

The Last Straw

Explaining the NHS nursing shortage

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Contents

Acknowledgements

Executive summary

1. Introduction 1

Background 1

Methodology 3

2. How the public views the NHS and nursing 4

A generally positive image of the NHS 4

Changing expectations 4

Perceptions of nurses and nursing 6

The status of nurses 9

Violence and aggression towards nurses 10

3. Nurses' roles 12

What is a nurse? 12

Health care assistants 15

4. Recruitment and retention of nurses: positive factors 20

Varied reasons for becoming a nurse 20

What makes nurses stay? 23

5. Recruitment and retention of nurses: negative factors 27

Pay 27

Working conditions and facilities 32

Frustration at not being able to do the job properly 33

The need for more staff 38

Discrimination 39

How people are treated at work 41

Stress at work: the need for support 41

The need for more family-friendly working policies and practices 44

Better opportunities elsewhere to use transferable skills 45

6. Gender issues and recruitment and retention of nurses 47

A woman's career? 47

7. Education, training and development 49

The importance of training and development 49

Equal access to training and development opportunities 50

Leadership development 50

Time to reflect on practice 51

Project 2000 52

8. Organisational issues 54

Getting the basics right 54

Effective leadership and management 55

The role of the Region 56

Organisational instability and insecurity 56

9. Conclusion: next steps 58

Listen to staff and empower them 59

Do not rely on staff loyalty 59

More staff 60

Pay and conditions 60

Development for all 60

Tackle discrimination 60

An integrated approach 61

Appendix: Methodology 62

References 64

Acknowledgements

We would particularly like to thank all those people in the NHS and related organisations who took part in the focus groups and the interviews and who were so generous with their time and also their views. Our thanks therefore go to:

The NHS Executive

The London Regional Office of the NHS Executive

RCN

UNISON

UKCC

Outer London and Central and East London Education Consortia

The NHS Confederation

Barking and Havering Health Authority

East London and City Health Authority

BHB Community Health Care NHS Trust

Harrow and Hillingdon NHS Trust

Mayday Healthcare NHS Trust

St George's Healthcare NHS Trust

University College London NHS Trust

Romford, Hornchurch, Upminster, Barking and Dagenham Primary Care Groups

NHS Direct

University of Greenwich

Praise and thanks should also go to the long-suffering secretaries Karen Drake, Clare Ward and Ged Collins at Saxonbury Ltd, who patiently transcribed hours of dialogue, generally without complaint, and our colleagues at the King's Fund: Alison Hill, Steve Dewar and Sue Lloyd-Evelyn, who supported us through all the highs and lows.

Executive summary

About the research

This report examines key issues in the recruitment and retention of nurses in the UK. The research was conducted because there are currently significant recruitment and retention problems across a number of professions within the NHS, but particularly in nursing and the professions allied to medicine. The research consisted of:

- a review of the existing literature and research going back some 20 years, which highlighted a number of themes in the problems of recruiting and retaining nurses in the NHS
- focus groups with nurses
- semi-structured interviews with major stakeholders.

Findings

How the public views the NHS and nursing

On the whole, in spite of many problems, the NHS in general, and nursing in particular, were viewed positively. However, expectations are changing and it is possible that younger people are becoming less convinced, both about the aspirations of the NHS and about its ability to deliver what they want. Nurses were generally viewed positively, but there was a widely held view that all health care employees are viewed more critically than was once the case and nurses now experienced more violence and aggression in the course of their duties. However, generally positive views of nursing were often held alongside a paradoxical view that it was a low status career and not a good choice for one's own children. Some of the more negative stereotypes were thought to be attributable to media stories, but the impact of personal acquaintance with nurses and the NHS was also considerable.

Nurses' roles

Opinions varied on whether there was clarity about the role of nurses, and on whether that was a significant factor affecting the recruitment and retention of nurses. Some felt that the role of the nurse suffered from a range of sometimes-contradictory expectations. These encompassed extended roles and considerable autonomy on the one hand, but nurses still having to function within a narrow hierarchical context on the other. Nursing was seen by some as difficult to define, whilst others were clear about it offering skilled care. Some saw nursing as being squeezed between the role of the doctor and the role of the health care assistant, but on the whole, the contribution of health care assistants was viewed positively, subject to many concerns about the need for them to be properly deployed, trained and supervised.

Recruitment and retention of nurses: positive factors

The research identified a range of reasons why people became nurses, ranging from a wish to work with and care for people to hoping to have opportunities to travel, family background/being socialised into being a nurse and the perception of nursing as a secure career. Sometimes nursing had been the only alternative to unemployment.

Those who remained in nursing did so for a variety of reasons, in particular because of loyalty and commitment. However, there was a strong suggestion that this may not safeguard the future of nursing and such loyalty cannot be relied on. Flexible working and a family-friendly working environment were seen as important factors to encourage retention. Control and autonomy were highly valued where they existed. Opportunities for training and development were also seen as important.

Recruitment and retention of nurses: negative factors

A number of factors were identified as contributing towards nurses leaving their jobs or deterring people from pursuing nursing as a career. A number of individual problems were noted, but it was evident that a complex inter-relationship between

apparently small issues had a cumulative effect. Dissatisfaction with the level of pay was widespread, but was seen as only part of the problem. Other issues included having to leave clinical care in order to increase remuneration, poor working conditions and facilities, e.g. leisure and recreation facilities, child care facilities, catering for staff, car parking, and, above all, accommodation. Of equal importance were the widespread concerns of nurses who felt that they were unable to carry out the jobs for which they were trained to do because of a range of factors, particularly shortages of staff, budgetary constraints and organisational problems. These led to stress and a lack of control in one's job and an inability to work in accordance with training and professional and personal expectations. The transferability of nurses' skills was a further factor in staff moving on. There were also very serious issues of discrimination, particularly racism, in the NHS. Poor personnel practices and an insufficient commitment to family-friendly policies also caused nurses to leave.

Gender issues and recruitment and retention of nurses

As nursing is a predominantly female occupation, assumptions about gender were thought to have relevance to pay and status at work. Gender stereotypes were also seen as relevant to the assumed 'naturalness' of the caring role to women, with consequences for how their roles are perceived.

Education, training and development

Equal access to high quality training and development at all levels were seen as extremely important. However, criticisms were made about the education consortia and about the lack of flexibility in career development for nurses. Leadership development was seen as an important factor for NHS organisations as a whole. It was important to have time to reflect on one's practice, but pressures at work and pressures on budgets sometimes undermined those opportunities.

Views on Project 2000 were polarised. Some criticised it for having an inappropriate balance between theoretical and practical education, for being too academic/too

theoretical/too classroom-based and for being too focused on acute care. The status of Project 2000 nursing students and their level of bursaries were seen as being too low. On the other hand, Project 2000 also attracted positive comments. It was said to encourage assertiveness, to encourage nurses to ask questions and to equip nurses for modern nursing. Therefore, for some, it contrasted favourably with former education programmes for nurses.

Organisational issues

NHS organisations were seen as bureaucratic and not very good at listening to staff. They were seen as needing to improve their skills in listening to nurses and other staff and heeding what they had to say. Management needed to empower nurses to act to improve patient care, thereby also increasing job satisfaction. Commitment to supporting nursing at Regional level was not necessarily perceived at a local level. Moreover, the history and continuing experience of organisational change was seen as uncondusive to the factors supporting staff retention.

Conclusion: next steps

There has been an historic inability to take action on many of the factors that are highlighted in this research, although many of these factors have been noted for some time. It is clear that piecemeal attempts to solve problems will be doomed to fail, since the factors that undermine the stability of the workforce are themselves inter-related. Indeed, the reason why a nurse may finally leave the NHS is often a 'last straw', after years of frustrations and disempowerment, rather than a major cataclysmic event.

A whole systems approach needs to be pursued, based on the following principles and actions:

- listen to staff and empower them to make improvements to services and patient care

- do not rely on staff loyalty as an alternative to improving the working lives of nurses
- make resources available to employ more staff (nurses and support staff)
- review pay and conditions, including access to accommodation, leisure, transport and flexible employment practices
- develop opportunities for training and development at all levels
- tackle discrimination, especially racism, and promote good personnel practices.

Above all, an integrated approach is required. There can be no illusions about a once-and-for-all solution to the problems of nurse recruitment and retention. Only a sustained commitment from government and local NHS management, and an appropriate investment of resources (time and money) can enable full use to be made of the wealth of material that is known about the problems and the possible solutions to nurse recruitment and retention.

