0.2
<b>Total</b>	<b>1,948</b>	<b>100</b>

## 4

## Stress in the nursing workforce

**Table 7: Ethnicity**

	n	%
White	1,752	90.1
Black/African/Caribbean	80	4.1
Asian/Asian British	56	2.9
Mixed/multiple ethnic groups	21	1.1
Prefer not to say	23	1.2
Other – not specified	12	0.6
<b>Total</b>	<b>1,944</b>	<b>100</b>

Stress is the single biggest cause of sickness absence in the UK and its prevalence is particularly high among nursing staff. Pressure at work can be motivating and stimulating, but when it exceeds an individual's ability to cope this can lead to ill health. The subjective nature of stress makes it difficult to measure, but it is important that stress and its causes are identified in order to reduce stress-related absences and help staff return to work from stress-related illness.

### 4.1 HSE management standards

The Health and Safety Executive (HSE) has developed management standards and guidelines on work-related stress. These are an important tool in helping employers, employees and their representatives to assess the risk and potential causes of stress.

The HSE management standards approach assesses six elements of work activity that are associated with wellbeing and organisational performance: demands, control, social support, interpersonal relationships, role clarity, and involvement in organisational change.

<b>HSE management standards</b>	
<b>Demands</b>	<i>Demands</i> made of workers including issues such as workload, work patterns and the work environment.
	<i>Demands</i> on the individual are often quoted as the main cause of work-related stress.
<b>Control</b>	<i>Control</i> exercised by workers, including how much say the worker has in the way they do their work.
	Where an individual has little <i>control</i> in how their work is carried out, this can be associated with poor mental health.
	Where there are greater opportunities for decision making there is better self-esteem and job satisfaction.
<b>Support</b>	<i>Support</i> given to workers, including the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
<b>Relationships</b>	<i>Relationships</i> with and between workers, including promoting a positive working environment to avoid conflict and dealing with unacceptable behaviour such as bullying.
	<i>Relationships</i> is the term used to describe the way people interact at work. Other people can be important sources of support but they can also be sources of stress.
	At work <i>relationships</i> with colleagues at all levels can dramatically affect the way we feel. Two potential aspects of these relationships that could lead to work-related stress are bullying and harassment.
<b>Role</b>	<i>Role</i> certainty among workers. Whether all workers at every level understand their role within the organisation and whether the organisation ensures they do not have conflicting roles.
	The potential for developing work-related stress can be greatly reduced when a <i>role is clearly defined</i> and understood and when expectations do not produce areas of conflict.
	The main potentially stressful areas are <i>role conflict and role ambiguity</i> , together with the burden of responsibilities.
<b>Change</b>	<i>Change</i> to the conditions of workers. How organisational change (large or small) is managed and communicated within the organisation.
	Poor management of <i>change</i> can lead to individuals feeling anxious about their employment status and reporting work-related stress.

A key feature of the HSE approach is a survey called the *HSE management standards indicator tool* which is filled in by employees. The survey is based around the six management standards which help measure levels of key stressors and enable comparison with benchmark data. The HSE has identified that, if not appropriately managed, these areas have a negative impact on employee wellbeing.

There are 35 items in total, and survey respondents are asked about their health and wellbeing at work. The results are ranked using four colour codes to denote performance relative to the benchmark data.

	<b>Doing very well – need to maintain performance</b> Represents those at, above or close to the 80th percentile.
	<b>Good, but need for improvement</b> Represents those better than average but not at, above or close to the 80th percentile.
	<b>Clear need for improvement</b> Represents those likely to be below average but not at, below or close to the 20th percentile.
	<b>Urgent action needed</b> Represents those at, below or close to the 20th percentile.

The HSE management standards approach is designed to help simplify risk assessment for work-related stress; encourage employers, employees and their representatives to work in partnership to address work-related stress throughout the organisation; and provide the yardstick by which organisations can gauge their performance in tackling the key causes of work-related stress.

The 2012 RCN survey incorporated 22 of the 35 measures into the questionnaire and the results are presented grouped into the six management standard categories. Score comparisons are provided with the 2005 RCN *At breaking point* survey and the HSE benchmark data for 2008.

	1=low wellbeing 5=high wellbeing
I have to work very intensively	1.83
I have to work very fast	2.15
Different groups at work demand things from me that are hard to combine	2.48
I have unachievable deadlines	2.83
I have unrealistic time pressures	2.63
I am pressured to work long hours	3.04
<b>Overall</b>	<b>2.50</b>

It is clear from these results that RCN members are under a great deal of pressure at work and the level of wellbeing relating to demands made of them is far below the average for Britain's working population. The average score is **2.50** compared to the HSE working population score of **3.44** in 2008, and below that of the RCN 2005 survey (3.0). These results indicate that **urgent action is needed**.

The greatest source of pressure comes from working long hours, combined with unrealistic time pressures and unachievable deadlines, meaning that nursing staff have to work very intensively. A community nurse stated there is just *“one nurse to cover a large geographical area at the weekend with little support and high caseload while also being on call for referrals”*. Another respondent described the *“fear of making mistakes/patient safety issues/losing registration due to busy department”*.

<b>Table 9: Management standards – control</b>	
	1=low wellbeing 5=high wellbeing
I have a choice in deciding what I do at work	2.65
I have a say in my own work speed	2.94
I can decide when to take a break	3.25
I have a choice in deciding how I do my work	3.29
I have some say over the way I work	3.30
<b>Overall</b>	<b>3.08</b>

The overall level of wellbeing relating to control (**3.08**) is below the UK average (**3.32** in 2008) and lower than the RCN 2005 survey (**3.5**) and indicates that **urgent action is needed**. Respondents are more likely to be able to decide when to take a break, *how* they do their work and the way they work than they are able to decide *what* they do at work or their own work speed.

One staff nurse on a NHS hospital ward told us they were “*ill constantly due to lack of breaks, switching shift patterns too quickly, e.g. from lates to early shifts and long stretches of days in a row. Getting off late from shift most days due to ill patients, lack of staff and catching up with paperwork because workload is too big. Work makes you ill but then you’re told off for having time off. They don’t make the link between the two*”.

<b>Table 10: Management standards – managerial support</b>	
	1=low wellbeing 5=high wellbeing
I am given supportive feedback on the work I do	2.74
I can rely on my line manager to help me out with a work problem	3.25
<b>Overall</b>	<b>3.08</b>

While there are just two questions on manager support at work, the picture painted by these questions is generally encouraging, with the scores indicating a **good level, but with room for improvement**. The score for the UK working population in 2008 was higher at **3.77** and the 2005 RCN survey score was **3.3**.

Our telephone interviews generally revealed that most nursing staff had a good relationship with their line managers. However, descriptions of problems with senior managers were more common with some respondents telling us that there was a lack of understanding of their roles and support from senior management.

<b>Table 11: Management standards – peer support</b>	
	1=low wellbeing 5=high wellbeing
If work gets difficult, my colleagues will help me	3.47
I get the help and support I need from colleagues	3.58
I receive the respect at work I deserve from my colleagues	3.63
<b>Overall</b>	<b>3.56</b>

Confidence in peer support is below the average for the working population and the score (**3.56**) indicates a **clear need for improvement**. In 2008 the average score for the UK working population was **4.03** and the 2005 RCN score was **3.3**.

Our telephone interviews reveal that peer support is very important to nursing staff, particularly when they face heavy workloads and staff shortages. Many also pointed to the value they place on clinical supervision and the emotional support derived from colleagues. All too often, though, we heard examples of cliques forming in the workplace causing disruption and anxiety as well as examples of bullying behaviour between colleagues.

Table 12: Management standards – role	
	1=low wellbeing 5=high wellbeing
I am clear about the goals and objectives for my department	4.01
I am clear what is expected of me at work	4.30
I am clear what my duties and responsibilities are	4.35
I understand how my work fits into the overall aim of the organisation	3.87
I know how to go about getting my job done	4.41
<b>Overall</b>	<b>4.20</b>

While the average score for wellbeing relating to role at work (4.20) appears to be quite high and unchanged from the 2005 RCN score, it is lower than the UK working population average in 2008 which stood at 4.61, indicating a **good level, but with room for improvement**. Nursing staff appear to be more confident about what their own role entails and how to get their own job done, rather than the wider picture of how their role fits into wider organisational objectives.

An important issue emerging from the research is the extension and development of some nursing roles. For example ‘Kathy’, an emergency practitioner nurse, described how she and colleagues have undertaken extensive academic and practical training to develop their service. ‘Sue’, a district nurse, also described how she was taking on triage duties for the doctors in her practice in addition to her own duties. A survey respondent told us *“our roles are always extending under the PDP umbrella – more objectives set to achieve”*. Many nurses are justifiably proud of their skills and want to develop in their jobs. However, caution was also expressed that nurses should not be pressured into working too far beyond their scope or ambition.

Table 13: Management standards – change	
	1=low wellbeing 5=high wellbeing
I have sufficient opportunities to question managers about change at work	2.78
Staff are always consulted about change at work	2.79
<b>Overall</b>	<b>2.78</b>

RCN members were mostly negative about their engagement in workplace change, with the average score (2.78) for wellbeing at work relating to the management of change being substantially lower than average for Britain’s working population (3.54 in 2008) and lower than the RCN 2005 average score (3.1) indicating that **urgent action is needed**.

This latest research highlighted a high level of anxiety and uncertainty among nursing staff across all sectors, particularly about job security and personal finances. A school nurse told us *“the stress and the pressure is immense due to redundancies”*. Another staff nurse said that her employer’s *“handling of employees, expecting them to adapt to massive change with little support, is very much like corporate bullying”*.

Among NHS nursing staff very clear concerns were expressed about career progression and promotion. For example, an experienced Band 5 nurse we interviewed told us that a matron had told him that *“if I wanted a Band 6 post, one of the requirements is to put up and shut up, and not make suggestions”*. A sister added that *“staff are uncertain of their futures, no one is getting promoted as there is sideways movement of Band 6/7 from one site to another. This is demoralising for Band 5s. I would not recommend anyone to join the nursing profession at this current time; I feel sorry for all the students who have just qualified and cannot get a job”*.

We interviewed two nurses who had qualified in the past five years and who also feel that career prospects are being limited. ‘Richard’, a staff nurse, told us that opportunities for progression are slowing down and leading to resentment among band 5 nurses. ‘Will’ also told us he sees newly qualified nurses being increasingly employed on short-term contracts and says this is damaging for nurses’ security and their own peace of mind.

## 5

## Sources of stress in the nursing workforce

### 4.2 Summary

Measuring wellbeing using the HSE management standards suggests that nursing staff in the UK are experiencing higher levels of stress than the UK working population in general, and at a higher rate than we last surveyed the RCN membership. In particular their wellbeing relating to the demands of the job and workplace change are low, indicating that urgent action is needed.

These findings paint a picture of a nursing workforce struggling with both high workloads and the fast pace of work, while feeling unsupported and detached from changes being implemented within their workplace.

Respondents report working long hours combined with unrealistic time pressures and unachievable deadlines, meaning that nursing staff have to work very intensively. They also report low levels of control over their work which impacts on their ability to decide when to take a break, how they do their work and the way they work.

These sources of stress appear to be somewhat offset by respondents' confidence and clarity about their own roles and how they fit with wider organisational objectives. This is likely to be a factor of the highly defined and regulated nature of the nursing role; while it is necessary that staff have clear roles and responsibilities, jobs must also be rewarding and designed in such a way as to protect health and wellbeing. Ever increasing demands and workloads and uncertainties about organisational change will only negate any efforts to improve staff health and wellbeing.

The rest of this report examines in more depth the factors influencing health, wellbeing and stress among nursing staff including management and peer support, sickness absence policies, bullying and harassment and occupational health service provision. It also details recommendations for UK governments, health departments, regulators, managers and union representatives to take forward in the promotion of health and wellbeing in the workplace.

The previous section used the HSE management standards to evaluate levels of stress among the nursing workforce against the general working population. The exercise established that the workforce is certainly experiencing particular high levels of stress, working long hours, facing tight deadlines and achieving little control over their workload.

This section explores the issue of stress in more detail and probes the reasons why nursing staff feel under so much pressure.

Using separate questions from the HSE management standards toolkit, we asked respondents to rate their levels of stress on a scale of 1-10, with 1 being lowest and 10 the highest. The average score was 6.3, and for students the score was 6.6. The average score for staff nurses and practice nurses is 6.2.

We looked at the scores to assess whether there was any difference according to respondents' ethnicity, workplace, job title and area of practice. There was no difference in scores according to respondent ethnicity. While there was very little variation in average scores according to sector, there was more variation according to job title and area of practice. Table 14 indicates that average scores are highest for district nurses and health visitors and sisters/charge nurses/ward managers and lowest for occupational health nurses and health care assistants.

In relation to area of practice Table 15 indicates that average stress scores are highest for those working in management or leadership, for those working with people with long-term conditions and with older people. Lowest scores occur among nursing staff working in palliative health and occupational health.

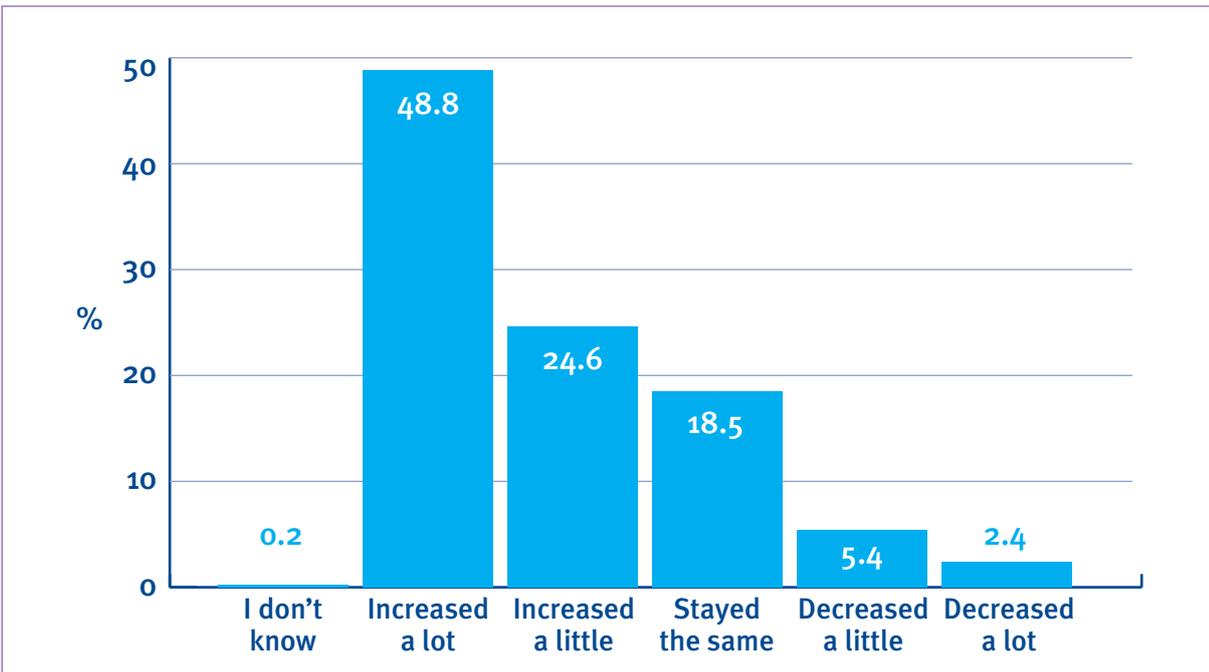
**Table 14: Job title – average stress scores**

Highest		Lowest	
District nurses and health visitors	7.0	Occupational health nurses	5.4
Sisters, charge nurses, or ward managers	6.8	Health care assistants	5.7

**Table 15: Area of practice – average stress scores**

Highest		Lowest	
Management/leadership	7.0	Palliative care	6.0
Long-term conditions	6.7	Occupational health	5.8
Older people	6.6		

Chart 1 shows that around a half (49 per cent) of all respondents told us that their own levels of stress have increased a *lot* in the last 12 months, and a quarter said they had increased a *little*. The main reasons for these increased levels of stress appear to be interrelated, as shown in Chart 2. It appears that staff shortages and high workload are combining to put so much pressure on nursing staff that they do not have enough time to perform their role. Other issues highlighted include not having enough time to take rest breaks and a lack of support from management.

**Chart 1: Over the last 12 months, my personal level of stress has... (n=1,926)**

**Chart 2: Reasons for high and/or increased levels of stress (n=1,588)**

We gave members the opportunity to go into more detail about the factors contributing to their stress levels. These have been grouped into the themes listed below.

- **Workload and staffing levels** – this was the primary causes of stress among nursing respondents, standing in the way of them doing their job to the standard they would like. For example, one specialist nurse told us *“staff are stretched without employing additional help. When you are off on sick or annual leave there is no one to do your caseload. You strive to do your best but corporate needs to realise that teams need to be formed”*.
- **Job role and content** – respondents pointed to intrinsic issues relating to their job role or content which cause stress, such as lack of rest breaks or facilities to take a break. Others pointed to shift working and particularly day to night rotations as contributing to high stress levels. One staff nurse working in the NHS told us: *“If we got breaks then maybe we wouldn’t be unwell. Also if our shift patterns didn’t change as much, with some days only 10 hours between shifts.”*
- **Working beyond scope** – several respondents reported feeling stressed by being pushed to a level beyond their scope of practice. For example, one interviewee (‘Kathy’) described how emergency nurse practitioners are being *“used in a medical role, but we should be supplementary to medical staff not a replacement”*. Another interviewee (‘Sue’) stated: *“I don’t have a problem with doing the job I’m trained for [district nurse]. I just have a problem with being a doctor. I’m worried something will go wrong and it’s my neck on the line.”*
- **Management support or style** – feeling insufficiently supported by managers. For example, a staff nurse in an independent sector care home told us that *“when I have taken unwell at work and felt unable to carry on safely, there is very little understanding from managers who say to carry on as there is no one else to take over. There appears to be very little tolerance and understanding for genuine illness in the workplace”*. Many respondents told us how much they appreciate a simple ‘thank you’ or ‘well done’ from management staff and feel upset when none is forthcoming.
- **Working relationships** – stressful working relationships with team members and feeling unsupported by colleagues or even facing bullying and harassment.
- **Organisational change** – stress from the impact of ongoing or planned change such as ward closures, service redesign or transfer to other organisations. Organisational change involves having to apply, often repeatedly, for jobs.