1. Introduction

This report examines key issues in the recruitment and retention of nurses in the UK. It is in a long line of publications that seek to understand the issues and set an agenda for change. Many – possibly all – of the concerns highlighted in the literature and by the fieldwork (interviews and focus groups) will be familiar. However, we wish to emphasise that the strongest message to emerge from this report is the inter-relatedness of all of the factors. For the purposes of coherence and comprehensibility, issues have been separated out to some extent, but the reality was that no such separation was made by those who were closest to nursing in the NHS – the nurses themselves.

It is essential that the issues that are outlined in this report are understood singly, but put into practice as a whole system. More pay may attract new nurses but they will leave if they are unsupported. Effective supervision can only take place where there are sufficient resources to enable it. Attitudes to nurses reflect societal attitudes to the caring professions in general and to women in particular. Attracting young black and minority ethnic nurses into the NHS will only work if the NHS actively tackles institutional racism. There is no magic bullet. The only magic is in keeping all balls in the air at once and tackling issues in a holistic way. That is the key message of this research report.

Background

There are currently significant recruitment and retention problems across a number of professions within the NHS, but particularly in nursing and the professions allied to medicine. In addition, there has been a poor uptake of government initiatives such as the New Deal, Single Parent and Modern Apprenticeship Scheme. Feedback from the employment services tells us that the NHS is generally not seen as an attractive place to work by job seekers (Bradshaw, 1999).

The shortfall of nurses is estimated at between 8000 (official figure) and 13,000 (RCN figure) (Bradshaw, 1999) out of a total NHS nursing, midwifery and health visiting workforce of 330,000. The number of nurses on the Register reduced by nearly 2 per cent in the 12 months to the end of March 1998. It is the biggest decline ever reported. The number of registered nurses available for nursing employment in the UK is reduced by three main factors. Firstly, 4 per cent of those on the Register are recorded as resident abroad. Secondly, 4.7 per cent are aged 60 or over. Thirdly, an unknown number of nurses, perhaps 8 per cent, are employed in non-nursing work.

Projections have demonstrated that almost half of the nursing workforce in Great Britain is aged over 40. This proportion is forecast to rise to nearly 53 per cent by the year 2010, when one fifth of all nurses will be aged over 50. As a consequence, the level of retirements is projected to grow from around 5500 per year in the late 1990s to over 10,000 per year by the middle of the next decade.

Surveys by the Royal College of Nursing (RCN, 1999) and UNISON (Thornley, 1998a) have found high levels of dissatisfaction amongst those working in the NHS. The Institute for Employment Studies found that 8 per cent of nurses planned to leave the NHS within two years, of whom only one third were over 50 (Secombe and Smith, 1997).

An NHS Confederation Survey (NHS Confederation, 1998/99) found that 78 per cent of trusts had difficulty recruiting nurses and that turnover is high. Changes are occurring in the nursing career structure, often in an unplanned way. There is a growing demand for nurses who specialise, but often the technical nature of some of these roles leads to job dissatisfaction.

The proportion of nurses in the independent sector (acute and nursing homes) rose from 11.5 per cent to 17 per cent between 1990 and 1996, to a total of almost 58,000. The proportion of newly qualified nurses going straight into the NHS fell from 99 per cent in 1991 to 90 per cent in 1996. More than half of nurses leaving the NHS remained in nursing employment in 1995/96, yet three quarters of private nursing homes report difficulties in recruiting nurses. All the evidence points to the fact that there is definitely a significant shortfall of nurses. What is far less clear is which

factors are working together and have combined to produce 'the worst nursing shortage crisis in 25 years', as described by The Baroness Gardner of Parkes in her address to the Lords in February 1999 (available from the RCN Parliamentary Office).

All of these factors, together with reported and apparent societal changes, have a bearing on the recruitment and retention of nurses in the years to come. In this report, we aim to examine and integrate key themes that emerged from the review of literature, interviews and focus groups in order to identify the main areas of concern and some opportunities for action to build a strong nursing workforce for the 21st century. The section after this introduction looks at what the research found about how the public views the NHS and nursing. A section on the role of nurses follows this. Positive and negative factors in relation to nurse recruitment and retention are then examined, followed by a brief account of gender issues, education, training and development issues and organisational issues, all of which were found to have a bearing on how to recruit and retain nurses in the NHS.

Methodology

A review of the existing literature and research going back some 20 years highlighted a number of apparently consistent themes in the problems of recruiting and retaining nurses in the NHS. The reality of these findings was then explored with groups of nurses in the field through focus groups, and with major stakeholders through semi-structured interviews. More details regarding the methodology are attached in the appendix.

2. How the public views the NHS and nursing

A generally positive image of the NHS

One of the main contextual issues for recruitment into nursing and retention of nurses within the NHS workforce is the way in which nursing is perceived in the public mind. If young people are to consider nursing as a career, and if mature nurses are to consider remaining in their chosen career, nursing needs to have a positive and attractive image. In this section, we look at the current 'image' of nursing and, in particular, we examine how nurses and others associated with the NHS feel that nursing is perceived by the general public.

On the whole, in spite of many problems, the NHS in general, and nursing in particular, are viewed positively. As a senior civil servant put it:

The NHS represents the things the public believes are right, equity, access, health, to do with societal good if you like. So I think the public sees the NHS as a very positive organisation from that point of view.

Changing expectations

Several people suggested that this warm view of the NHS was not necessarily to be taken for granted as a permanent fixture of the social landscape. While older people held the NHS in great affection, it was possible that younger people were becoming less convinced, both about the aspirations of the NHS and about its ability to deliver what they wanted. For example, it was suggested that people aged between 20 and 45 tended to be particularly dissatisfied with having to wait to get appointments in primary care. However, on the whole, there was a broad consensus that the public was well disposed towards the NHS and held it in high esteem, in spite of changing expectations and even though they were aware of its shortcomings. That said, it may

well be the case that public opinion is 'on the cusp' and that there is no room for complacency.

If the public view of the NHS is changing, it is not always obvious what is driving those changes. Generally, it was felt that while high profile incidents, such as Dr Shipman's notorious murders or the reported poor outcomes of paediatric cardiac surgery in Bristol, attracted much publicity, these were not seen as representative of the NHS or as emblematic of its shortcomings. Rather, it was the cumulative impact of everyday personal experiences that formed public opinion, as suggested in these quotations from two senior civil servants:

Sitting waiting for two hours when you can't actually work out why they can't do the operation.

Some of the public views of the NHS are related to the perception of their grannies who didn't get fed when they had a stroke, so poor care, poor conditions, some of the scare stories about dust and dirt, lack of privacy, lack of dignity, for their relatives and family. Some of that is from their own families' experience, some of it is from media stories. Equally there's the other side, all the triumphs and successes, you know the child who had his surgery, liver transplant that survived, and all those sort of things.

Many people agreed that expectations were changing and that there was now less tolerance towards the shortcomings of the NHS. Many interviewees referred to a greater awareness of individual rights amongst patients, and this was not necessarily seen as a bad thing. However, it was felt that this trend could go too far and an essentially individualistic perspective could actually be harmful to the NHS. For example, this quotation reflects the experience of many nurses:

But you also get patients forming a party to come up and complain to you because the woman in the bed at the end is confused and is calling out at night and disturbing their sleep and can't you get her moved somewhere else? And we are still a hospital providing a treatment for people and I think people are much more selfish. (Nurse in focus group)

However, nurses were sympathetic to how patients felt when things went wrong.

If you get your operation cancelled four times and there is a slight delay when you are in there, you can imagine how someone feels. (Nurse in focus group)

The media were seen as important in shifting expectations too.

I think society has changed and the media has encouraged that, that people have the right to be happy and the right to be comfortable and the right to have everything they want. (Nurse in focus group)

To some extent, it may be that the perceptions of the public as citizens and the consumers of media stories are not quite the same as those of people when they actually encounter services. As one interviewee observed:

There is a large public concern about the NHS. Undoubtedly all the media stories, and a lot of what is happening, the problems that the service has, have caused huge worries. It's interesting though ... surveys will show that, on the whole, perceptions of individual experiences when they come into contact with the NHS remain remarkably high. So you've got this interest, public and patient – different experience.

Perceptions of nurses and nursing

There was a range of views on how nurses and nursing were perceived, with a majority view that nurses, as individuals, were still viewed positively, particularly in comparison to other health care professionals. However, nursing itself was a little more tarnished in its image.

There was a widely held view amongst interviewees and focus group participants that all health care employees were viewed more critically than was once the case – possibly another manifestation of higher expectations and a more informed and

critical public. But within this, nurses were generally viewed relatively sympathetically.

Where this was not so, negative perceptions did not necessarily apply across the board.

Nurses in the public view are still seen as the good guys, it's when we're seen as bad guys, it's on a very individualistic level, it's the individuals that are seen as the bad guys, not the whole of the nursing profession.

Nevertheless, as the public face of the NHS, problems in the NHS generally could and sometimes did affect the image of nursing and nurses. The following quotations reflect a widespread view:

I think [the lack of public trust in nurses] is because people have had bad experiences, they [have] been poorly cared for because wards are so badly staffed compared to 20 years ago. Twenty years ago everyone thought nurses were wonderful because they were able to deliver good care, but that's not the case now. (Ward manager in focus group)

I think nurses are still held in very high regard generally, but of course they are the people, particularly in stressful situations in hospitals and increasingly in the community, with whom the people have contact. So there is something of the shoot the messenger in this and if that is combined with some loss of respect for the profession then that makes it very hard and they will get bruised.

The paradox of how nursing is perceived was well expressed by one interviewee:

There still remains an astonishingly high level of regard for nurses. I think they always come out above doctors in terms of trust and support in general terms and also in the care they get from nurses when in hospital, but at the same time that seems to be coupled with 'yes but I wouldn't want to do it or I wouldn't want my child to do it.'

It is interesting to ponder how far this contradiction reflects well-intentioned campaigns that have tried to improve conditions for nurses by highlighting poor pay and conditions. We will return to this question later (see p.29). As one interviewee remarked:

If you spend your time saying how utterly dreadful everything is, people believe you ... It ain't the best way of getting people into nursing ...

On the other hand, personal acquaintance with nurses was also a powerful factor in forming opinion. A number of people agreed with the following opinion:

I always remain firmly convinced that everybody knows somebody who works in the health service. And on the whole the biggest recruiter or anti-recruiter is what you hear from Auntie So-and-so and the next door neighbour, the person you meet everyday at the bus stop going off to work, and if there is that drip-feed message – oh God its dreadful down at St Whatsits – one shouldn't underestimate the message that those give ...

This latter comment echoes exactly the findings of Lucy Land in 1993, when she reviewed current recruitment and selection practices within nurse education. She found that the students interviewed were often greatly discouraged in applying by family and friends. Parents and partners held the strongest opposition, mainly because nursing was perceived poorly in terms of status and pay and conditions. Both younger entrants and more mature students talked of having to persuade partners and family to support their career decisions. Most student nurses referred to the usual range of media stereotypes: angel, carer, sex object, handmaiden, etc. There was a feeling that while the public may be highly appreciative of the role of the nurse, the media malign this by repeating these negative stereotypes.

This was also found in the survey carried out by Southampton University amongst pupils aged 10, 15 and 17, which found that young people admired those going in to nursing but did not want to become a nurse themselves. They saw caring as a passive role with none of the high status associated with the role of the doctor (Foskett and Helmsley-Brown, 1998).

The status of nurses

The status of nurses is a complex issue, encompassing changing public attitudes and expectations and also issues of power between professions. Status remains important to nurses and potential nurses as an attraction or deterrent to nursing. Status has a relationship to pay and conditions, but is not linked to them in a simplistic way, although one interviewee argued that this was becoming more so:

I think you have to contrast ... with what maybe our parents' generation had as their background, which was the war. People who could alleviate pain, save a life, that was very high up. We haven't got that. We're not going to be bombed tomorrow. So nurses, auxiliaries, people with those kind of skills are maybe not perceived in the same way. What's replaced that is this status equated to money rather than status equated to how useful the job is. That's a shame.

A nurse in a focus group of NHS Direct nurses felt the lack of status very keenly:

When you go to a meeting, if you introduce yourself as a nurse you are obliged to show how you are something more than just a nurse always – that's my experience. You always have to prove the reason why you are there ... anyone else, any other profession – OTs, dieticians, pharmacists – they naturally assume that they are valuable, but with a nurse [there is] that little extra bit that you want to capitalise on ...

In a similar vein, comments from other nurses included:

I think that in the pecking order in the NHS the therapists are seen as different and perhaps a little bit better than your ward nurses.

I think that sometimes nurses aren't treated on the same playing field as other professionals: OTs, psychologists, doctors. I don't know why because a lot of us are well educated enough to be at that level as them, so I think it is a perception of nursing sometimes.

There was little doubt that more needed to be done to make nurses feel more valued. Indeed, there were many ways in which this was currently being done, ranging from achievement awards, increasing the profile of nurse consultants, devising statements of values, describing nurses by a variety of titles, etc. But one weary nurse complained about having to work so hard at improving the status of nursing:

But why should you have to, you know if you say you are a doctor people value you, if you say you're a nurse ...

In sum, while nursing and nurses were generally seen in a positive light within an NHS that was itself largely viewed as a national asset, there was much disquiet about how nurses were perceived in relation to other colleagues. There were also concerns that the warm glow that generally attached to images of nursing was not guaranteed as a fixture for all time.

Violence and aggression towards nurses

Many interviewees and focus group participants felt that nurses are encountering increased levels of verbal aggression and physical violence in the course of their work. Nurses were five times more likely than average to report being attacked at work (HSE, 1998). It is not possible to be sure to what extent this reflects possible wider changes in levels of violence and aggression in society as a whole and how far it is a window on changing attitudes to the status of nurses and other NHS staff in particular, as discussed above. But whatever the balance between these and other factors, there was no doubt about the negative impact of the perceived trend towards a more aggressive working environment.

I think that the whole society is getting more violent, the rules and regulations are breaking down, there is less respect for the uniform. I think there was a time when a district nurse could walk through a no-go area because she would get respect from her uniform, I think now it is more advantageous to hide your uniform because your uniform means that you might have hypodermic syringes in that bag and it is best not to carry a black leather bag. It is better

to carry a Tesco bag because you are making yourself a target. (Non-clinical focus group)

Some people were very aware of the factors in society that might lead individuals to behave in unacceptable ways. However, the impact on nurses was no less severe, and many nurses endorsed the civil servant who said:

I have got no doubt that there is more aggression, there are more demands made on people which tip over into aggression than I think there were and sadly I think it is every nurse's experience. Partly due to the nature of the work that they are doing, they are dealing with very vulnerable people in very vulnerable situations and that's when people tend to tip over the edge in terms of albeit verbal abuse, emotional abuse, physical abuse, probably the tip of the iceberg, but I sure that every nurse has been sworn at or been shouted at or been treated rudely or abruptly in some way.

While violence and aggression are clearly seen as detrimental and completely unacceptable, it is interesting to note that violence was not seen as a single negative factor in recruitment and retention. Rather it was seen as part of a package of influential factors. This inter-relatedness of factors, typified by the following quotation, is a theme that we shall return to throughout this report.

If [nurses] send a message out that it is a really good job to have, it's safe, it's secure, it's relatively well paid, and it will improve in the future, then recruitment and principally retention will be very positively affected by that. If you get the opposite message being sent out – oh, for God's sake, try and find another job, at least there you won't be attacked, you won't be threatened, you won't be called names, etc., and you'll get more than £17,000 per year after 45 years, or whatever it is, then that sends out a message that this is a job that is worth going into, or it's not.

3. Nurses' roles

What is a nurse?

Is there clarity about what nurses do, and is that relevant to the ability to recruit nurses? These issues were discussed at length in focus groups and interviews. Interviewees wondered whether the general public, and those who might consider nursing as a career, knew what nursing in the modern world actually was. Nurses themselves also found it difficult to define their role. Although they were clear what their role was not, they were sometimes less clear about what nursing specifically was. There was some feeling that the role of nursing had lost clarity, though as one person (not a nurse) put it:

Many nurses have lost clarity of role, but they have lost it in a profession that is still very hierarchical and rigid.

In addition, it was suggested that nurses suffered from a range of sometimes-contradictory expectations. At one end of the spectrum, extended roles gave a great deal of autonomy, similar to that of a doctor; at the other end, roles were very close to the traditional, hierarchical model.