- **Job security and changes to terms and conditions** – worries about job security, employment status and pensions are sources of stress for many respondents. One interviewee ('Gill') stated *"We all feel very frightened. There are so many nurses and they don't want to pay us. So they're trying to downband our jobs and people feel very helpless and very demotivated. We are frightened for the future"*.
- **Challenges to the image of nursing** – respondents are conscious of how nursing and the image of nursing are being tested and state that this leaves them feeling under pressure. A telephone interview participant told us she feels there is a *"misconception that you can train people to do tasks and pay them less [in reality] you need well trained staff, able to understand and interpret as well as valuing 'basic' nursing care"*.
- **Targets and paperwork** – the time spent on paperwork, taking nursing staff away from direct patient care, causes concern. An NHS community nurse stated they face *"pressure to achieve targets, demands to follow procedures which duplicate practices and increased paper exercises which impact on practice and decision making"*. A mental health nurse told us they have *"targets to meet which are unrealistic, it appears stats are more important than quality time with clients"*.
- **Lack of resources** – including bed shortages, problems with IT, poor quality equipment or lack of office space.
- **Patient demands** – many respondents felt under pressure from increasing patient demands or even verbal or physical abuse from patients or members of their family. One staff nurse reported that her team *"frequently get verbally abused due to patients waiting for theatre, facing long waits, especially when we have no beds available or they get cancelled"*.
- **Personal issues** – personal circumstances such as death or illness among family members or friends make it difficult to cope at work. Personal health problems are also caused or aggravated by stress at work.
- **Emotional stress** – many respondents described their work as emotionally stressful, particularly dealing with dying patients. Several described their jobs as having led to post traumatic stress disorder.

## 5.1 The impact of stress on health and wellbeing

Many respondents described the impact of stress on their health and wellbeing in some detail. The quotes below clearly demonstrate the potential circularity of stress, with worsened health and wellbeing leading to higher rates of stress.

*"The job is taking over my life. I take work home most nights. I have unachievable deadlines. My colleague took MARS [mutually agreed resignation scheme] two years ago and I got her responsibilities. I constantly feel stressed and it is getting worse not better. I feel tearful quite often and unwell due to work pressures."*

NHS district nurse

*"Diagnosed with inflammatory arthritis. Off sick for couple of months. No support on return from work from line manager or matron. Discussed difficulty in working nights and told tough and maybe I am in the wrong job."*

NHS staff nurse, hospital ward

*"I once came into work on a night shift when I was unwell. At the end of the shift I made a drug error involving a controlled drug and I vowed after this never to come into work when I was unwell again as it risked my registration."*

Staff nurse, hospice

## 5.2 Summary and recommendations

Health and social care organisations within the public, private and voluntary sectors all face ever higher demands, leading to increased workloads and pressures of work for their staff.

Faced with these pressures, it is essential that staff motivation and engagement are developed and improved in order to support the workforce's contribution to delivering better and effective patient care. This must include creating a healthy workplace; it is essential to improving productivity, staff motivation, ensuring quality patient care and improving patient outcomes.

This must start with safe staffing levels. Insufficient staffing levels result in increased pressure, stress, higher levels of

burnout, lower job satisfaction and a greater inclination to leave among the workforce. A downward spiral often follows as morale declines and sickness absence increases, leaving fewer staff available to work and creating even more pressure on existing staff.

RCN members tell us that workload and safe staffing levels are the most pressing problems they face on a daily basis. Yet despite the evidence linking staff levels of patient outcomes, there has been a failure to act.

### 5.2.1 Safe staffing levels

At the heart of the RCN's *This is nursing* ([www.rcn.org.uk/thisisnursing](http://www.rcn.org.uk/thisisnursing)) initiative is a drive to improve and promote safe staffing levels. *This is nursing* makes it clear that the time has come to for providers, regulators and commissioners of services to set clearly defined standards and adopt mandatory staffing levels. The RCN is committed to working with governments, health departments and key stakeholders on developing and implementing staffing level recommendations.

The RCN's *Guidance on safe nurse staffing levels in the UK* (RCN, 2010) highlights the evidence between nurse staffing levels and patient outcomes. It does not advocate a universal nurse-to-patient ratio and recognises that nurse staffing levels must be set locally. Local factors such as nature of the service, specialty and patient needs have to be taken into account through a rational and systematic, evidence-based approach.

The guidance highlights and assesses the variety of methods for planning and reviewing nurse staffing and suggests ways they can be implemented and embedded within organisations. It is accompanied by a [policy briefing](#) (RCN, 2012b) which sets out the RCN position on mandatory staffing levels and provides an overview of the evidence relating to nurse staffing levels and outlines available guidance relating to staffing levels in different fields of nursing. It also includes an overview of the experiences of other countries which have introduced mandatory nurse-to-patient ratios.

The RCN has also developed [guidelines](#) (RCN, 2012c) on safe staffing levels for the care of older people. Designed to help support a review of staffing on hospital wards where older people are cared for, the guidelines can also be used to help address any associated leadership and workforce issues.

In Scotland, the Nursing and Midwifery Workload and Workforce Planning (NMWWP) Programme has developed a range of tools to measure workload to determine staffing levels and to be used in workforce planning for the NHS Scotland nursing and midwifery workforce. NHS boards are required to use these tools to develop annual plans from April 2013 ([www.workforceplanning.scot.nhs.uk/home.aspx](http://www.workforceplanning.scot.nhs.uk/home.aspx)). The RCN supports the principle behind this programme and is negotiating how these tools effectively can be effectively implemented.

### 5.2.2 Time to care

In September 2012 the RCN in Wales launched the second year of its *Time to care* campaign which stresses the importance of ensuring that staff are given time to perform their role to their highest caring ability. The campaign highlights the experience of care that patients and the public expect and the significance, diversity and essential nature of the nursing contribution to caring of nursing.

### 5.2.3 Shift working

The [HSE management standards](#) revealed that nursing staff are working at high levels of demand and workloads. As a result they often work long hours without sufficient rest breaks; this can lead to exhaustion and fatigue and, in the longer term, damage health and wellbeing. Employers have a duty to implement safe shift patterns compliant with the Working Time Regulations and to ensure that staff are able to take rest breaks in a suitable environment with access to refreshments. The RCN calls on employers and regulators to pay attention to the impact of working hours on health and wellbeing and the importance of rest breaks.

There is a need for more research evidence to understand the impact of shift working on patient safety. In particular, the RCN believes more research is needed on the differential impact of working long (12 hour) shifts which are planned; working long hours through back to back shifts, overtime or additional jobs; and shorter shifts.

The RCN publication *A shift in the right direction* (RCN, 2012a) provides useful guidance and information to support shift workers' health and wellbeing. It states that service provision relies heavily on nursing staff working shifts and that adapting to shift patterns or changes in shift patterns can be difficult. It warns that if the associated risks are not managed properly, this can lead to ill health and fatigue, which in turn can have an impact on patient care.

### 5.2.4 Workplace stress risk assessments

Our research shows high levels of stress among nursing staff, particularly relating to the demands of the job and a feeling of lack of control over their work. The Management of Health and Safety at Work Regulations 1999 set out the duties on organisations to carry out suitable and sufficient risk assessments on workplace stress. The Health and Safety Executive's management standards provide a framework health care organisations can apply to prevent and reduce the risks of the work-related causes of stress. The RCN calls on all health care organisations to use the HSE's framework in order to support staff and identify and manage sources of stress including all NHS staff surveys. The RCN would also like to see the HSE framework regularly updated so that it continues to be an effective benchmark in the measurement and management of stress. In relation to workloads and demands the HSE expects organisations to:

- provide employees with adequate and achievable demands in relation to the agreed hours of work
- match people's skills and abilities to the job demands
- ensure jobs are designed to be within the capabilities of employees
- ensure employees' concerns about their work environment are addressed.

The RCN published [guidance on work-related stress](#) for RCN representatives (RCN, 2009) which goes through the HSE's management standards and the process of conducting a stress risk assessment. It details how RCN safety representatives can get involved in each stage of the risk assessment process and provides case studies that illustrate how RCN representatives have implemented the HSE management standards in their own workplaces.

[Joint guidance](#) produced by the CIPD, Acas, the HSE, and Health, Work and Wellbeing (CIPD, 2010) summarises the legal duties that employers have to reduce and, where possible, prevent work-related stress impacting on the health of their employees. It provides a starting point to help understand the legal requirements, and suggests actions that employers can take to help to not just comply with the law, but improve the working conditions for all employees. Designed for directors and managers in organisations of all sizes in the public, private and third sector, the publication will also be of interest to those in supporting professions such as health and safety practitioners, HR practitioners and occupational health practitioners.

### 5.2.5 Staff engagement and consultation

The research also found that nursing staff are anxious about the level of change and the lack of consultation and communication about changes made within their workplace. Poor staff engagement is linked to increased absenteeism, presenteeism, lower levels of performance and productivity. It is therefore important that health and social care organisations consult and involve staff and trade unions around the management of change. It is particularly important that organisations engage and consult with RCN and other trade union safety representatives to identify and address the possible health and safety impacts of any planned changes. Information about the RCN representative roles can be found on the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk)

*The Acas guide to Trade union representation in the workplace* (Acas, 2009) is for employers, trade unions and union workplace representatives. It gives advice on the provision of time off, training and facilities to enable union representatives to carry out their duties, and covers statutory and non-statutory representatives.

Finally, the RCN would like to see the HSE take a robust approach to organisations that fail to manage to meet the legal requirement to assess and manage the risk of work-related stress. Historically, NHS organisations have been subject to enforcement action in the form of improvement notices. We believe enforcement action is a proportionate response, as stress can impact negatively on individual health and wellbeing, team relationships and ultimately affect patient care.

## 6

## Presenteeism

In any work setting there are obvious risks arising from employees being at work when they are unfit or unwell – including risks to health and safety and to productivity. In a health care setting these risks are even more acute as they can impact heavily on patients, service users and their families. For nursing staff the pressure to attend work when unfit or unwell is arguably mostly self-directed, as they are acutely aware of the impact of being away from work will have on colleagues and patients/service users. In addition the Boorman report (DH, 2009) found that ‘presenteeism is greater in those who work long hours and experience managerial pressure to return to work’.

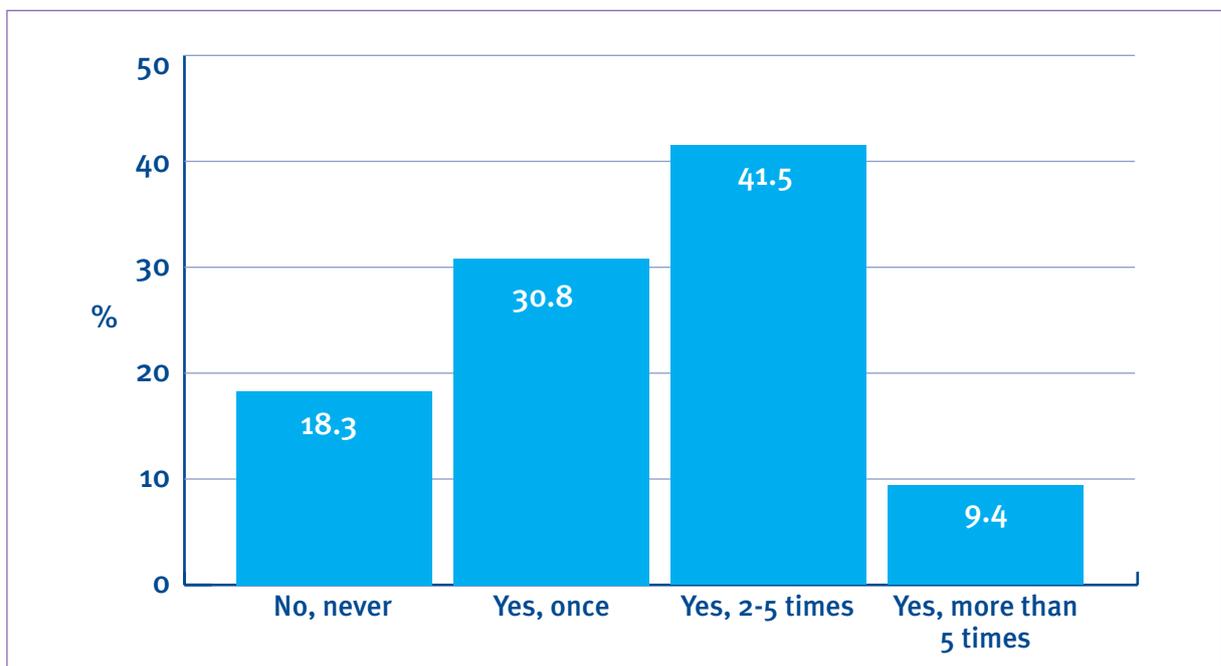
Professor Cary Cooper, a leading expert on stress, warns that the risk to mental health caused by presenteeism is potentially even greater as it is easier to hide than a physical ailment. He also warns that when competition for jobs is high people are even more wary about admitting to feeling stressed or giving any sign they may be struggling to cope, although heavier workloads and external pressures mean this might be perfectly reasonable.

The Sainsbury Centre for Mental Health has estimated that presenteeism accounts for 1.5 times more working time lost than absenteeism and that the costs to UK employers of mental health problems are around £15 billion a year (SCMH, 2007).

Research published by The Work Foundation (TWF, 2010) reveals a connection between sickness presence and poor performance, and established a significant link between presenteeism and personal financial difficulties, work-related stress and a perceived workplace pressure to attend work when unwell.

The RCN 2012 member survey asked whether nursing staff had gone to work despite feeling ill in the previous 12 months and found that the majority (82 per cent) had done so. Closer examination of these findings reveals little variation in nursing staff, reporting they had worked despite feeling unwell or unfit according to whether they worked full-time, part-time or occasional/various hours or according to ethnicity. Similarly, there was little difference in the likelihood of working unwell according to job title or type of organisation. This suggests a widespread problem of presenteeism.

**Chart 3: Over the previous 12 months, have you gone to work despite feeling that you really should have taken sick leave due to your state of health? (n=1,926)**



We can compare these figures to the NHS Staff Surveys for England and for Wales which both asked the same question, albeit in a slightly different way: “In the last three months have you ever come to work despite not feeling well enough to perform your duties?” The 2012 NHS Staff Survey for England showed that almost three-quarters (73 per cent) of registered nurses and midwives and a similar number of nursing/health care assistants (72 per cent) said they had done so. The 2013 NHS Staff Survey for Wales showed that 70 per cent of all staff had worked in the previous three months despite not feeling well enough.

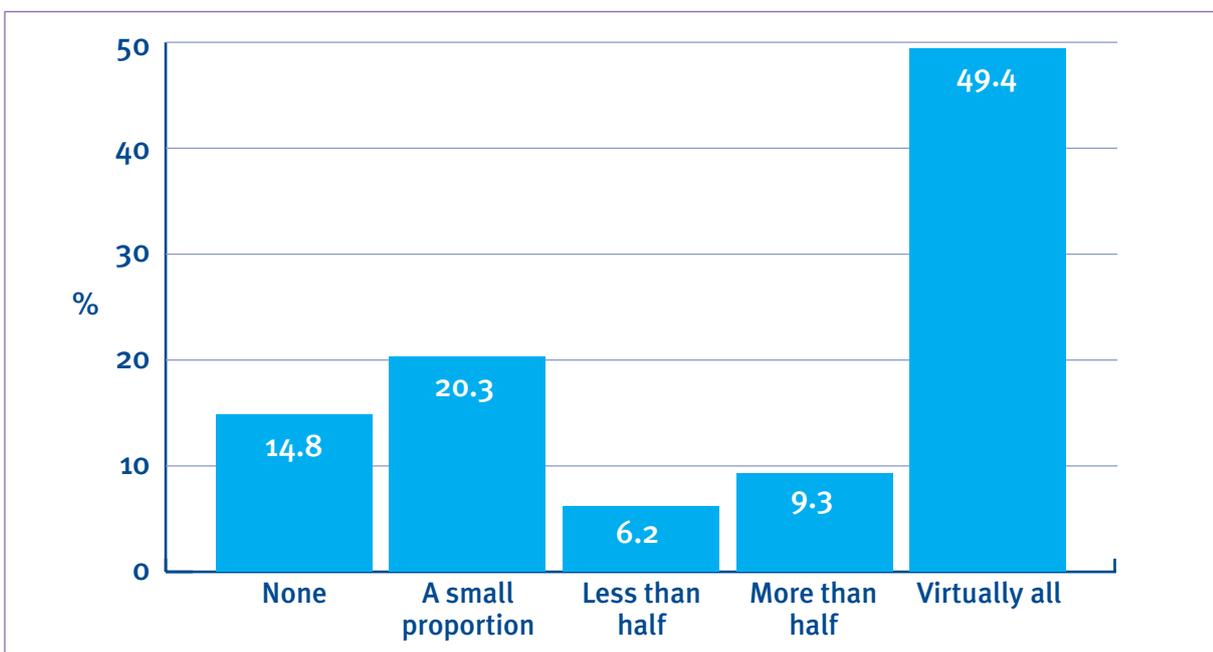
We asked a follow up question about the amount of work that nursing staff are expected to catch up with if they are absent from work for any reason (Chart 4). Well over half (59 per cent) said they had to pick up half or all of their work, indicating one of the primary reasons behind a reluctance to take sick leave.

Nursing staff working in universities (94 per cent), in hospital outpatients departments (66 per cent) and in the community (63 per cent) were most likely to state that they had to pick up half or more of their work on their return.

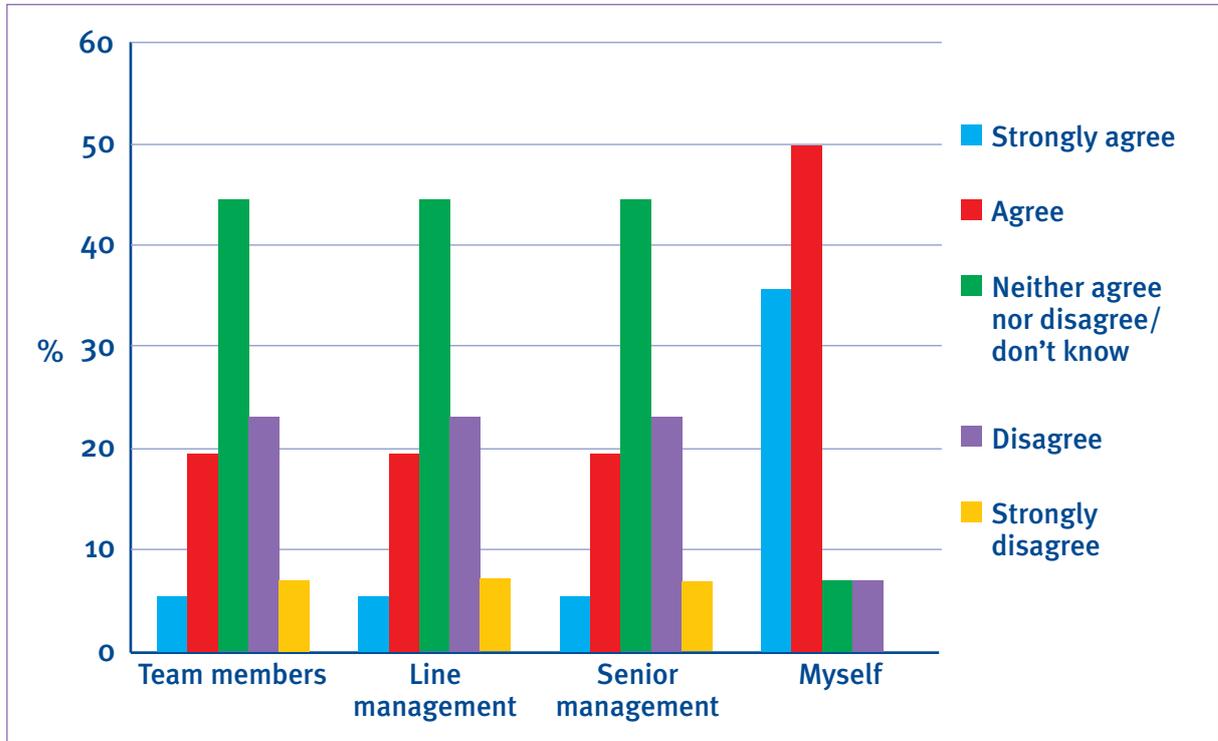
The RCN survey went on to ask respondents whether they feel under pressure to go into work when they feel unwell. By far the biggest pressure comes from respondents themselves (84 per cent), with pressure also being felt from line managers (45 per cent), senior management (44 per cent) and colleagues (36 per cent).