Some of the data supported the view that the nurse role was tending to be squeezed out between the role of doctors and that of health care assistants. One person, who was not a nurse, observed:

They feel often that their expanded role is not being thought through logically ... that they are getting what the doctor doesn't want to do and the doctor can always move on because there is no-one on the other side of the doctor. They bump up against the doctor and they are being bumped up against the doctor by the health care assistants so I think sometimes the profession feels a bit beleaguered.

This perception lends weight to the 'polo mint' problem as outlined by Celia Davies (1995), that is, the caring role of nurses can fall through the hole in the middle of the multiplicity of roles. There may be a Catch-22 situation, in that anybody can do nursing because we cannot define what is special about it, but we cannot demonstrate its 'specialness' because many different people are doing it.

More commonly, there was a feeling that even if nursing was hard to define, it was reasonably easy to recognise as it included an important component of caring for the whole person on a day-to-day basis. One person described nursing as 'skilled care', which was a common core for all nursing, with technical skills that may vary according to the kind of nursing that was being carried out. A trust chief executive gave a similar view:

I have a generic view of what the key component of a nurse is, which is to look at the patient as a whole and not just to think of themselves as the super-specialists in health care. It is how they can care for the patient, the client, the visitor, whoever comes into this organisation, each other.

A former nurse suggested:

You can get too hung up on defining the role. Patients know what nurses do for them – intimate care, helping with privacy, dignity, etc.

However, that is not to negate the widespread concern that existed amongst nurses themselves about the extent to which they have to turn their hand to anything and everything – not because it is an aspect of all-round care but because wards and departments would not function otherwise, as these quotations indicate:

I mopped the floor yesterday as well. I think its because the nurses are there 24 hours a day, so you are always the one to step in if someone else hasn't done their job. And you know if more resources were put into the structure generally and everyone was well established and able to provide good support services, that would make our job so much easier. (Nurse in focus group)

It's difficult to clarify what our roles are. We know what we'd like our roles to be but sometimes it just spirals out of control and that happens on a daily basis. It's so frustrating all the little things, they build up so much ... (Ward manager in focus group)

I think that a lot of things that nurses do could be done by other people but the other people, like medical secretaries, ordinary secretaries, ward clerks, are not paid enough to attract people into those jobs and so it ends up jack of all trades, ending up doing everybody else's humdrum pieces of work and if those supporting people were valued and paid accordingly, it would be more expensive but I'm sure would be good. (Nurse in focus group)

There is going to be a huge reduction in the number of junior doctors and from August this year, we lose eight junior doctors so the discussion revolves around who will do that work and although we are getting four consultants in replacement, you know well that we will be doing what the eight junior doctors did. At the moment, we are looking at all of this because we have got to change the way we work in order to take on even more roles. (Nurse in focus group)

Throughout the research, we noted that nursing was attempting to combine traditional, caring elements with expanded roles that would have been the province of medical staff not so long ago. For some nurses, this is a welcome development, permitting the best of all worlds and enabling holistic, person-centred care to be delivered with greater expertise and technical competence while also providing intellectual challenge and fulfilment. For others, changes and expansion to the nursing role represent a threat rather than an opportunity, at least within current resource levels. One interviewee – not a nurse – candidly observed that there was an apparent paradox, as nurses wanted more hands-on contact with patients while possibly not wanting to perform more menial tasks if they were educated to graduate level. Another – an NHS manager – stated:

The nurse's role has changed almost unrecognisably in the last five to six years and that caring role has been taken away, and it's the health care

assistants we rely on for the bedside, and attention to detail, and caring/feeding, etc. I think that is why a lot of the nurses don't intend to persuade other people to come into the profession.

However, nurses themselves did not usually express this view in those terms. As we shall see, in spite of many detailed concerns, nurses tended to be relatively comfortable with seeing how their own role fitted in alongside health care assistants. It was the practicalities – making things work in practice, when they perceived themselves to be overworked and under-resourced – that led to misgivings, rather than the way in which the concept of modern nursing has developed.

Health care assistants

The role of health care assistants (HCAs) is inextricably bound up with the development of modern nursing and is discussed here because of the actual and potential impact of HCAs on the role of the qualified nurse and the attractiveness (or otherwise) of nursing as a career. The main impetus for the introduction of HCAs came in the mid-1980s, with proposals for changes in nurse education (Project 2000, discussed below, p.52). These proposals involved a greater reduction in the role of student nurses on the ward, the 'red circling' of the Enrolled Nurse (EN) grade and the development of 'aides' or 'support workers' to plug the gap. In August 1996, Department of Health figures suggested that the various grades of staff classified mainly as HCAs and support workers constituted 11 per cent of the workforce. The breakdown identified 13,090 whole-time equivalents as HCAs with the remaining 74,450 whole-time equivalents listed as support workers. There are no national pay grades or terms and conditions for these staff and their introduction was viewed as local pay by 'the back door' according to Thornley (1997) in her survey of over 1000 HCAs and 80 trusts.

At the same time, there are nursing auxiliaries (NAs) who have been an important part of the nursing team, albeit unqualified, for some time. Since the 1980s, the number of NAs has remained broadly constant as a share of the nursing workforce (around 25 per cent). However, since the introduction of HCAs the number of whole-time

equivalents has dropped in absolute terms from over 100,000 to around 84,000. Most NAs are very negative about transferring to being HCAs, although they do the same job, because of the lack of national pay grades and terms and conditions and also because HCAs are not recognised by the Pay Review Body as being part of the nursing workforce.

The emergence of a graduate-level nursing workforce has developed alongside (and been made possible by) the role of the HCA, whose training is typically built around National Vocational Qualifications (NVQs). Opinions of interviewees varied about the appropriateness and workings of the NVQ system. It has been estimated that only about 30 per cent of HCAs hold NVQs. Thornley's 1999 study revealed that as many as a third of trusts do not offer NVQs and, where they do, prospects typically do not improve even with NVQ attainment

On the whole, nurses in the focus groups valued their health care assistant colleagues, particularly if they had been in post for a considerable time and staff turnover was low. However, some nurses, while recognising the competence of their health care assistant colleagues, had some reservations about whether the care that they delivered was the same as that delivered by a nurse. Discussion at a focus group of nurses elicited this comment:

Health care assistants can wash a patient, but a qualified nurse doing the same job can get a lot of information and chat with them and find out about their circumstances, for example if they need help living on their own, social services might need to help. They know the right questions to ask, the nurse is thinking all the time, not the same as a quick wash and then on to the next patient like with the assistant ... Nursing is doing tasks with reasons and actions to be taken. Thinking all the time.

One focus group of nurses working with older patients and mental health patients declared:

We couldn't do without them. They are a great to help to us.

Another focus group comprising similar staff expressed positive views, albeit a little more critically:

There is a limit as to what they can do, they are extremely valuable but what you want is people who can go in and assess situations and act on what they see, and cope with it and deal with the whole thing. Rather than constantly coming back to you with all the problems that you then have sort out.

A ward manager commented:

I think a good health care assistant is worth his or her weight in gold. If they are trained properly, which obviously we are responsible to do, its another of our responsibilities, then they can be absolutely fantastic and certainly the ones I've got on the ward are happy to take on extra roles with supervision.

Many other interviews and focus groups reported positive views of the contribution made by health care assistants, often noting how their role dovetailed with that of other members of the health care team. For example, a chief executive said:

I think it is to take on part of the old role of the nurse, leaving the nurse to do nursing duties and potentially take on some of the roles of the doctors But where the health care assistant comes in is that they actually look after the person so if that person needs to be moved, taken to the toilet, have flowers put in the vase, etc., that's what happens. But in liaison with the nurse around health care because the nurse is the health care professional and expert.

Others stressed that health care assistants could bring in essential caring skills based on life experience, while at the same time (for those who chose to follow this path) it could be a rung on a career ladder.

I think it is a career option for someone who either has not the confidence or the qualifications to go and do nurse training, or perhaps someone has been made redundant in their 40s/50s (male) or has bought up a family and wants to come back to work and had a lot of life skills. And I think that they can

bring an awful lot of common sense, a lot of practical life issues, and relate very well to people, and we need them to develop the professional nursing role as an advisory and senior technical type role with these health care assistants, both delivering the hands-on work, and the patient caring, and the time, the talking, what have you. But also we have got the opportunity with health care assistants to make them generic health social care and physio-type assistants, and they can cross those boundaries, and support the professionals. The professional will determine the care plan and the health care assistant, or whatever they are called, will deliver in conjunction with the patient.