The 2012 NHS Staff Survey for England also approached this issue, with similar findings. It asked respondents who said they had come into work despite not feeling well enough to do so in the last three months if they had felt pressure to do so from managers, colleagues or themselves. Around a third of registered nurses and midwives (32 per cent) and health care assistants (35 per cent) said they felt pressure from managers, while slightly fewer (26 per cent of nurses and midwives and 23 per cent of health care assistants) said they felt pressure from colleagues. The majority (93 per cent of nurses and 85 per cent of health care assistants) said they felt pressure from themselves. The 2013 survey for Wales showed that 39 per cent indicated that they had felt pressure from their manager to come to work and 26 per cent said that they had felt such pressure from colleagues, along with staff shortages.

**Chart 4: If you are absent from work for up to a week what proportion of your tasks must you take up again on your return? (1,903)**



**Chart 5: Do you feel under pressure (from other team members/line manager/senior managers/myself) to go into work when I feel unwell? (n=1,925)**



We asked respondents to share their experiences about working well, unwell or unfit. Many nurses had positive stories to tell; that they are generally fit and healthy and rarely have to take time off work while others told us that if they did take sick leave, colleagues and managers are supportive. For example, one nurse said: *“I find that colleagues and management are generally supportive towards each other in times of sickness or difficulty – quite rightly so too, in the caring professions.”*

However, a much higher number were negative and a common thread runs through their comments; they feel guilty about being off sick and were worried about the impact on colleagues, or feel under pressure from managers to return to work from sick leave, or do not to take sick leave in the first place despite feeling unwell or unfit.

## 6.1 Sickness absence policy

Many respondents told us that stringent use of sickness absence policies was placing undue pressure on staff to attend work when unwell or unfit and to return to work before they are ready. A description often used about the sickness management process was *intimidating*.

We heard from a wide range of respondents that they, and their colleagues, have taken sick leave then returned to work still unwell or unfit which has often made their health worse. This second period is treated as a new episode, but they face some form of disciplinary action if a certain number of episodes of absence are taken over a set period of time.

*“I think it is unfair to use the NHS policy of no more than three absences in 12 months. It treats all episodes the same whether one day or one month. You come into work ill rather than have to face HR.”*

Staff nurse, hospital ward

*“Our trust makes you take time off for counselling, hospital appointments or visiting the GP out of annual leave entitlement which means I avoid going to the GP until I hit crisis point. I have depression but turned down counselling for this reason.”*

Admiral nurse, NHS hospital ward

*“We are threatened with disciplinary action if we go over three episodes of sickness over a 12-month period. The reasons for sickness are not taken into account.”*

NHS community nurse

*“Due to Bradford Scoring, there is now pressure to come into work even if you are feeling unwell. Three episodes of sickness in three months can make you very aware you may be getting a written warning if sickness continues.”*

Staff nurse, hospice

## 6.2 Organisational change and restructuring

Other respondents made a link between the use of sickness absence monitoring policies and wider reorganisation or restructuring within their organisation. Nursing staff are clearly fearful that poor absence records may be used against them when decisions are made about future staffing levels.

*“Due to current reorganisation staff are concerned they may have to reapply for their job so don’t want sickness on their record.”*

NHS community nurse

*“Ward rationalisations are pending, staff will have to be deployed and you don’t want your attendance record to be affected so you work when you should really stayed at home.”*

Staff nurse, NHS hospital ward

*“With redundancies high on the agenda and staff having to attend meetings where they have to pledge they won’t be ill again, most people are terrified of going off sick. Patients complain we are working when ill and managers often turn a blind eye, especially on nights, to someone being unwell. Also it seems against the rules to swap a shift with another member of staff and work later in the week; it has to go down as a sick day which looks bad on your file.”*

Staff nurse, NHS hospital ward

## 6.3 Impact on colleagues and patients

Over and above any concerns about sickness absence policy, nursing staff voiced concerns about letting down colleagues and patients/service users if they take sick leave. All too aware of tight staffing levels in their teams or departments, nursing staff are reluctant to be away from work even when ill or unfit.

*“I feel compelled to work, working on bare minimum of staff – I feel I can’t let my colleagues down.”*

Staff nurse, NHS hospital ward

*“I think habitually nurses come to work unwell to avoid shortages and support colleagues. We are a culture of people who look after others extremely well but not ourselves.”*

Staff nurse, NHS hospital ward

*“Patients are inconvenienced if I take time off sick due to appointments having to be cancelled. No one else can do my areas of practice so this has a knock-on effect on future appointments.”*

GP Practice nurse

## 6.4 Staff shortages and workload

While many respondents spoke of a reluctance to take sick leave due to staffing levels and high workloads, others more directly described staff shortages and the impact on their workplace. They also explained that financial constraints mean that absences are less likely to be covered by agency staff or through overtime, thus adding to staffing pressures.

*“My area is so short staffed I feel compelled to work, as patient care is compromised.”*

Staff nurse, NHS hospital unit

*“Because of staff shortages most staff feel pressured to work even when unwell. Should they not go into work there is no backup. Staff have to work short staffed.”*

Staff nurse, independent health care provider

*“If I don’t come into work there is just too much to do when I get back.”*

Senior nurse, charity/voluntary sector health care provider

*“It isn’t worth being off sick as the work is still waiting when you come back. It just puts added stress on you.”*

NHS community nurse

## 6.5 Feelings of guilt

While many talked about their reluctance or refusal to take sick leave due to the impact this would have on colleagues or patients/service users, others explicitly viewed these feelings of guilt as instilled by line managers or other senior managers.

*“Sometimes I’m made to feel guilty by my ward manager if I’m off sick. I would get regular phone calls asking when I would be back and no questions asked to check about my wellbeing.”*

Staff nurse, NHS hospital ward

*“You are made to feel guilty when you come back by the HR department.”*

Staff nurse, NHS hospital ward

## 6.6 Workplace culture

Closely linked to feelings of guilt are descriptions of a workplace culture in which people taking sick leave are poorly judged and commented on.

*“There is a culture of talking about staff who are off sick. Even managers pass comment on staff, for example “she’s never in”.”*

Staff nurse, NHS hospital unit

*“Sickness targets make me feel I’m letting others down. Going off sick is seen as a weakness.”*

Staff nurse, NHS hospital ward

## 6.7 Long-term conditions and injuries

Many members of the workforce have long-term conditions and injuries, and workplace interventions can be put in place to support or rehabilitate them. However, these interventions require a sympathetic culture, where team members, managers and policies and procedures support staff with illnesses and injuries.

*“I have recently been diagnosed with MS and feel under pressure to turn up otherwise work piles up. I go into work early every morning and often have to work late in order to complete my work.”*

General practice nurse

*“I’ve been told that if I don’t meet the 100 per cent attendance at work I will be up for a capability hearing. I had three admissions into hospital due to a cardiac problem, so if I get chest pain I have to ignore it because I have to go to work.”*

Staff nurse, NHS hospital unit

*“I have asthma and neck problems. There have been occasions when colleagues have asked me go home, but knowing my Bradford score has exceeded 90 points, I feel I have to avoid being unwell. However, I have an extremely supportive matron and colleagues are also very supportive.”*

Staff nurse, NHS outpatients

## 6.8 Occupational health and work adjustments

Occupational health services play a vital role in promoting health and wellbeing at work, by controlling risks, helping adapt work to people and adapting people to their jobs. It is therefore of concern when staff feel let down or unsupported.

*“I have returned to work with a back injury on admin duties. I have had to pay for private physio as the current OH provider no longer provides physio support and I would have to wait for a GP referral. OH previously provided six sessions of physio and counselling – this was stopped last year.”*

NHS community nurse

*“I had an injury requiring a workplace assessment which identified equipment for me to do my job, but three months later I still don’t have equipment.”*

NHS mental health nurse

## 6.9 Summary and recommendations

This research indicates that presenteeism is prevalent among the nursing workforce. It is linked to many different and overlapping factors, including types of illness, workload and level of cover; work-related stress and perceived pressure from colleagues; line managers and senior managers including HR.

It is important that presenteeism is given full recognition as a health and wellbeing issue; it can lead to negative health and wellbeing outcomes for staff and can also impact on patient outcomes, particularly if staff members are infectious or suffer from fatigue. Many organisations use

results from staff surveys or other tools to identify ‘hot spots’ of presenteeism and explore the underlying trends and drivers.

The Acas employer guidance (Acas, 2010a) on absence and attendance management at work states that ‘it is important to create a culture where people are able to inform their employer that they are unwell and take the necessary time off to recover’. Another key message from Acas is that effective absence management depends on early intervention and communication with employees.

Along with staff shortages, punitive sickness absence policies have been identified as a factor which can lead to increased levels of presenteeism. Some degree of sickness absence should be expected amongst health care employees, particularly those exposed to a range of occupational hazards with public facing roles. But policies need to be fair and supportive.

In the NHS, the RCN strongly advocates the implementation of jointly agreed national guidelines on sickness absence policies at a local level:

- in England – see the NHS Staff Council’s 2012 *Guidelines on the prevention and management of sickness absence* (available online at [www.nhsemployers.org](http://www.nhsemployers.org))
- in Scotland – see the NHS Scotland Managing health at work partnership information network (PIN) *Guideline 2: promoting attendance* (available online at [www.scotland.gov.uk](http://www.scotland.gov.uk))
- in Wales – see the Welsh NHS Partnership Forum all Wales sickness absence policy (available online at [www.wales.nhs.uk](http://www.wales.nhs.uk))
- in Northern Ireland – see the circular HSC AfC (1) 2013 advising health and social care employers of the sickness and annual leave policy (available at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)).

7

# Working life and wellbeing

There are many factors that impact on an individual’s health and wellbeing, including their lifestyle and personal characteristics. Other important factors include job design, workplace relationships, the working environment and workplace management practices.

Respondents were asked about the impact of working life on their health and wellbeing. A third (30 per cent) told us that work *often or always* has a negative impact, while almost half (49 per cent) said it does so *sometimes* (see Chart 6).

Nursing can be a physically demanding job, with high levels of musculoskeletal stress and a high risk of infection. It can also be mentally demanding – it requires individuals to be constantly on the ball – as well as emotionally draining.

Work stressors and hazards can have an impact on health outcomes. Stressors can arise from the way the job is organised, such as shift working, overtime and long hours,

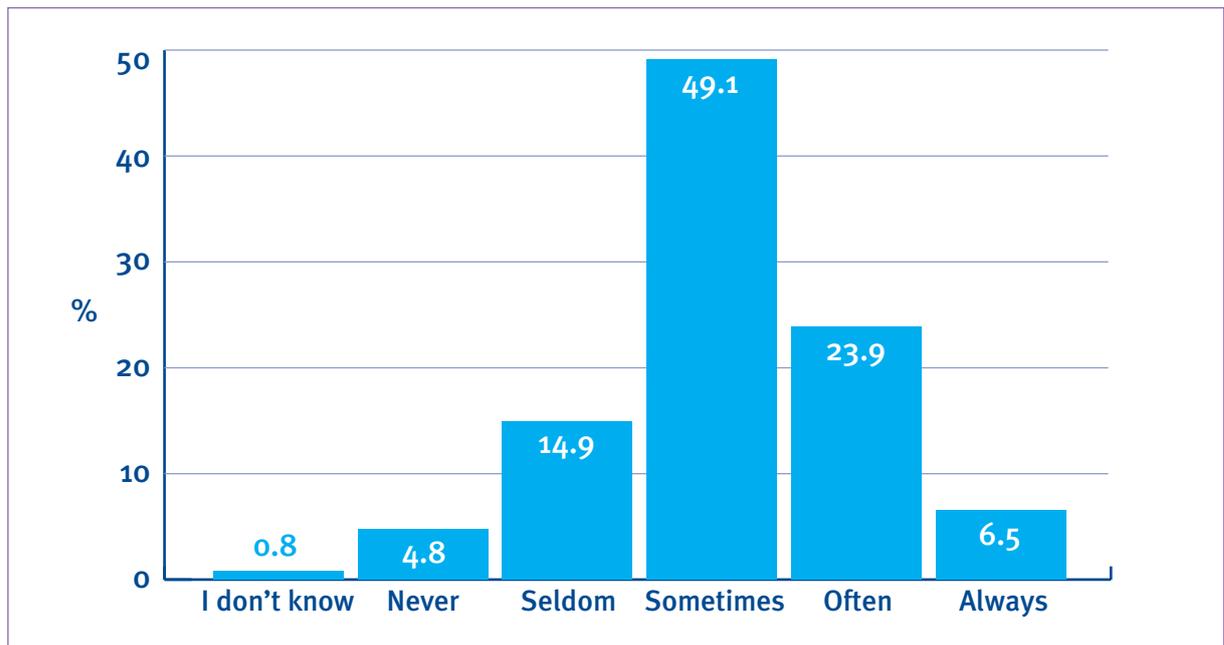
while hazards can include needlestick injuries, exposure to harmful substances, patient violence and abuse and physical job demands.

When probed further about the causes of ill health or injury at work, the biggest culprits by far for nursing staff are the dual causes of stress and workload. Around a third of respondents also cite the impact of relationships with managers or colleagues, reinforcing the findings reported in Section 4 which covered the HSE stress management standards.

**Table 16: During the last 12 months have you felt unwell or been injured as a result of any of the following at work?**

	All %
Stress at work	54.8
Workload	45.9
Relationships with managers/colleagues	32.0
Moving and handling	11.5
Needlestick/sharps injuries	4.4
Slip, trip or fall at work	3.4
Exposure to harmful substances	0.9

**Chart 6: My working life has a negative impact on my health and wellbeing (n=1,594)**



## 7.1 Stress, depression and mental health

A literature review undertaken in 2011 (Mark and Smith, 2011) as part of a research project into mental health among nursing staff showed that health professionals as a group are at significant risk from the negative effects of stressful workplaces. The authors state that nurses in particular are at risk from stress-related problems, with high rates of turnover, absenteeism, and burnout, and go on to declare that ‘nurses can be exposed on a daily basis to a large number of potent stressors, including conflict with physicians, discrimination, high workload, and dealing with death, patients, and their families... and that many situations encountered by nurses at work have a high cost in ‘emotional labour.’

The high incidence of stress in the health care workforce has been well documented and widely acknowledged as having a major impact on recruitment and retention. Indeed, in the joint union survey submitted to the NHS Pay Review Body in 2012, 60 per cent of nurses responding to the survey stated that they had considered leaving the NHS in the previous 12 months. Among these respondents, 83 per cent identified stress as the main issue prompting them to consider leaving. This latest RCN health and wellbeing survey appears to show that nursing staff are highly concerned about the lack of appreciation or management of the issue, as many people’s situations continue to just get worse.

*“The service is under pressure and many staff are stressed, sickness levels are high and other staff have to take on the work of others leading to more stress. Targets are unrealistic... there doesn’t seem to be any regard about how staff will cope.”*

NHS Community nurse

*“I have suffered from stress due to working conditions and was given no assistance to cope with ever increasing demands.”*

Staff nurse, NHS hospital unit

*“I have depression. The lack of insight and appreciation of my health problems from management is a big stress for me.”*

Staff nurse, independent health care provider

*“I’ve been seen by an MHP for stress and depression. Manager aware and mildly sympathetic but no change in workload.”*

NHS clinical nurse specialist

*“Depression is not a tolerated illness despite reassurances otherwise.”*

Staff nurse, NHS outpatients

## 7.2 Long working hours and shift working

The RCN guidance on shift working (RCN, 2012a) noted that there has been much debate over the benefits and risks of eight-hour shifts versus 12-hour shifts, yet explains that evidence on the impacts on patient outcomes and staff safety are often conflicting. Previous RCN member surveys show that some prefer 12-hour shifts as they need to do fewer shifts and have more days off. However, long hours, fatigue and lack of rest breaks or time to recuperate between shifts are associated with an increased risk of errors.

*“My team have been put on 12 hour days and I have noticed a deterioration in my health, both physical and mental.”*

NHS community psychiatric nurse

*“Feeling tired due working lots of time over my contracted hours just to get the job done. Going in when absolutely tired, washed out, stressed out, but needing to because if I go off sick the pressures are even greater upon my return to work.”*

NHS community mental health nurse

*“I took time off with stress-related symptoms...the shift patterns and lack of knowing where I was working from one week to the next affected my ability to plan a social life. Limited social life and not seeing my family equals no life for me.”*

NHS staff nurse, hospital ward

## 7.3 Burnout

Burnout is often described as the extreme experience of stress due to physical, emotional and mental exhaustion. Research at King’s College London found that nurses in the UK demonstrate the highest rates of work-induced stress in Europe, with 42 per cent describing themselves as burnt out. In 2012 Dr Jocelyn Cornwell of the King’s Fund commented in the *Nursing Standard* that: “Many nurses feel under enormous work pressure, but also feel they are not delivering the care they would like and are letting people down. If that goes on for an extended period, and there is no way of thinking or talking about it, it can be destructive. It leads to people shutting off and depersonalising patients.”

We spoke to one nurse who has recently left the NHS after more than 20 years. She left on grounds of ill-health and capability. By the time she left she had anxiety performance, loss of confidence and a phobia of nursing. She described how, over time, she had increasingly found herself in conflict between what she was being asked to do and her values as a nurse. She explained that she had tried to bring things up in meetings, but nothing was done and subsequently she felt undermined. Facing other pressures due to high workloads she became increasingly ambivalent, lost confidence and had communication problems. She finally told her manager at her appraisal that she was burnt out and was then redeployed to another job. She feels let down that the symptoms were not spotted and she was not sufficiently supported.

## 7.4 Emotional support

Several respondents highlighted the need for emotional support in their job, particularly the need to offload to a manager or colleagues. This might be done through clinical supervision or regular meetings. One respondent working as a specialist nurse expressed how grateful she is to have regular access to a clinical psychologist to be able to talk through what are often traumatic aspects of her work. A community nurse told us: *“I would like to feel that I could take the liberty to go off sick for emotional stress, though this doesn't seem allowable, even in a mental health trust.”*

## 7.5 Needlestick injuries

A small number of respondents (4.4 per cent) reported that they had received a needlestick injury in the previous 12 months. NHS Employers confirms that 40,000 incidents are reported each year in England, and that a similar number go unreported. While the majority of needlestick injuries are not life threatening, the possibility of developing infectious diseases such as hepatitis B, hepatitis C or HIV can cause immense distress, anxiety and anguish for nursing and other health care workers.