Several interviewees favoured multi-level entry points and stop-off points in recognition that the career aspirations of health care assistants varied immensely. Some were relatively content to remain as hands-on carers, while others might wish to progress within nursing or any other health care profession.

Broadly, most of the concerns in the fieldwork about health care assistants were not fundamental ones about their role, but were significant and detailed points made about their training, accreditation, regulation and systems for ensuring consistent and safe practice. There were also some concerns that skill-mix reviews had often been motivated by financial necessity rather than by a genuine desire to find an optimum balance of skills and levels of training and competence. Where that was perceived, the employment of large numbers of health care assistants was likely to be viewed with more suspicion. However, some of the literature is more critical. Surveys carried out in 1998 and 1997 by Thornley for UNISON into the NHS have shown that many HCAs and NAs carried out jobs that encompass important aspects of direct patient care and contact:

	HCA's (%)	NAs (%)
Talk to/reassure patients and relatives	97	96
Make beds	86	87
Help bathe patients	83	82
Help feed patients	79	74
Help with catheter care	61	63
Help with drug administration	42	42
Invasive procedures	18	21
Take blood samples	11	11

Source: Thornley, 1997; 1998b.

Fifty-three per cent stated that these tasks were being carried out with little or no supervision. It is likely that there is an even greater lack of supervision present in the area of social care, where qualified nurses are much fewer in numbers. These figures suggest that these support workers are engaged in potentially hazardous work with little or no recognised training.

4. Recruitment and retention of nurses: positive factors

In this section, we examine what the data revealed about the reasons why people choose a career in nursing, and what factors are relevant in retaining them in their chosen career.

Varied reasons for becoming a nurse

Moore *et al.* (1983) conducted a large study into the reasons why nurses chose to enter the profession and why they stay in, leave or re-enter. The reasons for entering nursing which were ranked the highest were:

I wanted to work with people. (Ranked 1st)

I wanted a worthwhile career and not just a job. (Ranked 2nd)

The Price Waterhouse survey in 1988 found that 75 per cent of nurses were not interested in work that had no contact with patients. Collings carried out a more recent study in this area (1997). She found that the two most important reasons for entering nursing were the desire to ‘work with people rather than things’ (68.5 per cent of respondents) and ‘being caring and helpful to others’ (52.1 per cent). These three studies, conducted over a 14-year period, continue to show that people entering nursing predominantly want a caring job with people.

Likewise, interviewees and participants in focus groups indicated a wide variety of reasons for becoming nurses, with many referring to the human element of nursing. Some were vocationally-driven and knew from a young age that they wished to be nurses, while others became nurses almost by accident, for reasons such as lack of opportunities to enter other employment.

The area that I came from in Merseyside at the time I was growing up, unemployment was very high then and it was difficult and you had very few

options and so for me it was probably a choice between working for the local council, either going into the coal industry or nursing, because we had two large psychiatric asylums near us. That was my choice. (Nurse in focus group)

Some had made a positive choice to do nursing, while others had come to nursing because of what it was not (not too academic, not too much like a commercial business). There was no indication that these widely different kinds of motivation had any ultimate bearing on job satisfaction or on people's wish to remain nurses.

The wish to work with people and care for them and the desire to do something useful was mentioned often, sometimes with a degree of self-conscious embarrassment. For example:

It's really trite, but it is a treat for me to help someone out, it really makes a difference to that person or family. I go home and say 'Oh, I've really done something good today,' but I have never been attracted to working for a business. I feel like doing something worthwhile, for someone else. (Nurse in focus group)

I can't really quite remember precisely why I wanted to be a nurse, but I didn't want an academic type profession, I wanted to do something practical, I took a year out after school, didn't want to go to University and I wanted, although this may sound mealy mouthed, I did want to do something that made a difference to people's lives and I always think that nursing is a two-way process – you may be giving care to the patients, but they are also giving something back. In a sense, making your life more worthwhile and I don't think that that's untrue for being trite. (Ward manager)

Other reasons for becoming a nurse included:

- opportunities to travel
- socialised into becoming a nurse
- family background
- perception of nursing as a secure job.

Sometimes, several reasons rolled into one.

At the start I wanted to do something useful that would enable me to travel.
(Nurse manager)

I remember going through the career books and trying to think of something I wanted to do. At the time I didn't particularly want to go to University and I wanted to do something that was useful and interesting, and at that time nursing was actually quite an attractive career to go into, it opened up doors, you could travel, you could do a variety of different jobs and it really was an attractive alternative to the more academic careers that people gained. (Nurse in focus group)

Opportunity to travel was quite important for a number of nurses and was a factor in attracting them into nursing. However, those same opportunities were also significant in enabling them to leave the NHS and to travel elsewhere.

Even though you need to take different exams, you can work in the States, you can work in Canada, you can work anywhere, literally anywhere in the world. I think a lot of people [are] being mercenary, they use the job to go and work in Saudi, and they come back and can pay for the deposit on a house, and other attractions that people might want. (Nurse in focus group)

Interestingly, no-one reported that they had chosen nursing in order to pursue academic or intellectual interests, although several said that they had chosen it to avoid an over-academic career.

Some of those who had become nurses because of the apparent security it offered now questioned whether that was still the case. Several nurses had been interested because they wished to work with people and have a varied career, and they saw nursing as offering a reasonable and secure package. A civil servant also saw this as an important factor to recruit mature entrants into nursing as a second career:

A smaller group have actually had an opportunity to compare nursing with other career paths, maybe from experience they're coming in as a second career change and they actually see the attractions of nursing in terms of security of employment, pay, pension – some of the HR things that everybody says are dreadful, but in fact aren't that bad, so they actually see nursing as a secure career, for a good second career choice.

What makes nurses stay?

Those who stay in nursing have a variety of reasons for doing so. Some are pleased to find that their expectations are fulfilled and they stay for the very reasons that they joined.

I just really enjoyed it and have been nursing now, well more management of late, but for the last 18 years. I have got no intentions at all of leaving and I have thoroughly enjoyed it, it is not just a way of earning money, I actually find it stimulating and interesting although it is very stressful nowadays.
(Nurse in focus group)

I think going back to what I said as to why I wanted to be in nursing, things that I enjoy are the things that represent that. They are actually being with patients and making a difference to their lives and them acknowledging that to some extent. Those kind of interactions on a day-to-day level still are rewarding. They are equally challenging as well and equally a focus of a lot of my stress, but it's like a counter balance, you can't have one without the other.
(Nurse manager)

In addition to personal satisfaction, there were many examples in the research data of nurses staying in the NHS because of loyalty and commitment, rather than for reasons of personal satisfaction. For many NHS nurses, loyalty is a 'default setting', which they offer patiently and in spite of many difficulties. However, it is a setting that can be abruptly changed if any number of 'last straws' destabilise their willingness to continue to tolerate frustrations. Also, Price and Mueller (1986) reported that

professionally trained nurses had a stronger affiliation with the nursing profession than to the specific employer. Parasuraman (1989) found that the higher the job level within the organisation, the lower the likelihood of the person leaving.

There is a thing about principles of the NHS to me. The basis of universality, the access – for me that's important (Nurse in focus group)

However, people outside nursing, including commentators from the trades unions and from the NHS Executive, noted that relying on loyalty was not likely to work indefinitely. One person described this attitude as 'a potential hand grenade being left behind for the next generation'. What was needed was to tackle some of the problems and the reasons why dedicated staff decided to leave.

Flexible working and a family-friendly working environment were seen as important factors and, interestingly, they appear on both sides of the equation. Some nurses cited opportunities for flexible working as a reason for staying in the NHS, while others, as we shall see, lamented the lack of flexibility and cited it as a reason why people move on. However, providing family-friendly hours was seen as a double-edged sword by those without caring responsibilities because of a lack of staff to enable them to provide such working arrangements.

Likewise, opportunities for training and development can be an important factor in encouraging retention, and the lack of these can be a factor in deciding to move out of nursing. This issue will be discussed fully in Section 7.

A further issue of great importance in retaining staff is the issue of control and autonomy. Many nurses discussed limitations on their ability to control their working lives as negative factors, but it is also noteworthy that some nurses made positive references to the benefits of autonomy. For example:

Talking about why people will stay, it's about flexible working, being able to help write your own job description and being able to tailor the job to what you want, achieving organisational aims but by actively tailoring it so that you get some satisfaction out of it. It's very important to me and I think that would

be one of the reasons why I would stay in a job, actually being able to have an influence of what my performance targets are, and the boundaries of those, how much time I would be expending on paper work and how much time I would spend, or would want to spend with patients. That's the important thing for me – the interface between myself and the patient and my staff and the patient. (Nurse manager)

It is very clear that there is no single answer, and certainly no simple one, to address problems in retention of nurses. Like almost all aspects of recruitment and retention in the NHS, it is multifaceted. As one chief executive observed:

I think we have got to do something about raising the profile of the NHS so you don't need 12 GCSEs to come and work for the NHS, there are other ways. I think we need to get messages into schools and colleges. I think we have got to make the training and the courses more flexible. We have got to make the work more flexible, we have got to have role models ... there aren't many senior black people in the NHS, in nursing or anything else. So I think that all of that and just getting the message out about some of the things we say we do on paper, so compassionate leave, and flexible employment, and maternity leave, and help with child care, and all those kinds of things, training opportunities.

It is evident that a great deal of time and energy is currently devoted to trying to improve retention at a local level in both health authorities and trusts and within the Department of Health and NHS Executive. Sharing good practice in retaining staff is essential in order to maximise these efforts. Regional Offices of the NHS Executive have an important role to play and in the London Region there are a number of important initiatives in progress. These include an action plan on recruitment and retention, comprising (among other initiatives) radio campaigns, a 'housing moderniser' to look at issues around nurses' accommodation and the appointment of a recruitment and retention co-ordinator.

In sum, recruitment of nurses is always important, but retention is the key to maximising the input of those who are already in the NHS and those who are minded

to join. The factors that underpin successful recruitment and retention are often woven together as a package.

5. Recruitment and retention of nurses: negative factors

In this section, we will examine some of the factors that contribute to nurses leaving their jobs and some of the factors that might deter people from pursuing nursing as a career. In some cases, these can be inferred from the factors that make people join or stay as nurses. In other instances, as we shall see, a complex inter-relationship between apparently small issues has a cumulative effect.

Pay

The issue of nurses' pay was discussed widely within this research and findings are in line with other investigations in so far as pay is seen as an important issue, but by no means as the only issue. For some nurses it may not be the most significant issue, but it assumes a greater significance alongside many other unresolved concerns. The context of much of the discussion indicated that while all nurses would like more pay, the level of pay became an unbearable irritant if they felt unduly overworked, undervalued or unheeded about the conditions in which they had to do their jobs.

This is in line with the findings of Secombe and Smith (1996) in their research on the nursing workforce. They found that for a growing proportion of nurses, particularly those in the NHS, there is a significant mismatch between the rewards, including pay, career prospects, working hours and the level of management support offered by the working environment, and their needs and expectations. Increasing workloads, the excessive hours of work expected, the need to do bank work as well as a main job, skill-mix issues, shortages and cutbacks have all contributed to low professional morale. In a slightly later piece of work (Smith and Secombe, 1998), nurses who left the NHS in 1997–98 were asked to indicate what, from a list of 14 influencing factors, might have reduced the likelihood of their leaving. These data show considerable support among recent NHS leavers for opportunities to develop skills (86 per cent), improved promotion prospects (81 per cent), career structures (77 per cent) and greater availability of flexible working hours (75 per cent). These are factors that can be impacted on by trust managers. Messages for the NHS as a whole are that almost

all (93 per cent) of these leavers pointed to better resources to do the job and better pay (88 per cent) as factors that would have reduced their likelihood of leaving.

It may be the case that the views of those who have already become nurses are not wholly representative of the population as a whole, since those who chose nursing as a career generally knew from the outset that there were more lucrative options available and chose not to pursue them. In contrast, some people who did not choose nursing might have done so if the financial rewards were higher. If that hypothesis is correct, those interviewed (who were largely nurses or associated with the NHS in some way) may ascribe a lesser significance to pay than others.

Satisfaction with pay varied considerably. This may reflect personal acquaintance with higher earners in other fields. One staff nurse lamented:

In another job you would be paid four times as much – outside the health service. My brother-in-law who started off the same time as me, he pays in tax what I earn in a year.

Several nurses reported difficulties in making ends meet and as one staff nurse commented:

I think the issue of money becomes much more acute living in central London – a tremendously expensive place. The seventh most expensive place in the world to live! On a staff nurse's salary – life's not easy.

It was also suggested that actual pay was not as poor as some people might think, and that part of the challenge was to convey the reality of a nurse's pay package. However, this comment was made not by a serving nurse, but by a senior civil servant!

We could all do with more money but if you actually say, look, predictably this is what you would get as a senior staff nurse. It is not the same as going into the City in the stock market, but actually it does compare quite favorably with

quite a few things that you do, so there is an awful lot of that to try and get through to people.

Several people commented that campaigns to improve the pay and conditions of nurses may have had negative as well as positive effects in so far as they may have contributed to a public image of nurses' pay that was even worse than the reality. As a consequence, some people were deterred from nursing needlessly. A report for the Department of Health, *Perceptions of Nursing as A Career* (Foskett and Helmsley-Brown, 1998), pointed the finger at the unions and the media for promoting a negative image of the nursing profession. Researchers at the University of Southampton, who carried out the study, said media images of downtrodden, low paid nurses have reinforced negative perceptions of nursing as a career – an image unconsciously reinforced by nursing unions. The report particularly refers to a 1997 poster with the slogan: 'When you pay peanuts what do you get? A caring, competent and completely undervalued woman'. The damage of such promotion appears to be considerable – for nursing and for women.

In addition to the national pay context, there are particular issues for London. Several interviewees compared their pay with that of City workers, as jobs in the financial sector in the City of London were within easy travelling distance for many of those interviewed. Even more so, interviewees and focus groups expressed concern about the attitudes and aspirations of their children, which they felt augured badly for the future of the NHS. Some attributed the more financially-driven attitudes to the change in political values prevalent during the 1980s and early 1990s.

Where we live on the outskirts of London our sons or daughters are going into the City and earning big money and I felt very demoralised recently when my son came home very disgruntled because he had only got £2500 bonus and a £3000 pay rise. And I tried to say to him you earn more money than a ward sister with the responsibility of 25 lives, and he said to me – well then she is a mug then isn't she, why doesn't she go down to the City and do what I do?
(Participant in non-clinical focus group)

Given that nursing is not a particularly highly paid career, we sought views on how far people saw pay as a major issue in retention, rather than recruitment.

There was a broad consensus that more pay was a vital factor in retaining nursing staff, but that money was only one of the important issues. This comment from a focus group of nurses working with older people and mental health patients was typical:

It is the whole package, money is a big thing, let's not get away from it, money is the driving force for most people coming to work because it pays your mortgage, and a lot of people could earn far greater working outside of nursing than in nursing. There has got to be the right package of training, and the right courses available so that people feel trained enough to do the job they are meant to do ... Is the environment making sure people feel safe coming to work, making sure that if they have a problem they don't have to go through six layers of something to get to something, whether it's money, whether it's a resource. So it is the whole deal.

There was also some support for financial rewards being linked to long service. A ward manager suggested:

I think they could consider some bonus scheme. There's no financial incentive here, for example for long service, for not going off sick, I know that's very controversial – but if you look at places that have done it then their sickness rate has dropped dramatically. There's no incentive to be conscientious.

A nurse who had worked in Singapore referred to a bonus scheme there where nurses got a '13th month' salary.

Even small acknowledgements of effort are much appreciated. Nurses in one trust where the chief executive had awarded an extra day's leave in recognition of hard work during the winter were very pleased with this gesture. They recognised that funds were not available to grant them extra rewards, but the extra day was a great morale booster.

Other nurses expressed concern and cynicism about the clinical grading structure and felt that this had not delivered the expected progression in salary terms. The current clinical grading system has imposed rigidities, created glass walls and ceilings trapping people and constraining career planning and progression. Automatic incremental progression has resulted in nurses and midwives getting stuck at the top incremental point with little prospect of further progression without a job change to gain promotion. Nearly 60 per cent of those in E grade, 80 per cent of those in G grade, 74 per cent of those in H grade and 81 per cent of those in I grade are at the top of their scales (JM Consulting Ltd, 1998). The system has hindered rather than supported those who have taken career breaks, has failed to reward competence and satisfactory performance or to properly value clinical expertise. Some of the most expert and able nurses who would prefer to remain in practice often see no alternative but to leave clinical work to advance their careers and earnings.

Several nurses in the focus groups noted that it was still largely necessary to move away from direct patient care if one wanted to improve one's salary position. The introduction of nurse consultants was welcomed by some, but was seen as not very relevant to the opportunities or remuneration for most nurses, as few nurses would aspire to or achieve nurse consultant positions.