Research published in *Occupational Medicine* journal (Green and Griffiths, 2013) demonstrates how the psychiatric impact of needlestick and sharps injuries are often overlooked; these injuries can result in nursing staff experiencing sustained psychiatric trauma of a similar severity as being involved in a road accident. The research

reveals the main health implications are psychiatric injury caused by fear and worry, often exacerbated by a long wait for blood test results.

## 7.6 Working with long-term conditions or disabilities

Nursing staff spend their working lives helping people experiencing ill health and injury and preventing ill health. But nurses can also become patients. It is vital then, that where necessary, nurses get the help they need to return to work and are supported well in work.

A large proportion of nurses with a health problem or disability are injured or made ill through their work and they should be fully supported by their employer through rehabilitation and return to work procedures. However, too often we heard from nursing staff who feel unsupported at work and in many cases pressured to return to work following absence due to their condition.

*“If I don't go into work, I will end up being in trouble and find myself on an absence caution and threats of dismissal. I am disabled with multiple sclerosis.”*

E-health adviser

*“I am currently off work following breast cancer. A senior manager called three weeks after my surgery and asked if I was coming back as people with cancer often don't return and they wanted to fill my post. There is no support and little if any contact, they rarely reply to correspondence.”*

Senior nurse, independent or private sector care home

*“It is a vicious circle that we are always under staffed, and become run down through overwork and become susceptible to illness, and when we ended up going off with illness, this puts more pressure on those remaining at work, making them more susceptible to illness.”*

Staff nurse, NHS outpatients

*“I have suffered depression/stress with leave, and feel like a ‘freak’ or ‘weak’ on return.”*

Health care assistant, GP practice

*“I have depression, long-term and occasionally debilitating. The lack of insight and appreciation of my health problems from management is a big stress for me.”*

Staff nurse, independent or private sector hospital

*“I have a couple of chronic health conditions and have asked for reduced hours to improve my sickness and am not being allowed to do this. I have been harassed into going back to work when still unwell and ended up collapsing and being admitted to hospital. My blood pressure is persistently raised probably made worse by work-related stress.”*

Clinical nurse specialist, NHS community care

## 7.7 Recommendations

### 7.7.1 Managing sickness absence

The Boorman report clearly showed that effective management practices can reduce both sickness and absence; these practices should include the consistent use of appraisals, a supportive approach to staff and fast access to care and support.

This survey, however, has identified that staff with long-term health conditions encounter a number of difficulties in managing their working life. Some of these problems are associated with punitive approaches to sickness absence management, and it is therefore important that organisations are mindful of the Equality Act 2010 in relation to disabled employees and make appropriate adjustments to support employment.

The Equality Act states that it is against the law for employers to discriminate against anyone because of a disability. It also states that an employer has to make reasonable adjustments to avoid employees being put at a disadvantage compared to other people in the workplace; this could include adjusting working hours or providing a special piece of equipment to help people undertake their job. Guidance for workers and employers on the Equality Act and disability can be found at the Equality and Human Rights Commission website [www.equalityhumanrights.com](http://www.equalityhumanrights.com)

NHS organisations need to ensure they are implementing *Annex Z: Managing sickness absences – developing local policy and procedures* of the Agenda for Change agreement. This sets out arrangements which are intended to support employers and staff in the management of sickness absence and in managing the risk of premature and unnecessary ill health retirements (NHS Staff Council, 2013).

The RCN also recommends that [NICE guidelines](#) (NICE, 2009a) on the management of long-term sickness absence are followed. These provide an evidence based framework to

support staff with long-term conditions and aim to help employers and employees work together to ensure the right support is available to help someone on sickness absence return to work as soon as they are able.

### 7.7.2 Mental health

A growing proportion of the working population has mental health conditions, highlighting the need for support and appropriate adjustments within the workplace. Yet all too often mental health issues are taboo in the workplace and many people find it difficult to talk to colleagues and managers. Health care organisations should be exemplar employers in this area; by demonstrating healthy work environments and successful employment policies they can then convince others to do the same.

There are a number of national initiatives which have been developed to promote and support the employment of staff with mental health conditions. These include [NICE guidelines on promoting mental wellbeing at work](#) (NICE, 2009b) together with guidance from Mind (2011) and Acas (2012). Guidance is also available from such organisations as Mind and Acas.

### 7.7.3 Older workers

Older workers form a large part of the nursing workforce and they are more likely to be living with one or more long-term conditions. Since the normal retirement age for all workers is set to increase and may be extended even further, it is vital that age-appropriate plans are put in place now in order to avoid difficulties in the future. In jobs with a high physical workload, such as nursing, reduced physical capacity can also be a problem. However, given the right conditions and environment, most older workers are able to stay healthy and physically able to do their jobs. The European Agency for Health and Safety at Work (EU-OSHA, 2012) makes the following recommendations:

- age-related factors are taken into account in assigning particular tasks to individuals to find the right balance between the work and the people who carry it out
- health promotion takes place to help workers adopt a healthy lifestyle
- proper risk assessments are carried out which take into consideration individual differences between workers in terms of their capacities and health
- individual work tasks are redesigned to suit older workers; for example, through the reduction of physical workloads, or regular short breaks through the working day.

The CIPD and TUC have published [joint guidance](#) (CIPD, 2007) on good age management practices and managing without a retirement age, reflecting the business case for extending working life and employing people of all ages.

[RCN guidance](#) (RCN, 2011c) on the employment of older nurses provides information for RCN representatives and officers to help them influence health and social care employers to apply good practice in the effective management of the older nursing workforce. There are mutual benefits for all: health and social care employers will improve retention of older, experienced nurses; patients will receive quality care from nurses who understand and can empathise with their needs; and nurses will feel valued at work and therefore more willing to consider working beyond retirement age.

#### 7.7.4 Physical hazards

It is important that physical hazards are not overlooked. Significant numbers of the nursing workforce continue to be exposed to risks from moving and handling activities, needlestick/sharps injuries, slips, trips and falls and exposure to harmful substances which could lead to dermatitis or asthma. There is a robust legal framework that employers must follow to ensure risks are managed.

In May 2103 new regulation on the prevention of sharps injuries came into force in the UK; the Health and Safety (Sharps Injuries in Healthcare) Regulations 2013 require employers to take specific steps to reduce the risk of sharps injuries. The RCN has produced [guidance to support implementation of the EU Directive](#) (RCN, 2011a) which is of particular use to health and safety representatives and members of the workforce with responsibility for infection control and occupational health.

The guidance states that ‘everyone has a role to play in the prevention of sharps injuries to health care workers. From the chief executive and board directors, who have overall legal responsibility for the health and safety of their staff, to the individual nurse or health care worker – all have a duty to ensure that they protect themselves and others around them by safely using and disposing of sharp equipment.’

[The NHS Staff Council Occupational health and safety standards](#) (NHS Staff Council, 2010) provides guidance for health care organisations on managing workplace health and safety and are designed to help trusts meet their legal obligations and protect both staff and patients.

#### 7.7.5 Managing health at work in the NHS

NHS Scotland has developed 10 guidelines around the protection and promotion of the health, safety and wellbeing of its staff. These range from stress at work to glove selection. The guidelines can be accessed at [www.staffgovernance.scot.nhs.uk/partnership](http://www.staffgovernance.scot.nhs.uk/partnership)

NHS Employers in England provides guidance on developing and implementing a health and wellbeing strategy, more information is available at [www.nhsemployers.org/HealthyWorkplaces](http://www.nhsemployers.org/HealthyWorkplaces)

#### RCN support for injured, ill and disabled members

The RCN runs a [Peer Support](#) service for injured, ill and disabled RCN members to share experiences and knowledge. It is a membership group for any member affected by physical or psychological injury, ill health or disability - whether work-related or not. The group exists to assist members in making connections with peers to give and receive support, and information on the group and its services can be found on the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk)

## 8

# Bullying, harassment and violence

We asked respondents about their experiences of verbal or physical violence and about workplace bullying. We found that well over half (56 per cent) have experienced verbal or physical violence from patients or service users and almost half (48 per cent) have done so from relatives of patients/service users.

The 2012 NHS Staff Survey for England found that a quarter (24 per cent) of registered nurses/midwives had experienced physical violence from patients, relatives or other members of the public and two-fifths (42 per cent) had experienced bullying, harassment or abuse. Among nursing and health care assistants, a third (35 per cent) had experienced physical violence from patients, relatives or other members of the public and 38 per cent had experienced bullying, harassment or abuse. The 2013 NHS Staff Survey for Wales found that 18 per cent of employees have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public. One in ten (11 per cent) have personally experienced physical violence at work from patients/service users or other members of the public.

The RCN 2011 employment survey asked respondents similar questions about violence and harassment; almost a third stated (30 per cent) stated that they had experienced violence or harassment from a patient/client or a member of their family. This more recent survey has captured a worryingly high level of verbal aggression perpetrated by patients or service users and their family members.

Around a fifth of respondents stated that they had experienced bullying from either a manager (23 per cent) or colleague (21 per cent). This is a similar finding to the RCN 2011 employment survey in which a quarter of respondents (27 per cent) stated that they had experienced bullying or harassment from a team member or manager. The 2012 NHS Staff Survey for England reported that similar numbers of registered nurses and midwives (27 per cent) and nursing/

health care assistants (22 per cent) had experienced bullying, harassment and abuse from managers, team leaders or colleagues. The 2013 NHS Wales Staff Survey showed that 18 per cent have personally experienced harassment, bullying or abuse at work from a manager/team leader or other colleagues.

**Table 17: Have you had personal experience of any of the following?**

		%
<b>Verbal or physical violence</b>		
Patients/service users		56.3
Relatives of patients/service users		47.6
Colleagues		20.7
Other members of the public		14.8
Manager/team leader		14.7
<b>Workplace bullying</b>		
Manager		22.6
Colleague		21.0

## 8.1 Physical and verbal violence from patients, service users or their relatives

A large number of respondents reported that some form of verbal or physical violence or abuse from patients, service users or their relatives was expected to some degree within their area of practice.

### Physical and verbal violence as 'the norm'

*"Abuse largely comes from confused patients to which there are limits to their management."*

Sister, NHS hospital ward

*"Because of the type of patients I care for, I experience verbal violence frequently and physical violence at least once on a monthly basis."*

Staff nurse acute/urgent hospital ward

*"I have received verbal violence probably on a weekly basis, mainly from irate relatives and 'confused' patients. I feel my employer's response is that of a 'it's part of the job' type."*

Sister, NHS acute/urgent hospital ward

While many members expect some degree of abuse or violence, a significant proportion also stated that they received good support from their managers.

#### Good management support

*“I felt very well supported by my line manager and by senior management after suffering from extreme verbal abuse in an incident this year.”*

NHS community mental health nurse

*“The nature of my job leaves me and my colleagues open to a lot of verbal harassment – we are supported by our managers, the PCT and the prison.”*

Practice nurse in prison health care department

*“Increase in patients with dementia, staff often abused verbally or physically. Trust now providing breakaway training and conflict resolution training.”*

Staff nurse, NHS hospital ward

However, a similar number also stated that they did not feel well supported by colleagues or managers, when having to deal with aggressive patients or members of their family.

#### Lack of management support

*“I was once punched in the face by a patient with dementia. I told the sister on duty who laughed and made no attempt to ask after my welfare. There is no point reporting these incidents formally as managers do not demonstrate any genuine concern for the physical safety and wellbeing of staff.”*

Staff nurse, NHS hospital ward

*“Often when patients and or relatives are angry, staff are encouraged to let it go or be sympathetic. It can be quite tiring or hurtful to staff leaving them feeling inadequate.”*

Staff nurse, NHS adult intensive care

*“I don’t always feel safe on the ward or supported with aggressive patients as we are short staffed or have too many special patients on the ward stretching the staffing levels.”*

Staff nurse, NHS hospital ward

## 8.2 Workplace bullying and harassment

Bullying can be overt and involve arguments and rudeness, but it can also be more subtle. Bullying can involve excluding and ignoring people and their contribution, unacceptable criticisms and overloading people with work.

We asked respondents to elaborate on their experiences of bullying and harassment in the workplace and nursing staff described both covert and overt bullying, for example one respondent stated: “Bullying and harassment is not easy to prove.” Another stated that: “Bullying is sometimes too subtle for the victim to articulate fully what is actually happening. And as such, is incredibly difficult to deal with,” while another respondent explained that “bullying is subtle, chipping away to wear you down”.

The range of responses shows that bullying and harassment can involve a wide spectrum of behaviours. For example, several members stated that bullying occurred through the allocation of duties or shifts while others described how workplace cliques cause disquiet and concern. The quotes below provide a small sample of the issues being raised around bullying and harassment in the workplace from managers, colleagues and from the organisation as a whole.

#### Descriptions of bullying

*“Our manager does the e-roster and gives no consideration to the outside lives of staff or the impact of poor shift patterns eg night shifts finishing on a Saturday morning with a day off on Sunday and back to work long days from the Monday. We are not allowed to have any sort of pattern to our duties; they have to be completely random or managers ask why we are working similar shifts most weeks – so no-one can book weekly educational or exercise classes without having to use up all of their requests. We are only allowed four requests in a four-week period. This is very restricting considering that we could be rostered to work any hour of any day throughout the whole year. If you want a long weekend off to visit family, you cannot make any other requests for four weeks. Caring profession? I think not!”*

Staff nurse, NHS hospital ward

*“Some senior managers bully covertly by keeping on saying about job losses. Our CEO said that any conduct that deviates from trust expectations, the person will be ‘dealt with’. Staff are ‘disappearing’ after being off sick with stress or investigations, there is a culture of fear and mistakes will be punished with no second chances given. Staff are being rebanded but still expected to do the same or more work. If anything is said by staff, they are spoken to for their attitude.”*  
NHS senior community nurse, learning disabilities

*“I would class it more as harassment and disrespect for my role. I think responses are reactive, not proactive with the attitude that heads will roll if targets are not met or practice is not improved.”*

Senior nurse, NHS hospital unit

*“Bank staff are bullied and harassed by permanent members of some units. The idea of team work is far fetched.”*

Health care assistant, NHS Bank

### 8.3 Bullying: firm management or unpleasant behaviour?

Bullying can be difficult to pin down; respondents pointed to instances of bullying in their workplace ranging from outright aggression to something far more subtle, while the comments of others raise questions as to whether what is perceived as bullying is in fact something else – firm management or just unpleasant behaviour. For example, one NHS sister said: *“Staff use the term bully very easily when they interpret this from just being managed.”* One of our telephone interviewees even referred to the *“right kind of bullying”* being used to get *“people to do things”*. Another nurse stated: *“There is a member staff who likes to talk loudly and have a go at you, but I don’t think this is bullying.”*

The following extract taken from Acas guidance (Acas, 2010) gives a helpful description of bullying and harassment at work.

#### **Acas guidance on bullying and harassment at work**

Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual.

#### **Examples of bullying/harassing behaviour include:**

- spreading malicious rumours, or insulting someone by word or behaviour
- copying memos that are critical about someone to others who do not need to know
- ridiculing or demeaning someone – picking on them or setting them up to fail
- exclusion or victimisation
- unfair treatment
- overbearing supervision or other misuse of power or position
- unwelcome sexual advances
- making threats or comments about job security without foundation
- deliberately undermining a competent worker by overloading and constant criticism
- preventing individuals progressing by intentionally blocking promotion or training opportunities.

Bullying and harassment are not necessarily face to face. They may also occur in written communications, email, phone, and automatic supervision methods such as computer recording of downtime from work or the number of calls handled if these are not applied to all workers.

Further information is available from: [www.acas.org.uk](http://www.acas.org.uk)

## 8.4 Management support

Bullying and harassment takes place in all sectors of the economy and nursing is no exception, yet all employers have a duty of care to provide a safe working environment. When asked to provide further information about workplace bullying or harassment, many members described how they are well supported by their manager. However, many more said they felt let down by managers.

### Positive feedback

*“One consultant has bullying behaviour but we have been supported wholly by our manager.”*

NHS district nurse

*“My workplace is very supportive and relationships between staff members are excellent. No bullying/harassment would be tolerated by anyone.”*

GP practice nurse

*“One of my colleagues was verbally abusive but this has been resolved by management and we now have a good working relationship.”*

NHS staff nurse

### Negative feedback

*“I was bullied by a consultant that I work for. My manager told me the consultant ‘wasn’t that bad’ after witnessing verbal abuse by the consultant towards me in a meeting. I therefore felt it was useless to put in a complaint as I would not be supported.”*

Sister, NHS mental health ward

*“I have experienced verbal aggression and intimidation from a colleague. I was not supported by my immediate manager or matron and subsequently experienced stress-related ill health.”*

Clinical nurse specialist, NHS hospital unit

*“No support from other senior staff or managers, when bullying or harassment is from another senior member of the nursing team.”*

NHS staff nurse, acute/urgent care

## 8.5 Corporate culture, bullying and organisational change

Many respondents referred to corporate bullying within their organisation, where bullying has become entrenched in the culture. This is often described as being linked to organisational change, as well as an increased emphasis on performance within tight budgetary constraints.

Looking at this issue in relation to the HSE management standards, organisational change can impact on all six factors. An increase in workplace **demands** may place pressure on individuals to work longer, faster or more intensively and result in undue stress. In turn, this impacts on the factor of **‘control’** and ability to be self determining. **Support**, in terms of management help and feedback, may be lacking during times of rapid change while clarity of **role** and quality of **relationships** may be undermined. **Change** is often imposed with a lack of, or perceived lack of consultation and communication.

*“I believe that corporate bullying is occurring in my organisation as it is impossible to achieve what is expected of us with the resources we are given. Staff have expressed concerns about standards and safety of patients and staff in writing without any response from any level of management.”*

NHS district nurse

*“The entire culture of the organisation is shifting, becoming hard line and unforgiving. As pressure builds up on individuals, some respond by exhibiting bullying behaviour to others.”*

Manager, NHS

*“Low morale and workload demand due to practices brought in by management have an impact on inter-department relations.”*

Sister, NHS hospital ward

## 8.6 Concerns about safety and quality of care

Several respondents described their inability to perform their job to the standard they would wish to achieve and their frustrations in a perceived lack of support from their managers. In many cases nursing staff equated this to a form of bullying.

*“I felt that I am bullied when I object to certain duties that I consider unsafe.”*

School nurse

*“Under ongoing pressure to provide beds on an acute ward through inappropriate outlying of patients and early discharges due to bed crises and lack of staffing.”*

Staff nurse, NHS acute/urgent care hospital unit

*“Bullying is a difficult concept to define – unrealistic deadlines and pressure to complete tasks are more common. Unrealistic workload and areas of responsibility with constant expectations to ‘work smarter’ without additional resource to undertake a high quality approach to role.”*

NHS senior infection prevention nurse

*“Difficulties experienced in rotating to other clinical areas to update. Had to threaten those responsible for allocations with outside intervention unless they helped me to fulfil my competences.”*

NHS midwife

## 8.7 The middle management squeeze

Responses from senior nurses, matrons and sisters reveal the extent of pressure they feel from all sides – from members of their team as well as senior managers. Some comments highlight respondent concerns about the impact of pressure they receive from senior managers which, in turn, is felt by their team. In other cases respondents share anxieties about managing bullying by colleagues within the team they lead or even feeling bullied by their team.