For both pay and conditions, nurses were aware that the private sector often offered better rewards. The loyalty factor was a significant one in not seeking those rewards. However, while NHS employment has remained fairly static since the late 1980s, the number of nurses working in the private sector has tripled. As at March 1998, 475,000 people were holding effective registration with the UKCC. Of these, 300,000 were directly employed by NHS trusts and health authorities, 18,000 by general medical practitioners and 66,000 by private hospitals, homes and clinics (UKCC, 1999). There is no room for complacency.

Also, for those who worked on the edge of London, a perceived competition with possibly more prestigious London NHS teaching hospitals was a factor thought to make both recruitment and retention more difficult.

Working conditions and facilities

The tone of the discussions and interviews about working conditions and the (non-) availability of attractive working conditions and facilities was very bleak. Adverse comments were made about range of facilities, with particular reference to leisure and recreation facilities, child care facilities, catering for staff, car parking and, above all, accommodation.

A nurse at a central London hospital said:

If we're going to offer proper benefits to staff, actually having a proper gym facility or a decent membership of a gym, travel concessions, all those kind of things I think are very important to make it more attractive, not only in the work environment but in the leisure side of things.

Another suggested:

A 24-hour crèche would be good, because people who want to do night duty because it fits in. At the moment, you have full-time nurse who has a baby, she comes back, she can only do reduced hours, or hardly any because of lack of crèche facilities. Particularly for single parents, it's extremely difficult.

Very ordinary, basic amenities were sometimes lacking. A chief executive expressed concern that there was nowhere suitable for nurses to get a proper meal during night shifts.

The highest level of concern was reserved for accommodation difficulties. This was raised repeatedly by nurses, managers and external commentators. The difficulties in obtaining affordable housing were thought to be especially bad in London because of the high costs of private rented accommodation and of housing to purchase. These difficulties were compounded by the variable, and often very poor quality of nurses' accommodation. It is worth quoting at some length to show the depth of feeling on this issue.

If I look on application forms, and if I see accommodation wanted, I think 'Oh no' because I'm so embarrassed telling them when they come and they ask if we provide accommodation and we say 'yes' and we've warned them they are basic, but there is basic and basic. (Ward manager)

I trained at [a central London hospital] and I can remember getting to the accommodation and bursting into tears and thinking I'm going home, I'm not going to be a nurse. (Nurse manager)

The rooms are so dirty, the bathrooms, the toilets are filthy ... If the Chief Executive was expected to live there, they'd soon change.

These experiences were contrasted with facilities provided abroad and by the private sector in London.

Transport in London was another issue that concerned nurses. In some respects, their concerns were similar to those of other workers in the capital city, but unsociable hours added to their transport problems. The possibility of withdrawal of or charging for car parking provoked despair and discontent and was seen as adding insult to injury.

The tone of these discussions about facilities and conditions was often depressed because nurses pointed out that they had been having similar discussions for 10 or 15 years, with little apparent progress, even though discussions about nurse shortages had been going on for so many years.

Frustration at not being able to do the job properly

Anger and frustration at poor facilities were surpassed by widespread concerns by nurses who felt that they were unable to carry out the jobs for which they were trained because of a range of factors, particularly budgetary constraints or organisational problems. The largest degree of frustration concerned the lack of relatively

inexpensive equipment, such as pillows. This made nurses feel incompetent in front of patients. These findings were consistent across the literature and the fieldwork.

A survey of more than 7000 nurses carried out by Price Waterhouse in 1988 showed that the greatest frustration for nurses was the lack of resources to get on with the job. Over 70 per cent said that there were not enough people to do the work and two thirds said that not having enough time to do nursing was their real frustration. More than three quarters of them said that they were mentally exhausted after work, over half worried about work at home and felt they were under too much stress.

An RCN survey, reported by Brindle (1993), questioned 2000 nurses and found:

- almost two in three nurses believed that there were too few staff on their wards to provide proper patient care
- only one in five nurses was confident that managers would act on concerns about staffing.

This view was echoed in an RCN snapshot survey taken on a specific day in September 1998, which covered 55 general medical wards in NHS trusts across the UK (RCN, 1998). Key findings included the following:

- nurses felt they were often prevented from providing high quality care because of lack of staff, particularly lack of registered nurses
- 95 per cent of nurses in charge of the wards said patient care was compromised by short staff at least several times a month; 37 per cent of wards reported patient care being compromised on most shifts
- on day shifts, just under half the nursing staff were registered nurses – the majority were health care assistants
- almost one in five staff nurse posts were vacant.

Nurses and their managers referred to not having sufficient time to talk to patients as much as they would wish, and not having sufficient time to care for patients properly. Shorter lengths of stay had led to wards being occupied by patients who were more

dependent than hitherto, while year-on-year 'efficiency savings' had eroded budgets for staff and other essentials. A management culture where managers had been judged by their ability to trim their budgets was blamed by some.

Nurses were often personally distressed at these shortcomings and expressed sympathy with patients who were not getting a good enough level of care and who might feel that they had no option but to complain. One manager suggested that this inability to deliver a good standard was one of the reasons why nurses might not be recommending nursing as a career to their own children.

A sense of frustration was often the result of a large number of small things, and these all reflected an inadequate infrastructure. One chief executive observed:

We have got problems getting theatre nurses, and then when you go and talk to the theatre nurses at some of the hospitals, they say well we spend half our time sterilising equipment and utensils, and things, why don't we have other people to do that, so they can do the nursing skills. So not a good use of their skills, and that is replicated in many examples. Not enough infrastructure in terms of the ward clerk, the domestic, or the whatever, so you spend your time doing all of that. Lack of budgetary responsibilities so they can't get the window mended, toothbrushes for people who are picked up in the middle of the night, pillows, and all those kind of basic housekeeping things, so a huge sense of frustration.

Even more plaintively, a nurse in one of the focus groups reported:

You are all so affected by what's going on in the hospital and the resources, like when there are no spare pillows left and you are stuffing blankets under or having to rush around and find one. It's pathetic and embarrassing. Not enough pyjama bottoms and pumps for feeding mothers, running round trying to find things. It is frustrating because you know what needs to be done and you know what you need but you can't get hold of it. Your role is so much affected by the rest of the hospital and the way it works. Glasses go missing. That is my biggest frustration as well, the wards being ancient, not enough

room and knocking stuff off pulling curtains, due to lack of room around bed areas, all those little things.

This kind of problem also seemed to afflict newer parts of the service. NHS Direct nurses had experienced problems in not being able to find a seat or a working telephone by a computer. The mood was summed up by a hospital-based nurse who despaired at:

Ridiculous, nonsensical, easily solved problems that take on gargantuan proportions.

Opinion was divided as to how much these problems reflected a simple shortage of money. Certainly, unrealistic budgets over a long period were thought to be a major contributory factor, but some thought that it was also a question of using available resources in a better way. Also, there was a degree of optimism (more pronounced from civil service employees than from nurses themselves) about the likely impact of additional funding for the NHS, which was coming on stream as this research was conducted. However, the frustration at what could not be done was evidently a problem that was keenly felt by nurses, and seemed to reflect an inability to control their working environments as well as reflecting long-term underfunding. The relevance of this frustration to the retention of nurses can hardly be overstated. The impression given was of a powder keg ready to explode. Individuals could only take so much frustration, could only apologise to so many patients for shortcomings before the strain became too great. One can only guess at how many nurses had decided that they had had enough because they were unable to fulfil the standards set by their profession, but which were apparently impossible to deliver. As one person said:

Where you don't have the power it is a constant sapping of energy because all your energy is going into trying to bridge the gaps of the lack of equipment or the whatever.

A recurrent theme was that nurses lacked control.

Certainly for nurses, a major point to stress for nurses is lack of environmental control, so they have lots of responsibilities heaped on them, both by their patients and by other staff, managers, employers in terms of what is expected of them but actually very little power in some cases to change the systems around them that would enable better care. Trolley waits are a prime example.

We were told of:

experienced nurses with grades Fs, Gs and Hs leeching out of the health service because they are the ones who have all the responsibility heaped on them but with very little power and control and authority to actually change things around them.

Happily, there was a degree of optimism that this situation might be in the process of changing. Senior people told us that people needed to be seen as the solution, not the problem. Nurses in some work settings actually perceived that they were being listened to more.