*“Low morale and workload demand due to practices brought in by management have an impact on inter-department relations.”*

Sister, NHS hospital ward

*“When I emailed incident forms reporting risks to patients, I was made to feel the problem was with me and my team. Senior managers wanted to performance manage me.”*

Sister, NHS hospital unit

*“Some staff are aggressive verbally if they feel wronged and can be nasty towards me.”*

Sister, independent sector care home

*“Some of my staff have felt harassed from their colleagues. This makes me stressed as I feel I am not managing them well if they are making people feel like this.”*

Senior nurse, charity

Increasing numbers of her team, tell her they are worried about fulfilling the NMC codes of conduct. Meanwhile she feels under pressure from managers for her team members to undertake training but says *“we don’t have time for training and taking people out would mean dangerous staff levels, so as a team leader I’m caught in the middle.”*

Extract from interview with ‘Lucy’, NHS clinical team leader

## 8.8 Black and minority ethnic nurses

Concerns about the position and experiences of black and minority ethnic (BME) nursing staff in health care have been well highlighted by research which is often followed by policy statements and employment initiatives. Despite this, BME staff continue to be significantly underrepresented in more senior positions of the workforce and continue to report experiences of marginalisation.

The RCN survey found that a higher proportion of BME respondents, compared to white respondents, reported having experienced bullying from managers; a quarter (24 per cent) of white and Asian respondents, a fifth (20 per cent) of mixed race respondents and a third (36 per cent) of Black respondents reported they had been bullied by a manager.

A higher proportion of BME respondents also reported bullying from colleagues. Just over one fifth (22 per cent) of white and 11 per cent of mixed race respondents reported having experienced bullying from colleagues, compared to 31 per cent of black and 38 per cent of Asian respondents.

The following comments from the survey and telephone interviews highlight the scale of the problem among the nursing workforce. The research reveals how some BME nurses feel that they are not given support in career progression, and in some cases feel marginalised among their own teams. Among overseas nurses, we found exasperation that skills, qualifications and experience gained abroad are not sufficiently recognized; in one case a care home nurse described her frustrations at being tied to one employer as a condition of her work permit.

*“Being on a work permit and tied to one employer, it gives room for a lot of abuse and bullying. You’re afraid you might get sacked and having another permit will be a problem, so it goes unreported. There is a lot of abuse, bullying and intimidation in private sector where most workers are on sponsorship. I have been a victim and will continue to suffer until I’m a permanent resident.”*

Staff nurse, care home

*“As junior sister I am often ignored by my manager. Information is given to ward staff before me, I am undermined and ignored, the only real contact is via email to pass on management duties. I find it hard to talk to her as although not expressed I feel there is an underlying racial element and am aware the ‘non-white’ staff feel this. I tried to report this to matron two years ago but she said there was no evidence and things have been more difficult since.”*

Sister, NHS hospital ward

*“There is indirect racial abuse and blame culture, stopping people going on courses and work promotions even you have enough experience, qualifications and good skills. Because you do not belong to my colour skin and do not speak Queen’s English.”*

Staff nurse, NHS hospital ward

‘Rahma’ reported feeling embittered that her extensive qualifications and experience gained abroad are not fully recognised in the UK and that her skills have been underused. She feels that this is part of the culture, rather than specific to any particular organisation or sector. Extract from telephone interview with ‘Rahma’ NHS staff nurse.

## 8.9 Illness or injury and return to work

Several members described how they have felt under pressure to return to work after an illness or injury and how their treatment had felt like bullying or harassment.

*“I felt bullied into returning to work and having the threat of formal warnings for sickness hanging over me.”*

Staff nurse, NHS outpatients

*“Not bullying but made to feel time off sick may not be genuine – although I 100 per cent was. I was signed off with moderate depression.”*

Staff nurse, NHS hospital ward

## 8.10 Members accused of bullying and harassment

We also heard from several members who have themselves been accused of bullying and harassment by a member of their team; while some felt well supported, more felt aggrieved by how the situation was handled.

*“When I was accused of B&H and disciplined I was totally unsupported, nobody listened to me or looked at the causes and why things happened when I had become very stressed due to my work.”*

NHS community nurse

*“I have experienced a malicious bullying and harassment grievance by a junior member of staff who would not tolerate being managed by me. A full investigation occurred in which I was exonerated; however I do not feel I have been supported by my organisation during a very lengthy and stressful process. Managers should be supported throughout such processes and not be left to their own devices.”*

NHS social care manager

## 8.11 Taking a stand against bullying, harassment or violence

Some respondents have taken a stand against bullying, harassment or violence by directly confronting the bully, making a complaint or taking collective action. In other cases a more extreme position was taken; leaving the organisation or even the profession completely.

*“Have had to take time off with work-related stress and leave employment because of bullying and intimidation from manager and colleague.”*

Staff nurse, independent sector care home

*“No one would believe that I was being bullied for 7.5 years and only when I got to rock bottom and brought in the union was anything done about it. I now have it in writing that I was bullied and harassed by several staff, management and upper management. I was ready to leave nursing as I was made to think I was rubbish at my senior role. I now have my confidence and career back.”*

NHS community nursing sister

*“I left one job as there was continued and systematic abuse by a few band sixes/seven, thankfully not often directed towards myself but it was difficult to work in that atmosphere. It was reported by the junior staff member but nothing was done.”*

NHS community nurse

## 8.12 Recommendations

### 8.12.1 Violence and aggression

All too often violence and aggression are seen as part of the job for health and social care workers, but physical assaults can have an instant impact and result in absence from work and even long-term psychological trauma. Constant verbal abuse and dealing with challenging behaviour such as hair pulling or pinching on a daily basis are also damaging to health, wellbeing and morale.

The RCN regularly works with employers to ensure that they have robust risk assessments in place to address the underlying causes of violence and aggression in health care environments. [The RCN tool](#) (RCN, 2008) on work-related violence provides a framework to address risks and identify

necessary changes to the physical environment, safe staffing levels and training, provides practical support, in completing assessments of work-related violence, and allows employees and organisations to gain more knowledge of the risks involved, and subsequently more control over reducing work-related violence.

In cases where staff have been assaulted at work we call on employers to fully support staff; this support should include effective liaison with the police. In turn, staff must be encouraged to report all instances of physical and verbal abuse, even where it is not appropriate to prosecute an individual with limited or no capacity. Employers need to assess the risks and take action to reduce the likelihood of assault, and staff must be provided with feedback on what actions have been taken as a result of an assault.

Violence should never be seen as part of the job and all nursing staff have a right to work in a safe and secure environment. Governments, health departments and enforcement bodies must send out this clear message to health care staff, patients, clients and their families.

### 8.12.2 Bullying and harassment

The survey has identified that bullying and harassment are an ongoing concern for members. Sadly this is a recurrent theme of numerous surveys and high profile inquiries into systematic failures in health care provision. While the majority of organisations have programmes and policies in place to cover dignity at work and bullying and harassment – the reality for many is a far cry from such policies.

The RCN calls on all health care organisations to ensure they regularly carry out suitable and sufficient risk assessments on workplace stress, as directed by the Management of Health and Safety at Work Regulations 1999. The HSE's stress management standards provide a framework for health care organisations can use to prevent and reduce the risks of work-related causes of stress. In relation to bullying and relationships at work, the HSE expects organisations to:

- promote positive behaviours at work to avoid conflict and ensure fairness
- ensure employees share information relevant to their work
- have agreed policies and procedures to prevent or resolve unacceptable behaviour
- have systems in place to enable and encourage managers to deal with unacceptable behaviour

- ensure systems are in place to enable and encourage employees to report unacceptable behaviour.

The RCN and other trade unions regularly work with organisations to identify bullying hot spots using staff survey results and other sources of data to take measures to tackle the underlying causes of bullying behaviour.

The RCN is clear that bullying is best dealt with when staff, their representatives and managers work in partnership, and endorses an active approach to reducing bullying and harassment and encouraging “a workplace culture in which everybody treats their colleagues with dignity and respect, and where all steps are taken to minimise the occurrence of bullying and harassment”. Achieving this culture depends on effective management practices that promote fairness and addressing concerns promptly; from the board down, line managers play a key role in setting a culture of respect that does not tolerate bullying behaviour.

The RCN's *Working with care toolkit* (RCN, 2005) provides a framework for promoting positive working relationships in health care environments and supplies self-assessment toolkits to help organisations support and nurture relationships within health care teams.

National partnership initiatives such as NHS Scotland's *Dignity at work toolkit* (available online at [www.staffgovernance.scot.nhs.uk](http://www.staffgovernance.scot.nhs.uk)) provide effective frameworks for local implementation, while the Welsh Partnership Forum's dignity at work guidance *Working in partnership: bringing respect to work* (2007) sets out core standards that are expected of all NHS staff.

### 8.12.3 Challenging racism and discrimination in the workplace

Nurses from black and minority ethnic backgrounds are often significantly under-represented in senior nursing posts and a disproportionate number are represented in disciplinary cases (Nursing Standard, 2012); in addition a disproportionate number of BME registrants are referred to the Nursing and Midwifery Council.

BME staff are more likely to be involved in disciplinary proceedings and to experience bullying and harassment than their white counterparts, and are under-represented in senior posts. This underlines the need for improved data collection on the employment experience of BME nursing staff so that effective action can be taken to provide support.

The RCN has implemented a three-year programme – *Is that discrimination?* – to tackle such systemic issues in the workplace and provide a coherent response to the issues of discrimination faced by BME nurses and health care support workers because of their age, disability, sexual orientation or religion, faith and belief for example. The project itself has three phases:

- raising member awareness of different forms of discrimination and the importance of exercising their employment rights
- enhancing the learning and development support available to accredited RCN representatives and caseworkers to improve their skills in identifying and challenging discrimination in the workplace
- working in partnership with employers to improve their employment practices and deliver more equitable outcomes for their employees; the RCN will employ a range of new techniques and skills to help organisations in tackling discriminatory workplace cultures.

#### 8.12.4 NHS career pathways

The RCN has been concerned at the loss of investment in programmes such as the NHS *Breaking Through Programme* which, as a result, will further constrict developmental and career progression for BME nurses. We are also concerned that a reduction in posts held by senior BME nurses appears to be exacerbated throughout successive NHS reorganisations. We therefore urge employers to invest in the development and training of all nursing staff and ask them to pay particular consideration to the needs of BME staff.

In September 2012 the RCN, in partnership with the NHS Leadership Academy, agreed to sponsor a joint project aimed at supporting BME nurses leaders in response to growing concern about the sharply declining numbers of senior BME nurses. As a result of this work the RCN has committed to establishing a BME group within the Executive Nurse Network to address a range of issues, including career progression. Details of the BME Leadership Forum, which is hosted by the NHS Confederation in partnership with the RCN, can be found at [www.nhsconfed.org](http://www.nhsconfed.org)

#### 8.12.5 Nurses trained outside the UK and the European Economic Area (EEA)

This research highlighted ongoing confusion surrounding the rights and status of overseas nursing staff. Anyone wanting to work in the UK as a nurse must register with the Nursing and Midwifery Council (NMC), however this does not provide the right to work in the UK. Nurses can apply to be on the NMC Register; if they meet NMC standards their training will be compared with that required in the UK.

The only route to NMC registration for nurses trained outside the UK and EEA is through the [Overseas Nurses Programme](#) (ONP). The scheme provides a compulsory period of protected learning and, where appropriate, supervised practice; individuals must have a sponsor (the employer) in order to enter the UK to complete an ONP.

An overseas nurse who has a work permit and wishes to take work additional to that for which the permit was issued, may do so provided the work is:

- outside of their normal working hours
- no more than 20 hours per week
- in the same profession and at the same professional level for which the permit was issued
- not employment by a recruitment agency or employment agency.

Additional work can bring significant benefits in terms of professional experience and development as well as personal finances.

For overseas nurses who cannot register to work as a registered nurse or midwife and are currently living in the UK, the only method of upgrading overseas nursing qualifications is by undertaking a pre-registration nursing or midwifery programme at a university.

Many RCN members have concerns about working under a permit, or the points based system for managing student and employment migration to the UK; [RCN Member Support Services](#) can provide free confidential advice, guidance, representation and support.



## Occupational health

While the promotion of good health and wellbeing is everyone's responsibility, occupational health services play a vital role and perform a wide range of functions; these include pre-employment health screening, implementing strategies to prevent illness and injury; helping get people back to work after illness or injury, and health promotion.

The Boorman Review (DH, 2009) stated that reducing working-age ill health has the potential to save the UK up to £100 billion a year. The RCN has consistently argued this can only be achieved through the adequate resourcing of occupational health services to support the implementation of proactive measures and not to simply engage in attendance management and reactive services.

We asked nursing staff to describe their level of access to occupational health services. The majority (86 per cent) stated they have access to these services at work, yet just over half (54 per cent) felt confident these would be helpful. In addition, just under two-thirds (61 per cent) said that they could access occupational health services without a referral.

**Table 18: Access to occupational health services**

	Yes %	No %	Don't know %
I have access to occupational health services at work	86	9	5
I feel confident that occupational health services would be helpful if I contact them	54	17	29
I can access occupational health services without a referral	61	10	26

An examination of these findings in more depth reveals that nursing staff working in the NHS, for social enterprises and universities were more likely to report having access to occupational health services than staff in other sectors. The majority of NHS nursing staff (98 per cent) stated they have access to services compared to just 54 per cent of those working in GP practices, 45 per cent in the independent sector and 66 per cent in the charity/voluntary sector.

However, confidence in the helpfulness of the services offered is consistently much lower across all sectors, particularly for those working in the charity/voluntary sector where just 31 per cent stated they felt confident that occupational health services would be helpful if contacted.

The group of nursing staff least likely to state they can access OH services without a referral are those working in universities and the independent sector, while respondents working in the NHS or for social enterprises are most confident of being able to refer themselves.

**Table 19: Access to occupational health services – by sector**

	NHS %	GP practice %	Independent sector %	Charity/voluntary sector %	Social enterprise %	University %
I have access to occupational health services at work	98	54	44	66	93	93
I feel confident that occupational health services would be helpful if I contact them	54	50	55	31	56	54
I can access occupational health services without a referral	67	52	43	50	72	15

We gave members the opportunity to share their experiences of occupational health services. Responses are divided into different themes below.

## 9.1 Positive feedback

Positive comments were made about quality of or access to services provided. A staff nurse working in the independent sector stated: *“occupational health is routinely done and I believe if I have the need for help it will be easily accessible to me”*, while a GP practice nurse told us that: *“I recently had a needlestick injury from an unknown source and the occ health department have been really helpful and supportive.”*

An NHS staff nurse also said: *“I work in a busy emergency department which can have traumatic events; we regularly are debriefed and also given further opportunity to talk if needed. I have access to counselling services for both work and personal problems and this is easily accessed and extremely helpful.”* Positive feedback was also made about the ability to self refer to occupational health services.

## 9.2 Negative feedback

### 9.2.1 Difficulties in accessing services

Respondents stated that they have had difficulties in accessing OH services. Problems relate to long waiting lists, services located too far away or in an inconvenient location and lack of information on services provided. In some cases respondents stated that their employer offered no occupational health services at all.

One nurse working in the NHS stated: *“I recently had to make a 60 mile round trip to see an OH doctor”* while another stated *“I heard our OHS has moved to another area and merged with another organisation. I have not received any communication regarding this. So I do not know how to contact OH. Also it is an hour’s drive away from where I work.”* We were also told by an NHS staff nurse that: *“As I work night duty occupational health is unavailable during my working hours.”*

### 9.2.2 Line management referral

Several members described how they were unable to self refer, but had to go through their line manager. In some cases members were put off approaching their manager, while in others they were actively blocked from accessing services by the manager. A typical response from one member was the following: *“If I need to go to occupational health my Clinical Lead has to refer me first so I have to explain why to them. It is not confidential.”*

### 9.2.3 Negative perceptions of occupational health

Negative views mostly relate to a perception that the services are not confidential and in some cases that using occupational health would be used against them. One nurse working in the independent sector stated that *“occupational health was used as a threat and not as a positive thing”* and another working in the NHS stated that *“records held by occupational health can affect employment opportunities.”*

Other typical statements were that occupational health services are *“not really open to staff in the way they would want, many staff are fearful of this dept and the support is not constructive. It is seen as a management tactic without solving the issues”*.

An occupational nurse saw the problem as lying with line managers, stating: *“I see the results of extensive harassment and bullying on staff. I have even faced attempted bullying from executives to produce a report in their favour instead protecting a deserving staff member.”*

### 9.2.4 Health and wellbeing issues not properly addressed

Respondents also expressed frustration or dissatisfaction with the service received from occupational health, either because their specific needs were not fully addressed or not enough time was invested in tackling their problems.

We were told by a nurse practitioner working in the NHS that they had accessed OH services for a psychological problem, reporting that: *“The clinician did not have any skills in mental health issues. The appointment left me feeling worse.”* Meanwhile, a district nurse working at a GP practice stated that *“they cannot offer any practical solution apart from telling me to take my breaks that is not possible all the time”*.

### 9.2.5 Problems with OH recommendations being implemented

Problems were also highlighted with OH recommendations being implemented in the workplace. Typical responses included *“whilst they can speak with you about health problems and so forth they can only make suggestions to the manager, not tell them what should happen”* and that *“when occupational health have given their instruction on matters, my line manager has baulked at it and said that she has no intention of being told what to do by them”*.

### 9.3 Recommendations

Occupational health services play an important role in promoting the health and wellbeing of staff. The RCN supports the implementation of Safe Effective Quality Occupational Health Service (SEQOHS) standards and the process of voluntary accreditation ([www.seqohs.org](http://www.seqohs.org)). A number of NHS organisations have already achieved SEQOHS accreditation, and all providers of occupational health services to health care organisations should meet these standards. Investment in good OH support, which is valued by staff, will contribute to patient outcomes through its role in supporting the health of staff.

In addition to the SEQOHS standard around accessible OH services, the RCN believes that health care staff should be able to self refer to OH services. Self-referral provides an opportunity for staff to commence early interventions, as well as protecting confidentiality and promoting trust in occupational health services. Above all, it sends a clear message that staff are valued.

A number of reviews and audits into sickness absence in health care, including the Boorman review (DH, 2009), have recommended the implementation of early intervention programmes which allow prompt access to treatment and rehabilitation services for health care staff. Such programmes have been found to be cost-effective, ensure that staff absence (and time away from patient care) is minimised, and reduce the risk of conditions such as musculoskeletal disorders developing into long-term conditions. The RCN calls for the universal implementation of early intervention programmes for the nursing workforce.

NHS Employers (NHS Employers, 2012) has published [guidance for NHS organisations on how to manage rapid access services for staff in their organisation](#). The rapid access system is designed to secure rehabilitation and OH treatment for NHS employees with a view to facilitating a return to work which is, as fast as practical, and reasonable.

## Pre-registration students

This section reviews results for the 56 respondents who indicated they were pre-registration students.

Student retention has been an issue for concern for many years, with various factors associated either with the students themselves or the university or practice environment contributing to students' decisions to leave.

Research carried out by *Nursing Standard* shows that across 30 universities across the UK, 21 per cent of those who embarked on the three-year degree in 2008 did not complete it in 2011. This is a long-standing issue that has implications for NHS finances and for the future supply of nurses.

Gaining the student viewpoint of their placements can provide an insight into the student experience as they make the transition from the academic setting to the practice setting. Placements represent around 50 per cent of the course programme and are often singled out as a primary reason for student attrition.

While this is a small group of survey respondents, their feedback provides an interesting perspective on health, wellbeing and stress among those students who have recently undertaken placements.

Placements are a vital part of nursing degrees, allowing students to develop clinical and inter-personal skills. However, organisational cultures within the workplace can also be highly influential in affecting both the quality of the placement, and learned behaviours of the students. It is important therefore that these cultures do not undermine efforts to provide high-quality learning experiences for the next generation of nurses.

## 10.1 Profile of student respondents

- The majority of the student respondents are aged 44 or under and are white.
- When asked about their current or latest placement, the majority worked in either acute/urgent care or on an adult/general/medical/surgical ward or a hospital unit.

	n	%
25 or under	27	48.2
26-34	9	16.1
35-44	16	28.6
45-54	4	7.1
<b>Total</b>	<b>56</b>	<b>100</b>

	n	%
White	49	87.5
Black/African/Caribbean	2	3.6
Mixed/multiple ethnic groups	2	3.6
Prefer not to say	1	1.8
Other – not specified	2	3.6
<b>Total</b>	<b>56</b>	<b>100</b>

	n	%
Acute/urgent care	16	29.1
Adult/general/medical/surgical	13	23.6
Children and young people	6	10.9
Learning disabilities	6	10.9
Mental health	5	9.1
Primary/community care	3	5.5
Surgery	2	3.6
Long-term conditions	2	3.6
Older people	1	1.8
School nursing	1	1.8
<b>Total</b>	<b>55</b>	<b>100</b>

## 10.2 HSE management standards

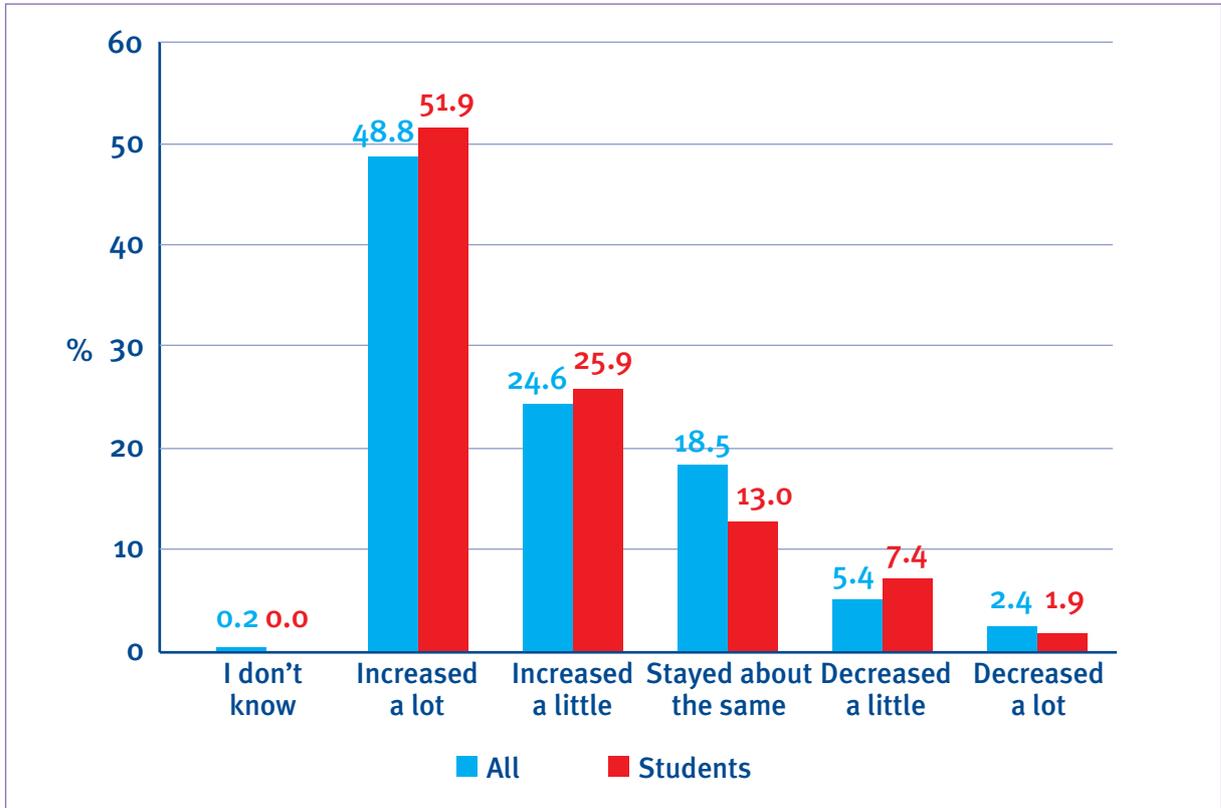
This section looks at the findings from the HSE management standards indicator tool, comparing results for students to the whole group.

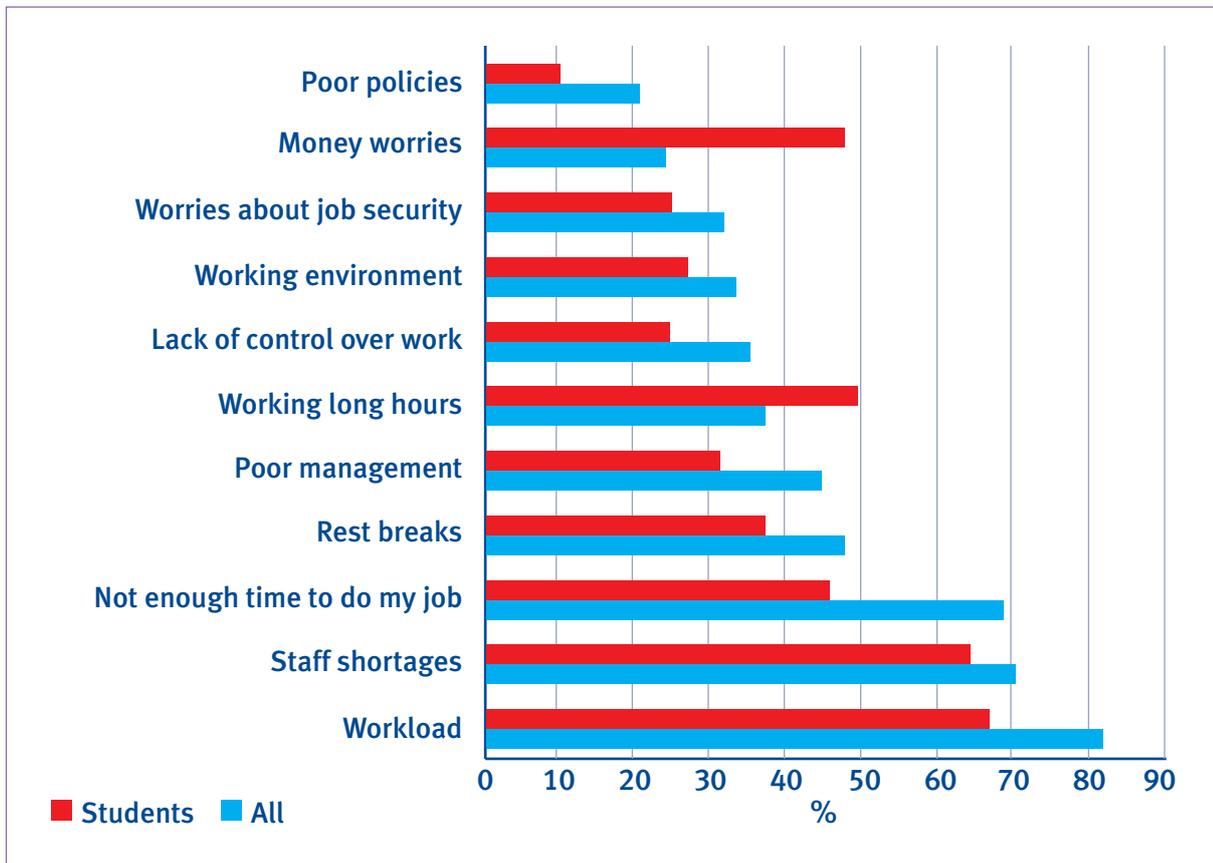
	All	Students
	1=low wellbeing 5=high wellbeing	
Demands	2.50	2.86
Control	3.08	2.79
Managerial support	3.08	2.79
Peer support	3.56	3.69
Role	4.20	4.01
Change	2.78	2.75

Overall, pre-registration students on placement indicated a marginally higher level of wellbeing than nursing staff in general in relation to the demands made on them and peer support. However, levels of wellbeing relating to control over work, job role and change at work are all lower, suggesting dissatisfaction at how placements are designed and managed.

Chart 7 indicates that a slightly higher proportion of pre-registration students stated that their levels of stress had increased over the previous year than the whole group (78 per cent compared to 73 per cent).

**Chart 7: Over the last 12 months, my personal level of stress has... (All n=1,926, Students n=54)**



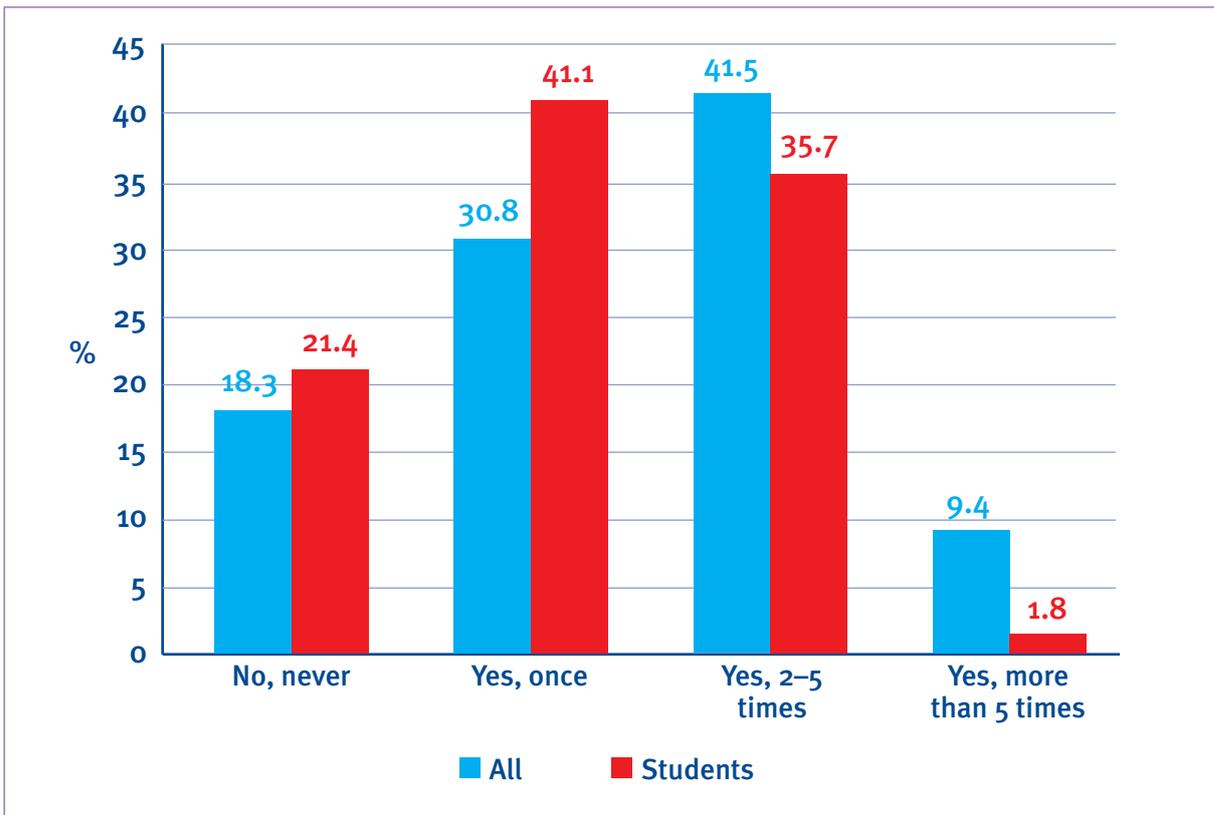
**Chart 8: Reasons for high and/or increased levels of stress (All n=1,588, Students n = 48)**

In common with respondents in employment, students expressed high levels of concern about staff shortages and workload. A higher proportion of students cited money worries and working long hours as a source of stress. In the comments given by students, many said they were anxious about fitting in training with university work, and felt unsupported during placements. One respondent said they felt under pressure because of “*not being able to do things as a student and not having a mentor around. Being treated as health care assistant and not being taught skills I need to learn*”.

## 10.3 Presenteeism

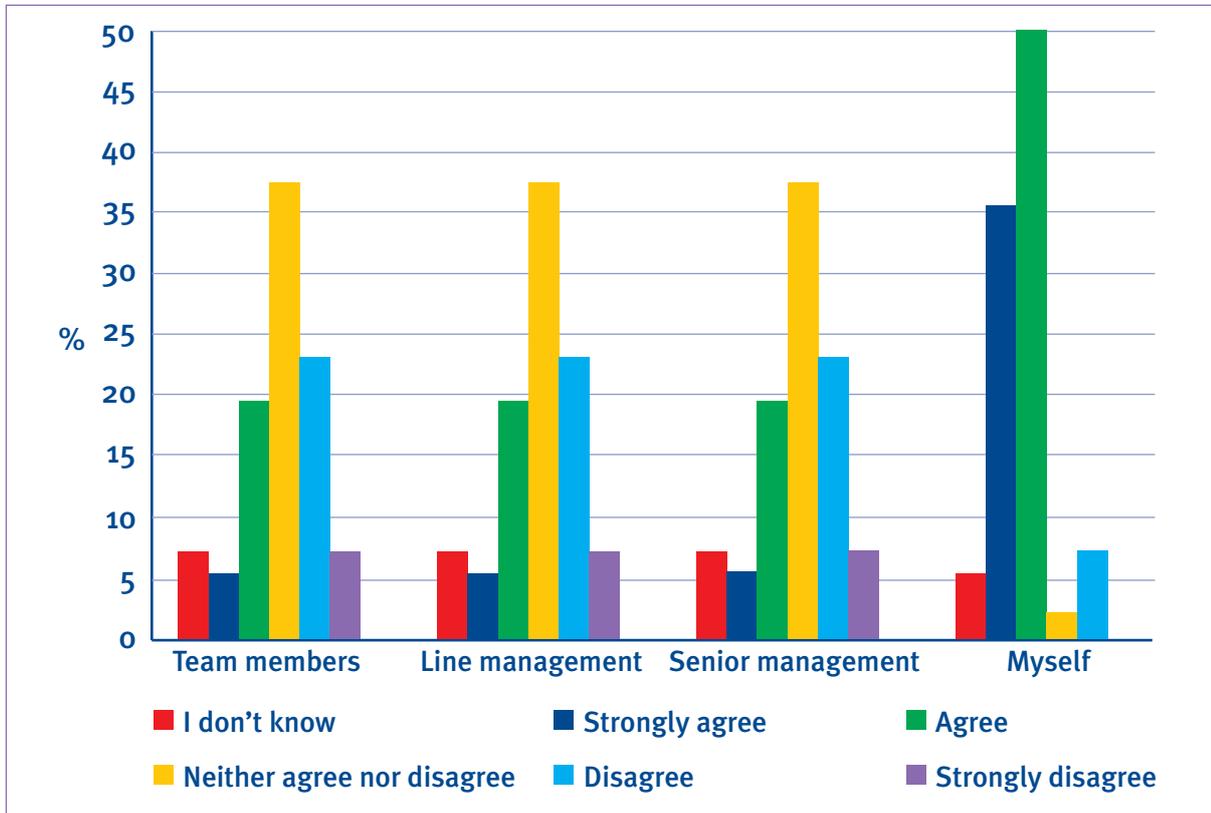
When asked about their current or latest placement, the majority of students (79 per cent) stated that they have gone into work despite feeling unwell or unfit at least once over the previous 12 months.

**Chart 9: Over the previous 12 months, have you gone to work despite feeling that you really should have taken sick leave due to your state of health? (All n=1,926, Students n = 56)**



Much like all nursing respondents, the pressure for students to go to work despite feeling unfit or unwell comes mostly from themselves. More than eight-in-ten (86 per cent) agreed or strongly agreed they feel under pressure from themselves, a third (30 per cent) said they feel under pressure from line managers, a quarter (25 per cent) said pressure comes from team members and 18 per cent said that pressure is felt from senior management.

**Chart 10: Do you feel under pressure (from other team members/line manager/senior managers/myself) to go into work when you feel unwell? (n=56)**



The comments below give sample of students' experiences of their placements. Universities require students to attend 100 per cent of their placements, and students are usually required report any periods of sickness or absence to their allocated practice placement and the university.

*"In my current placement I feel run down, psychologically exhausted. There is no one to turn to as there is nobody around. I feel helpless and guilty as I don't manage to fulfil demands of patients. It is hard to learn anything under stress like this. Most of the staff are extremely busy so I cannot say they are not supporting me, but I am endangering my health and the wellbeing of patients. I have never been off sick on placement but lately I've started feeling like I am giving up. Instead of learning clinical skills I perform basic and manual handling on my own."*

Pre-registration student on adult general/medical/surgical placement (aged 26-34)

*"I have repeatedly been told the serious consequences of being ill and missing placement."*

Pre-registration student on learning disabilities placement (aged 35-44)

*"I don't like to take time off as I feel it looks bad on my references and I have to make up the hours another time."*

Pre-registration student on mental health placement (aged 25 under)

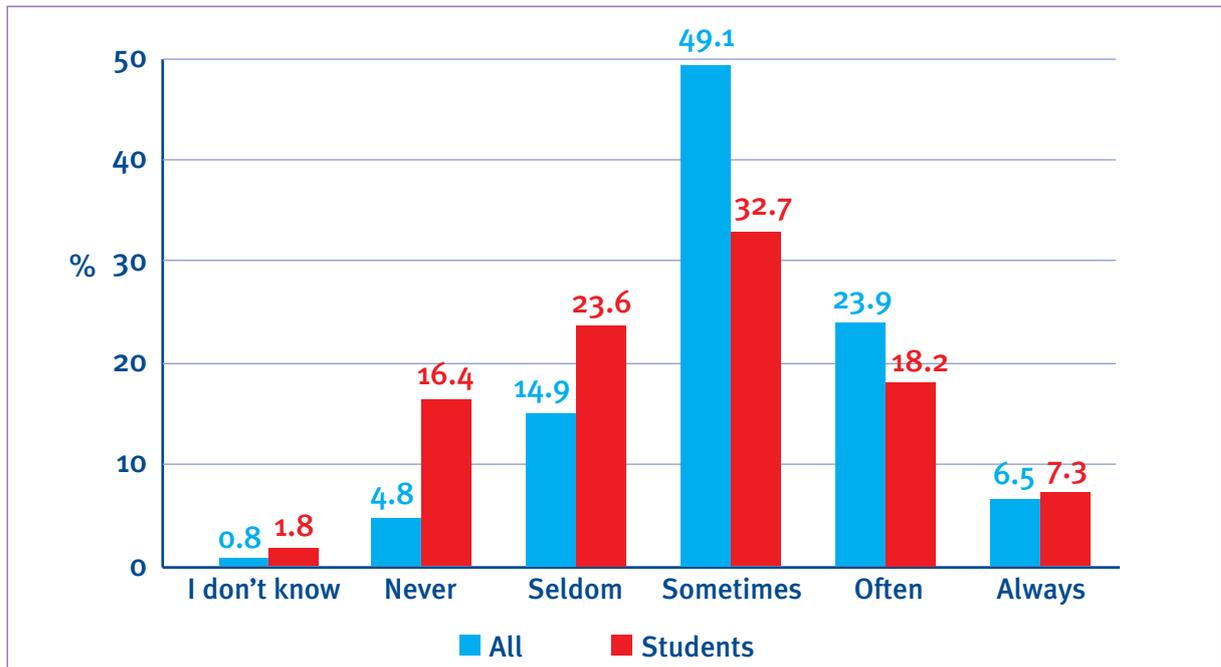
*"I am expected to ring in and give details on a daily basis of my progress through recovery, which I found intrusive rather than supportive. I was not advised that if I was ill for such a period of time that I would fail the placement."*

Pre-registration student on acute/urgent care placement (aged 35-44)

## 10.4 Health and wellbeing

Students are less likely than respondents in employment to state that their working life has a negative impact on their health and wellbeing, with around 40 per cent stating it seldom or never has an impact, compared to just 20 per cent of the larger group of respondents.

**Chart 11: My working life has a negative impact on my health and wellbeing (All n=1,594, Students n=55)**



When probed further about the causes of ill health or injury at work, it is somewhat alarming to note that students are more likely to cite moving and handling and needlestick/sharps injuries than those respondents in employment.

A higher proportion of students stated that they had personal experience of verbal or physical violence from patients or service users than respondents in employment, but a lower proportion said they had experienced violence from relatives of patients or users.

**Table 24: During the last 12 months have you felt unwell or been injured as a result of any of the following at work?**

	All %	Students %
Stress at work	54.8	42.9
Workload	45.9	32.1
Relationships with managers/colleagues	32.0	23.2
Moving and handling	11.5	25.0
Needlesticks/sharps injuries	4.4	8.9
Slip, trip or fall at work	3.4	3.6
Exposure to harmful substances	0.9	5.4

**Table 25: Have you had personal experience of any of the following?**

	All %	Students %
<b>Verbal or physical violence</b>		
Patients/service users	56.3	60.7
Relatives of patients/service users	47.6	26.8
Colleagues	20.7	14.3
Other members of the public	14.8	16.1
Manager/team leader	14.7	7.1
<b>Workplace bullying</b>		
Manager	22.6	12.5
Colleague	21.0	33.9

## 10.5 Newly-qualified nurses

Responses from relatively newly-qualified nurses provide an interesting perspective on the early stages of the nursing career, looking back at placements and preceptorships.

One staff nurse, currently working in a private clinic told us that: *“I did not have preceptorship after qualifying, I had a large preceptorship folder and a first meeting and never did anything after that. I was thrown in the deep end and although I had some great training opportunities and support from managers, other staff nurses were very unsupportive and expected far too much from me as a newly qualified nurse. Some colleagues are very intimidating at times and often try to blame you for their mistakes using the fact that I only qualified a year ago as an excuse. They use their age and years of experience to make me feel like I don’t know what I am doing.”*

Telephone interviews with two other newly-qualified nurses revealed similar experiences. For example ‘Richard’ described his preceptorship and whole first year of nursing as *“terrible”*, due mostly he says to the level of bullying towards new and inexperienced nurses and that *“often people don’t even know they’re doing it”*.

Richard believes that newly-qualified nurses need a great deal of guidance and help from other nurses and line managers as decision making and clinical skills are still developing. He points particularly to situations where he and fellow newly-qualified nurses have made mistakes and have got in trouble rather than the situation being treated as a learning opportunity.

## 10.6 Willis Commission

The Willis Commission on Nursing Education produced a report in autumn 2012 examining which features of pre-registration nursing education in the UK and what types of support for newly registered practitioners are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services (Willis Commission, 2012). The Commission found that high quality mentorship, preceptorship and continuing professional development are crucial to improving patient outcomes and made the following recommendations, with regard to practice placements:

- **the quality of many practice learning experiences urgently needs improvement.** Learning to care in real-life settings lies at the heart of patient-centred education and learning to be a nurse
- **employers and universities must together identify positive practice environments in a wide range of settings.** Many more placements must be made available in community settings, including medical general practice. The absence of funding to HEIs to support nursing students’ practical learning experiences must be addressed
- **employers must ensure mentors have dedicated time for mentorship, while universities should play their full part in training and updating mentors.** Mentors must be selected for their knowledge, skills and motivation; adequately prepared; well supported; and valued, with a recognised status.

## 10.7 Recommendations

The RCN toolkit *Helping students get the best from their practice placements* (RCN, 2006) makes it clear that practice placements are a vital component of the student experience. As well as setting out students’ responsibility while on placement, it also sets out responsibilities for providers, higher education institutions, personal tutors and mentors.

Providers have a responsibility to:

- recognise a student’s supernumerary status, so the student has the opportunity of learning in the practice placement
- ensure that the environment has a philosophy of care, and appropriate policies and guidelines for care
- ensure a meaningful mentoring relationship that enables a student’s development and promotes increasing confidence in professional practice
- provide students with an effective orientation and induction to the practice area, including policies on sickness, uniform and so forth
- allocate a named mentor within the first week
- provide opportunities for students to experience the 24-hour, seven-days a week pattern of care where appropriate.

## 11

## Conclusions

Higher education institutions (HEIs) have a responsibility to:

- monitor both the capacity and quality of all practice placements to meet statutory and professional body requirements
- ensure that practice placements meet all standards for the specific programme validated by the HEI
- provide sufficient numbers of link lecturers and practitioners to support students and staff in placements
- ensure students can readily access support structures while in their placement.

The findings of this survey highlight the high levels of stress among the nursing workforce. Stress can cause health problems, physical injuries, psychological effects and burnout. In addition to the high personal toll, stress is a major cause of both sickness absence and presenteeism and affects workers' ability to be effective.

The research reveals that the main causes of stress are high workloads, long hours, unrealistic expectations, lack of job control, conflicting roles, bullying and violence, poor working relationships and a lack of engagement in workplace change. Addressing these problems is an obvious way to improve nurses' working experience, while also improving the safety and quality of care for patients.

Issues of workload, stress and working life are often symptoms of systemic organisational problems. Poor work environments and working relationships damage the ability of nursing staff to provide safe care – there is a direct correlation between job satisfaction and patient satisfaction.

Nursing staff concerned about their inability to meet their professional standards of care must be able to raise their concerns in a safe and protected way.

The Francis Inquiry final report (2013) reinforced the importance of an open culture which enables concerns to be raised and disclosed freely without fear, and for questions to be answered. While this inquiry raises acute questions about whistleblowing and the importance of preventing and eliminating wrongdoing at work, the RCN believes that nursing staff should also be able to raise concerns about the issues raised in this survey – workload, staffing levels, bullying and working relationships. A *Nursing Times* survey (*Nursing Times*, March 2013) also found that a third of respondents felt they were likely to face negative consequences or be ignored as a result of raising concerns.

# Raising concerns

## RCN guidance

The RCN has produced a series of resources to provide guidance to members and RCN representatives on raising concerns, highlighting the responsibilities of all in respect of the importance of preventing and eliminating wrongdoing at work. The RCN recommends that members and representatives should be watchful for unsafe, illegal or unethical conduct and report anything of this nature to employers, who have a duty to respond; if they do not then the RCN can help escalate concerns.

One respondent to the RCN survey shared their experiences of raising concerns about demands and workloads:

*“Demands and workloads are completely unachievable, we are continuously threatened with disciplinary action if [data inputting] isn’t done within three days of patient visits despite having lists day in day out, [and the fact that] we are over capacity, working 62 hour weeks. When brought to managers’ attention they say it’s our fault saying ‘if you choose to work over your time that’s your choice’, ‘poor time management’, ‘driving like a snail’ or ‘being too thorough.’ It’s totally unachievable every single day and worst of all it is affecting patient safety and care. Currently commencing a procedure of ‘Raising Concerns’ with the RCN.”*

Community nurse, social enterprise

It is essential that health and social care organisations put in place effective mechanisms to enable staff to raise concerns on such issues as staffing levels and pressure of work, particularly when these get in the way of delivering patient care. Organisations should have policies in place outlining the processes to follow when raising concerns.

RCN members can draw on member resources and local RCN representatives for support on how to raise concerns; RCN workplace representatives can play an important role in supporting members in raising concerns and highlighting issues to management.

The RCN guidance encourages members to raise a matter or issue and ask the RCN to discuss and decide if it can be considered as a concern and, if so, respond collectively. It gives the following examples of issues or concerns:

- changes to the staffing or skill mix in an area will result/ is resulting in staff not having sufficient time to answer call bells promptly or monitor patients effectively
- changing mandatory training to an e-learning format that may not be fit for purpose or providing staff with the necessary skills to deliver high quality care
- changing shift patterns that may have an effect on the health and wellbeing of staff or effect their ability to deliver appropriate levels of care
- a lack of moving and handling equipment on the ward or poorly maintained equipment.

The guidance states that in matters such as these, representatives can work in partnership to raise these concerns in the appropriate forum (staff side, health and safety committee, training and education committee) and prevent a problem emerging in the first place.

By raising concerns early, before any impact on patient care, unions can offer support in finding pragmatic and workable solutions.

# Appendix 1: Pen pictures from telephone interviews

## **‘Ann’ is a full-time site leader in a private hospital in England. She is aged between 55 and 64 and is black.**

Ann’s working day is very busy and she works long days (usually 3 x 12 hour shifts). She says her job is very results driven, and that she derives satisfaction out of feeling able to get to the end of a shift having supported staff and patients. Her main worry is not having her and her team’s achievements fully recognised from senior managers. She says it would nice to feel appreciated once in a while.

When asked about her company’s policies on health and wellbeing, Ann feels it’s ‘talk-talk’ at the moment, but hopes this ‘talk-talk’ will translate into something positive with clinics for staff and improved occupational health services.

She acknowledges that presenteeism is an issue in the hospital and said: “You always think you’re going to let people down if you’re off sick. I feel under pressure from my manager but she’s under pressure from the top.” She links this pressure to feelings of stress among the whole workforce: “You have your manager breathing down your neck to cut costs and boost profits and on the other side you have patients who are paying for their care and their expectations are high. And there are rumours of redundancies, so we are under extreme pressure in the private sector.”

Her responses also highlight the sensitive and subjective nature of organisational culture and bullying, stating that there is a degree of bullying in the hospital and that “in one sense, it’s the right kind of bullying and trying to get people to do things. Sometimes, it’s the wrong kind because you don’t like the person because of her race or gender or whatever.”

## **‘Joanne’ is a full-time urgent care practitioner in Scotland. She is aged 55-64 and white.**

Joanne explains that her job can be very stressful, having to deal with an unpredictable flow of patients, with varying level of acuity. “It is highly challenging but I love it!”

Having a well-functioning service depends on having the appropriate level of staff and Joanne worries that staffing shortages are compromising safety. She told us that “the manager is doing what she can, but budgets are tight.” She also said that problems caused by shortages are only aggravated by staff sickness absence.

Stress levels are also heightened by the nature of the job, dealing with a constant flow of patients who can be anxious and in acute need of help. She explained that “nurses can be open to complaints and that can be very unpleasant and stressful - and this is getting worse”. She described instances of where patients had made complaints about the care she had given, but fortunately these had been handled well by her manager and she had felt well supported.

## **‘Barbara’ is a part-time occupational health nurse for a private company in England. She is aged between 55 and 64 is white.**

Barbara says the best thing about her job is helping people feel better about themselves, particularly when they are going through difficult periods in their lives, often compounded by the fear of redundancy. Frustrations with her job lie mostly with her inability to make positive changes to her clients’ workplaces, ranging from employers’ delays in putting in place appropriate changes in the work setting, to dealing with clients she believes are ‘bullied out’ of the workplace.

She describes having a good relationship with her team and managers, feeling that her work is valued and says that being able to offload to colleagues makes the biggest difference in being able to cope with the work.

Speaking as a nurse, rather than as an occupational health adviser, Barbara says she’s amazed about at the extent of mental health issues among fellow nurses, particularly low mood. She says: “There’s an expectation that as a nurse you can’t just leave if there’s work to be done. I believe consultants and doctors have no regard for nurses and undermine nurses. It needs to be a collaborative workplace.”

**‘Sian’ is a full-time senior specialist nurse in the NHS in England. She is aged between 26 and 34 and is white.**

Sian enjoys supporting her patients and their relatives in what she says is a highly emotionally stressful job, but gets frustrated by staff shortages in her department. While she describes having a supportive relationship with her line manager, she recognises that managers are under pressure to reach targets and this causes tensions. She cites problems caused by the sickness absence policy in place at her trust, which is causing anxiety among staff. Sian says that: “They say you need to improve sickness absence levels, but do nothing to support staff.” She also described feeling that she was letting colleagues down if she is off sick.

Sian is highly appreciative of having access to a clinical psychologist who works closely with staff, patients and their families. Apart from this resource, however, she says that health and wellbeing provision is poor. She advocates better guidance for employers and managers to support health and wellbeing, and in particular improved awareness of mental health issues. Nursing is an emotionally draining profession and staff need appropriate support.

She would also like to see major improvements in the trust’s treatment of complaints, feeling that instead of addressing a particular issue or problem, managers merely follow up complaints with emails to all nurses reminding them of trust policies. She says this only serves to upset the balance within the department.

**‘Helen’ is a full-time clinical nurse specialist in the NHS in England. She is aged between 45 and 54 and is white.**

Helen says every day is stressful and that this is mostly due to staff shortages and heavy workloads. Despite asking for over two years for at least two more part-time members of staff, this has been refused and recruitment freezes have been put in place. “You push yourself to the limit to make sure that no harm occurs,” she says, but feels strongly that staff do not feel cared for or supported by managers.

Helen considers that nurses can be their own worst enemy, saying “the more you deal with what you’ve got the more they [managers] will let you get on dealing with it... we’ve made a rod for our own back”. She says that problems caused by staff shortages and workloads are made even more serious if she or her colleagues are unfit or unwell. She says

that there are only two in her team and “we only phone in sick if we’re practically dead and that leaves the other with everything. And that’s not safe.”

Helen feels let down by the lack of support from managers and feels that she and her colleagues are never praised for their work and do not receive sufficient training and development. At the time of the interview, Helen’s trust had an emergency escalation situation over winter beds and staffing levels. She feels aggrieved about how this situation was dealt with, stating that she felt “emotionally blackmailed” to work overtime to cover extra shifts and while overtime pay was given, she would have preferred time off in lieu.

**‘Tamsin’ is a nurse adviser working for a private company in England. She is aged between 35 and 44 and is white.**

Tamsin works part-time ‘office hours’ and has worked for the company for about a year. She says that her job fits well with home life and caring responsibilities for children. Her previous job was in a nursing home, but left due to illness and sought alternative employment that was less physically demanding. She is pleased that the illness has not forced her out of nursing altogether and likes being able to continue using her skills.

Although she is still relatively new to the job she is highly appreciative of the supportive she has received so far from her manager and particularly showing understanding about needing time off for surgery.

When she started at the company she received relevant training, feels confident to be able to update her skills if necessary and that she can consult other colleagues on clinical issues. She is also satisfied with pay, terms and conditions and pensions.

**‘Sue’ is a full-time district nurse in Scotland. She is aged between 45 and 54 and is white.**

Sue says that contracted hours are 8.30am-5pm, but she usually starts work earlier and rarely gets home before 7pm most nights.

She describes a heavy workload, having to catch up with admin after seeing patients as she has no administrative support, and often drives around 70 miles a day to visit

patients. She also describes a high level of stress due to taking on a new role of triaging: assessing whether patients should be referred to a doctor. She says that this is on top of her own caseload and in any case does not feel sufficiently trained to carry out the role. She says: “I don’t have a problem with doing the job I’m trained for and the admin. I just have a problem with being a doctor.”

“GPs should be triaging their own calls, and if they want us to see somebody – it should be that way round. GPs are not really concerned about the impact of the workload on us. I’m worried that something will go drastically wrong and it’s my neck on the line.”

On top of this heavy and increasing workload, Sue has recently been diagnosed with a chronic illness and had to pull out of a clinical skills course. She feels that her employer has been supportive around her illness so far, but does not feel confident that they would be flexible with her hours or workload if her condition deteriorated. She says “I’m looking after everybody else. But who’s looking after me? Certainly not me. You just give them more and more, but I don’t want to be seen to be failing at my job because I’ll be shown the door.”

**‘Gill’ is a full-time health visitor in Scotland. She is aged between 55 and 64 and is white.**

Gill works office hours, but states she regularly works additional hours to keep on top of her workload, describing the paperwork as ‘horrendous.’ She says she feels stressed by having to keep up with new policies and guidance and record keeping, all on top of running clinics and conducting clinical supervision. Gill travels a lot with her job and states that problems related to parking, rather than travel itself, cause a great deal of stress. She also feels under pressure due to the sheer volume of change, with the introduction of new initiatives and ways of working, but says she has a good team leader who is looking at ways to give the team more support.

She also appreciates the good working relationships among her team members and points to the necessity of clinical supervision. She says it is vital that nurses are given the opportunity to talk things through at work, with emotional support. However, this confidence in her team is not matched by confidence in senior management. She says: “We all feel very frightened. There are so many nurses and they don’t want to pay us. So they’re trying to downband our jobs and people feel very helpless and very demotivated. That’s

how my colleagues feel and not valued at all and frightened for the future.”

She says these feelings of anxiety are made worse by sickness absence policies. “A lot of staff have said they’re frightened to take time off because they’ll get an interview. There are people coming in with heavy colds or coming back early. They’re either scared of racking up sick leave, or very, very aware of the pressure the rest of team is under and that their work will have to be divided among the team.”

Gill also points to the support available for lone workers, stating that while some structures are in place, there is no lone working system in place, despite working in environments that can be unsafe. She says: “We’ve waited months for the new system to be put in place. This just reinforces the feeling that we’re not cared for.”

She says she recognises that the NHS has tried to introduce initiatives to improve staff health and wellbeing such as healthy eating and exercise. Her response to this is: “It would be nice to have the time... These things aren’t helping us – we know we’re stressed out. We can see the need, but just don’t have the time.”

She ends the interview by stating: “I’ve always loved nursing but we always seem to be undergoing change and never settling.”

**‘Amy’ is a full-time staff nurse in an independent sector care home in England. She is aged between 35 and 44 and is white.**

Amy has recently started working in her current job after having poor previous working experiences at two different nursing homes, where she says there was no respect from the owners for either staff or patients.

In her previous role, she says her manager would not accommodate her requests on working hours and tried to force her to work a 60 hour week. She got a sick note for work-related stress, but her manager refused to accept it. She returned to work on reduced hours despite being signed off work, but when ready to go back to her usual hours she was told that those hours had been filled. Amy describes her treatment as ‘psychological abuse.’ In the job prior to this, she says that staff turnover was high in the home and that other members of staff had reported the owner for being disrespectful to nurses and other staff. Amy herself reported

a lack of equipment to the CQC feeling that problems there put her in a vulnerable position.

While she admits having reservations about moving to another nursing home after these two bad experiences, Amy says that her current post is a completely different environment: “It seems a lot better here and they are always asking if everything is ok. I feel like I’m respected. It’s early days, but so far so good.”

**‘Jan’ is a full-time senior nurse in a social enterprise in England. She is aged between 55 and 64 and is white. She is due to retire next year.**

Jan works for a community interest company treating NHS patients. She is a staff member on the board; she was involved in the transfer and continues to be involved in much of the decision making.

She enjoys working at the unit stating that there is a great team in place and everybody is very supportive. As a team leader she says that her main complaint is what she describes as the lack of flexibility with the Agenda for Change framework to be able to better reward health care assistants. Jan says she has tried to get the HCAs in her team upgraded, but cannot within the current system. She also says that the sickness absence payments are too generous and that she would like the flexibility to put in place different arrangements.

**‘Carrie’ works as a support worker in the NHS in England. She is aged between 35 and 44 and is white.**

Carrie works with children with severe learning disabilities and their families. She works condensed hours to fit with caring responsibilities.

She enjoys her job and likes being busy, and feeling she has good supervision and support, so if anything has gone wrong she feels able to pick up the phone to the lead clinician. She appreciates the opportunity to have time to reflect under supervision and said that: “If I’m not able to offload, that can be quite stressful.”

Carrie says she works in a small team, with most of her support coming from her supervisor than the team, but that she has good relationships with her colleagues. She says that apart from support from her supervisor, she does not feel well supported in terms of support for own health and

wellbeing. She adds that she has used occupational health services previously which she found useful, but found it frustrating having to chase everything up herself.

**‘Lucy’ is a full-time clinical team leader in England. She is aged between 55 and 64 and is white.**

Lucy is a team leader responsible for a large team of nurses and points to two main barriers to doing her job to the standard she would like. The first barrier is related to unclear lines of responsibility, with Lucy explaining that her work is governed by different managers, each responsible for different, and overlapping, aspects of performance.

She says that the result is feeling pulled in different directions at once, with lack of clarity or focus over decision making. The consequence of this can be poor policies or procedures, citing the example of meetings being arranged at inconvenient times. She also links this to lack of progress on health and wellbeing issues, with nobody taking direct responsibility.

The second major barrier Lucy identified is staff shortages, stating that her team is understaffed by almost half, leading to heavy workloads. She says that increasing numbers of her team tell her they are worried about fulfilling the NMC codes of conduct. Meanwhile she feels under pressure from her managers for her team members to undertake training, but says “we don’t have time for training and taking people out would mean dangerous staffing levels, so as a team leader, I’m caught in the middle”.

**‘Jenny’ is a clinical nurse specialist, working for a private hospital in England. She is aged between 45 and 54 and is white.**

Working as a specialist nurse is evidently a great source of pride and enjoyment for Jenny, having spent years developing both her own skills and the specialist service with the private hospital where she works.

Management decisions that challenge Jenny’s ability to deliver care in the way she aspires to are therefore personally disappointing and frustrating. For example, she described a recent decision to reduce both the number of clinics she runs and the length of appointments, stating “I just can’t deliver a good service in these circumstances. They didn’t consult me about any of the changes. I just run late all the time.”

Jenny understands the pressures facing managers in the private healthcare sector, but says that the combination of making profits and providing a high standard of care is difficult for nurses: “You’re trained to provide the best care you possibly can and go the extra mile for patients and the cost isn’t something you think about, but you have to in the private sector. Management say they want us to deliver high standard care and the patient is the most important but sometimes that doesn’t feel the case and making money is the priority.”

Nevertheless, she feels well paid for the private sector and points to good occupational health services and private medical insurance provided by the company. She feels it is overall a good place to work and would recommend the hospital to patients.

**‘Rahma’ is a staff nurse in the NHS in England. She is aged between 45 and 54 and is black.**

Rahma has recently moved to a specialist hospital after having worked in a general hospital in a different city, desperately frustrated at the lack of career progression opportunities.

She says: “Usually in the trust, you go for a Band 6 job and they train you on those skills. But they said they can’t offer me a Band 6 position because I don’t have those skills. People who had only been qualified for a few years were given opportunities, but not me.”

In her new job as a Band 5 staff nurse, Rahma’s manager has promised her the appropriate training to become a Band 6 nurse and feels confident that her manager is committed to help her progress. Rahma is determined to get on and become a nurse practitioner but cannot understand why she received so little support in her previous job, stating “If a person has been in a job for seven years and you haven’t developed them, you’re just using them and not seeing their potential.”

Rahma also feels bitter that her extensive qualifications and experience gained abroad are not fully recognised in the UK and that her skills have been underused. She feels that this is part of the culture, rather than specific to any particular organisation or sector.

**‘Liz’ is a clinical nurse specialist for a charity in England. She is aged between 55 and 64 and is white.**

Liz works with young people and derives a great deal of job satisfaction from engaging with her clients. Her main frustration and source of stress lies with feeling unsupported by senior management. She explains that: “Their understanding of clinicians’ roles is quite poor. You can tell them you have a problem, but often nothing is done to support you.”

Liz also feels frustration at the lack of time she is given to accomplish her job, particularly time for training and for regular team meetings. She says that the lack of regular meetings means there is no facility for people to ‘iron out problems’ before they get bigger. However, she appreciates the good working relationships developed with colleagues, particularly centred around clinical supervision.

She says that financial restraints mean that her team is understaffed and it is often difficult to get cover, stating: “We really have to fight for support if one of us is on annual leave. We carry each other and we know we’re going to be working long hours to keep the service going, basically doing two people’s work.”

Liz described wider issues in nursing beyond her own job and stated that there is a “misconception that you can train people to do tasks and pay them less”. In reality, “you need well trained staff, able to understand and interpret” as well as valuing ‘basic’ nursing care.

**‘Kathy’ is an emergency nurse practitioner (ENP) in the NHS in Wales working part-time hours. She is aged between 45 and 54 and is white.**

Kathy’s job has undergone enormous change in the last year due to widespread changes in the configuration of services in Wales. Having worked for many years in a nurse-led minor injury unit, the unit was recently moved to the A&E department of the local district general hospital as a temporary measure.

Kathy explains that the move was well supported by management and that her team were offered group therapy sessions which alleviated stress among her team to a large degree. However, a further change came after the unit was reopened with the team redeployed to rotate between the minor injuries unit and the A&E department.

She explains that this development has been extremely stressful for her and her colleagues, feeling forced to work at a level beyond their scope. She says that ENPs are being “used in a medical role, but we should be supplementary to medical staff not a replacement”.

Kathy feels that her unit has become the “victim of our own success”. She and her colleagues have undertaken extensive training, successfully completing a wide range of academic and practical qualifications, helping to develop and shape the service they provide. She acknowledges that some of her colleagues do wish to take on extended and advanced roles and to work as consultant nurses, but others prefer to work at their current levels. She states: “We provide a good service and have a high educational standard to support that service. Some nurses are keen to work at an advanced level, but the majority are 50 plus and we have reached an advanced point in our career that we’re happy with and don’t want to be pushed into anything. We’re more expensive than an A&E staff nurse but cheaper than a doctor. Doctors can’t mop floors and toilet patients, but nurses can’t order and interpret an x-ray. We can cover all bases for one wage so we can see how we’re being used financially. We feel like pawns in a game, with no one thinking we have opinions and ambitions.”

Further stress has been caused by having a split role between the minor injuries unit and A&E, meaning that she and colleagues work at different levels of competence depending on where they work. Being embedded in A&E also causes problems, with difficulties experienced by both nurse practitioners and A&E nurses in working alongside each other. Kathy says that this has been a source of stress for colleagues, with some having been referred to occupational health. Yet she is amazed at the low level of sickness absence through this period of change, which she attributes entirely to loyalty to the service they provide and colleagues.

Kathy is determined to make the new arrangements successful but has recently heard that the minor injuries unit will imminently be closed for good, and that redundancies are expected.

**‘Katie’ is a full-time staff nurse working for the NHS in England. She 25 years old or younger and is white.**

Katie has been a qualified nurse for around five years and currently works in an emergency assessment unit. She recently started this role after becoming dissatisfied with her

previous role. She explains that her frustration lay with her feeling that her line manager showed favouritism to certain nurses, by being less strict with one group and allowing them to take advantage of training courses. Katie says she is at the end of a long line of nurses who have left due to frustration with the management style. She says: “There wasn’t a week that would go past without someone being upset.”

Katie describes the environment as very cliquey and was frustrated that she felt unable to talk to some of the more senior nurses about the situation, while others outside the clique had no power to challenge the line manager.

She states that an unprofessional attitude had taken hold in the ward due to the favouritism shown by the line manager, meaning that she felt pressured to complete her workload without the support of colleagues. At the time of the interview, Katie was due to start a new job in the same type of ward but a different trust and seemed optimistic and excited about the new post stating, “I’m looking forward to the fresh start, there is better equipment and a better feel.”

**‘Will’ is a community nurse in the NHS in England, working full-time hours. He is 25 years old or younger and is white.**

Will qualified as a nurse in 2010 and has worked as a community nurse for around several months, having decided early on in his nursing career that he wanted to work to specialise in his area of interest. He explains that he didn’t have quite the right experience at the time he applied for the post, but his supervisor helped by organising the appropriate training and support to help him adapt. He says: “I feel grateful that I’ve been able to get where I want to be so quickly.”

It is obvious that Will is enjoying his new job and appreciates the opportunities it is giving him. He enjoys the multi-disciplinary nature of the job and the training offered. He recognises that the job is stressful and that the burnout rate could be high, but states that colleagues look after each other work and give each other a helping hand. He says that he benefits from clinical supervision and while he recognises that it doesn’t occur as often as planned, there are other opportunities to ‘offload’.

The main stress factors in his job relate to heavy workloads and bureaucracy, stating that everything has to be diarised

and that “you constantly feel you’re chasing paperwork.” However, after having unsatisfactory experiences in his preceptorship and previous job, the positive factors of his current job outweigh these problems.

Will states that he was bullied in his first job and was on sick leave for a long period because of it. This was obviously a distressing time for Will, but is now able to reflect on the experience, stating that “it makes you realise how important it is to find a good job with a good team and luckily at the start of your career you can slot into different areas”.

Will says he is very happy in his job, but feels frustrated that the job is on a six month contract. He is confident that his employers want to keep him on permanently, but acknowledges that the decision is due to financial pressures. He explains that most jobs currently advertised are short-term contracts and this situation is not good for nurses’ security or peace of mind.

**‘Richard’ is a full-time staff nurse in the NHS in England. He is 25 years old or younger and is white.**

Richard works as an intensive care nurse, working what he describes as ‘changeable, erratic shifts.’ This in itself, is not a problem, but explains that there is little consultation over rota scheduling.

As a relatively newly-qualified nurse, Richard’s experience of the preceptorship training and first years of nursing are significant to his outlook on nursing. Unfortunately he describes his preceptorship and whole first year of nursing as “terrible”, due mostly he says to the level of bullying towards new and inexperienced nurses and that “often people don’t even know they’re doing it”. He wonders how nurses can be “so horrible to each other, but so nice to patients and relatives,” but feels that this experience toughened him up, and now feels more confident.

He says that newly qualified nurses need a great deal of guidance and help from other nurses and line managers as their decision making skills and clinical skills are still developing. He points particularly to situations where he and fellow newly qualified nurses have made mistakes and have got in trouble rather than the situation being treated as a learning opportunity.

Richard describes two situations where he was told off by his manager, explaining that one instance occurred because there was nobody to ask for help. He says that in both cases he felt like he was being performance managed rather than supported by his line manager. He left this job stating that he “couldn’t cope with those kinds of working conditions”.

Richard says he recognises that managers are under pressure and that this can result in bullying behaviour, “because I can’t think of any other reason that people act that way”. He is aware that managers are under pressures from senior levels, and this has put him off being a manager in the NHS. Yet he also feels that career prospects for band 5 nurses are being limited, with opportunities for progression slowing down and so leading to resentment among the biggest group of nurses in the NHS.

Richard goes on to reflect on the impact of the recent criticism of nursing care on morale among the nursing workforce, stating that he feels like nurses are being victimised. He says that “I have never personally seen poor care, but I know that there are staffing shortages and that will affect care in some way”. He goes on to say that: “It’s not nurses’ inherent care or skill levels that causes problems, it’s staffing levels. If these were appropriate – care would fine and it’s insulting to say otherwise.” He finishes by saying: “I look after my patients and that is why you’re stressed. You wouldn’t be stressed if you didn’t care.”

**‘Martina’ is a full-time clinical nurse specialist in the NHS in England. She is aged between 35 and 44 and is white.**

Martina has worked as a nurse for around 20 years and is currently a nurse specialist. She trained abroad in Europe and has worked in the UK since 2006.

Martina explains that she used to work five days a week, and increasingly found herself working far longer than contracted hours. Without being able to get the time back, she moved to a compressed four day week with longer days. She states that she likes having the day off and feels more in control of her workload.

She enjoys her job and says getting acknowledgement or thanks from patients or their families makes all the difference. The negative aspects of her job she says come from strained relationships between teams: blaming each other when something goes wrong. She explains that the

biggest tensions exist between different disciplines, due to a lack of understanding of what other people do. However, she describes a good relationship between her and her line manager and clinical director and says they make her and her colleagues feel valued and supported. She also says her colleagues are very supportive of each other.

Martina also says that working with very sick children is highly emotionally stressful, yet feels that there is not enough support. She says that she would like more opportunity to reflect on the care she gives, but says “it’s hard to go home and not think about things, it is so emotional draining”. Martina also says that training has been limited only to mandatory study days, but would appreciate more opportunities for reflection or counselling.

She goes on to describe the tension between working with immune compromised children and looking after her own health and wellbeing. She says it is particularly important not to be working when unwell so as not to put patients at danger, but “you know that colleagues will suffer and you don’t want to let them down. We are very protective of each other”.

She also describes pressure from HR policies, stating that “you feel you have to justify yourself if you’re off work and you feel under pressure. Managers support us, but there is pressure from HR.”

**‘Fiona’ is an advanced nurse practitioner in the NHS in Scotland. She is aged between 35 and 44 and is white.**

Fiona enjoys the autonomous aspect of her job; she has her own caseload and generally manages her own hours and commitments. She enjoys the opportunity to both run clinics and work in the community, with flexibility around managing her time. She says she has good support from colleagues and enjoys working part-time hours, stating that this allows a good work-life balance. She recognises that colleagues working full-time are often more stressed.

Fiona says that both patients and consultants value her work and contribution to patient care. She says she particularly values the “huge change” she has experienced in working relationships with medical staff over her career in that there is more respect, with doctors actively asking for her opinion. However, she feels less valued by her line manager who only expresses appreciation when pressed to do so, with no “general culture of telling us we’ve done a good job”.

The biggest sources of stress for Fiona come she says from the negative impact of a ‘box ticking’ approach to management, and the need for more staff and resources. She makes reference to her team’s involvement in a range of pilots. She says that they are very interesting and valuable to the service, but team members don’t get enough time or support for them, as managers’ interest in them has waned over time.

Fiona also refers to lack of time and support for training and development, explaining that she and her team members are expected to attend courses in their own time. She states “I work at a senior level, but everything is constantly changing and we need to keep our knowledge and skills updated.”

**‘Daniel’ is a full-time NHS staff nurse in England. He is aged between 44 and 54 and is mixed race.**

Daniel is a highly experienced staff nurse, qualified for over twenty years. He regrets some of the changes he’s seen in the NHS over this time, particularly the speed that the system now works at, having to cope with ever increasing numbers of people. He says that this relentless pace means that “it’s become more possible over the years either to make a mistake, to forget something or not fully act to your potential as part of your duty”. Allied to that, he sees that the focus on nurses has changed from a professional to a more legal one, and this gets translated into ever more paperwork.

Daniel also believes that the pressure of high workloads means that staff don’t spend enough time with each other, reflecting on patient care and that they need more time for debriefing during the shift.

As an example, Daniel cites the example of hourly check rounds introduced as a pilot. He believes that the initiative felt for the most part like “lip service” stating that it is very difficult to go around a group of patients and make sure the boxes are ticked and do it contemporaneously rather than two to three hours after. “You just worry about missing a tick and somebody coming along later and asking why you haven’t ticked the box and you have to argue your decision.”

He states that while hourly check rounds “can mean that if everything has been done properly and people have made the right judgement, there are records,” but on reflection they also “take away the intention to think for yourself and use your skills.”

Daniel relates that there has been an increase in sickness absence due to stress in his department, and says that this is managed quite differently by different managers.

Acknowledging that sickness absence causes increased workloads for everybody else, Daniel states that the better managers in his department try to make sure that nurses take proper breaks, “but on some wards, you’re not far the end of your shift before you get the chance to have a drink and that can often be people working long days as well.”

Daniel goes on to state that many staff in his department are working long days. He states that long days are supposed to improve continuity of care, but doubts that they do, given the impact on staff wellbeing. He states “if you add in travel times it’s not good for staff, you don’t get chance to rest enough. It also impacts on staff numbers and training opportunities especially if you have even one person off sick.”

Daniel makes the link between national targets and corporate bullying, stating that it is a “significant part of what we go through every day”. He adds that on a one-to-one basis “the way managers sometimes approach staff is dismissive and in the worst cases pre-judgmental, taking the word of some above others, but it’s a very insidious thing and difficult to prove”.

As a Band 5 nurse, Daniel believes that his career prospects are somewhat limited, citing the example of being told by a matron that “if I wanted a Band 6 post, one of the requirements is to put up and shut up, and not make suggestions”. He says that “it’s difficult to look ahead, thinking I’ll be able to be independent and proactive, but I also see the downsides of being a manager and all the hassle that entails”.

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