Increasing control and autonomy, and making it possible to solve problems where they appear, are fundamental issues. Experience has shown that where staff are involved and allowed greater control over aspects of their working lives, they tend to be pragmatic, realistic and positive. This has also been demonstrated in such areas as agreeing work rotas. Given a chance to participate, nurses are able to plan sensibly to cover the needs of the service, while also being able to be involved in deciding their own shifts. In that mode, managers have a residual role to ensure that the system is efficient and fair, but they do not have to remove all responsibility from their staff in order to do so. One trust has found that the introduction of a computer package that allows nurses to choose when they work has led to a culture change whereby nurses feel more responsible towards their colleagues. At the same time, this have given them more self-determination, leading to greater job satisfaction (Mitchell, 1999).

The need for more staff

Many positive ideas were mooted to get the best out of staff, but there was absolute agreement from all parts of the research that more staff, and in particular more nurses, were needed. Indeed, having more staff was seen to be the key to enabling some of the proposed solutions to bear fruit. For example, better staffing levels would enable staff to take advantage of training and development opportunities. More staff would also enable nurses to derive greater job satisfaction, as they would be better able to look after their patients and communicate with them in a more relaxed manner. If more money became available, putting more staff in place was generally given a higher priority than increasing remuneration for existing staff. Thus the recruitment/retention problem was seen as inextricably linked. More effective recruitment would take the pressure off existing staff and encourage them to stay. A more stable nursing workforce would enable better care, better job satisfaction and lead to a less stressful environment, thus encouraging people to enter nursing.

Indeed, nurses themselves can readily identify the solutions. In their Eve of Congress Poll, the RCN (RCN 2000) found that the following issues, in descending order of importance, were felt to be crucial in overcoming nurse shortages by the 1277 nurses polled:

- right numbers/type of nurses
- employee-friendly policies
- well funded/supported professional development
- improved pay
- more student places/access to supported clinical placements
- expanded resources for clinical supervision
- measures to tackle student hardship
- the widening of nurse leadership programmes.

In the context of staff shortages, the research indicated some concerns about agency nurses, who were used frequently to fill gaps in the nursing establishment. The first major concern was about the quality of agency nurses. Sometimes, agency nurses

were regular nurses doing extra shifts, sometimes at their own usual place of work. Sometimes, the nurses were not known to their colleagues and they varied in quality, experience and personal competence. In extreme cases, nurses had doubts about the qualifications of some agency nurses and queried the thoroughness of some agency checks. One nurse manager asked:

Does the registration number actually belong to them?

The second cluster of concerns was about managing a group of staff who were not a regular part of the team. While an experienced manager can do this with comparative ease, patients in hospital wards may prefer to speak to a nurse whom they have seen throughout their stay, and this may cause a disproportionate amount of work for the established non-agency staff. It is just one more factor that may increase pressure on nurses where there are staff shortages, thus making it more difficult to fulfil their roles as well as they would wish.

Discrimination

One of the most serious issues that we encountered in this research was the impact of discrimination, and most particularly racism. Very senior managers and policy-makers acknowledged that the NHS had been marred by institutional racism and that individuals within the NHS, such as black nurses, had personally suffered racism in their own careers. The impact of personal experience by black nurses was seen by interviewees and focus groups to be a factor that deterred them from encouraging their children to follow in their career footsteps, or even made them actively discourage them from doing so.

Look at the West Indian nurses in the 50 and 60s. It will take more than a generation to undo the damage, as the way they were treated has been passed on.

One interviewee pointed out that nurses had experienced racism in the NHS in a number of ways:

I think it's a combination of what you would legally call direct and indirect discrimination over many, many years. Being concentrated on night shifts, being concentrated on lower grades, being subject to occasionally physical violence, but certainly verbal threats – principally from the public but it has to be said also from within nursing and from within hospital employees.

We also heard of very recent examples of frank racist language and behaviour in the NHS, in spite of attempts to eradicate it. It was not possible to assume that racism in the NHS was only a feature of the past.

The literature confirms the importance of this issue and sets it in a context of a long history of recruiting nurses from Ireland and then from the Commonwealth. By 1948, local selection committees had been set up in 16 countries (Doyal *et al.* 1981). The number of overseas nurses reached a peak in 1970 and has declined since that time. Baxter (1988) queries whether black nurses are fast becoming an endangered species. She states:

The nursing profession is rapidly becoming a far less attractive career possibility for black and ethnic minority groups than it used to be. British born black school leavers are reluctant to expose themselves to the humiliation and degradation endured by their parents, relatives and the community as a whole.

However, Paul Iganski *et al.*'s 1998 work for the English National Board for Nursing, Midwifery and Health Visiting (ENB) found that, whilst the discrimination experienced by earlier generations of black nurses may have a deterrent effect on current black applicants, it does not appear to be a sufficient deterrent to lead to under-representation of the group amongst applicants for nursing training when compared with their representation in the population as a whole.

There is also the question of what happens to black and minority ethnic applicants to nursing. In 1987 the Commission for Racial Equality (CRE) sent out a postal questionnaire to 32 schools of nursing. Thirty were returned. From the data collected it was evident that student nurses from black and Asian minorities were under-

represented in comparison to their white counterparts and also less successful in their applications. The ENB found that in 1993, a total of 29,126 applications were being processed for nurse training. Of these, 23,705, i.e. 81 per cent, were classified as 'white'. Of the total applicants, the number of students given 'offer accepted' status were 8123, of whom 92 per cent were 'white' (ENB, 1995).

On a more positive note, there seemed to be real progress very recently in acknowledging the prevalence of racism and in determination to tackle it. The Macpherson report (Macpherson, 1999) was seen as helpful and influential in suggesting a practical definition of institutional racism and, in fact, the experience of the police in trying to address their own institutional culture was seen as offering lessons for the NHS too. It was interesting that some interviewees were also prepared to reflect back on their own attitudes in the light of an increased understanding of racism.

How people are treated at work

In addition to racist discrimination, we heard occasional reports of other kinds of discrimination and poor personnel management, apparently reflecting inconsistent practice on the part of individual managers in matters such as allowing compassionate leave.

Pulling no punches, one of the most senior people interviewed also admitted:

The other thing about the NHS is, unfortunately, bullying, hectoring, harassment, is almost institutionalised in some of the professions. And that the NHS hasn't really got to grips with a lot of that.

Stress at work: the need for support

In view of the issues described above, it is hardly surprising that we heard a great deal about stress at work and the pressure of work. Occupational stress exists in all professions, but nursing appears to be particularly stressful. In a review of over 100

occupations, using a stress rating scale to compare work pressures, nursing had one of the highest scores among service occupations (Cooper and Baglioni, 1988). Nurses complain of tiredness and ill health, resulting in high levels of absenteeism and subsequent attrition of nurses from the profession. Similar messages were conveyed by nurses at all levels, in all kinds of nursing and also by their managers. A chief executive commented:

I think from what nurses say to me, fewer people come into nursing because it's seen as a high pressure environment, and some ward sisters are saying to their kids, well I don't think you want to go into nursing because it is high pressured.

Some nurses felt that 'nurses are blamed for everything' and they would be less stressed if others ceased to hold them responsible for shortcomings in the service that were not in their control. Nurses also felt unsupported and harshly judged when they made mistakes and they contrasted their treatment with that of doctors and felt that doctors were forgiven their mistakes much more readily. Fortunately, it was suggested that a change in culture was underway. Nurses in a focus group reflected:

... if someone makes a mistake, they try and get away from that [punitive approach] and we can try and open up risk management and try to report adverse instances and drug errors and make it more a culture of learning from the mistakes and make sure it does not happen again.

This kind of change was seen as an important aspect of support to nurses.

In spite of pressures within the NHS, there was no real impetus for trying to turn the clock back. A pressured working life was accepted as inevitable. However, what was suggested were better ways of enabling people to cope with it, through better support, clinical supervision and by valuing staff more highly. Meanwhile, support was not universally viewed as adequate and one person stated:

People literally feel themselves going grey overnight with the weight of responsibility.

Managers appreciated the need to support staff (and to be supported themselves) but were subject to the same pressures as nurses.

A very important part of my role is actually walking around the wards seeing staff, seeing if they are supported. I provide a good line of communication. If I walk around the wards, see and speak to staff, you bump into everybody so I might just be providing a line of communication, but you see and you talk to people, and that is the bit of my job that when I am really pushed I don't get to do. Which I think is a very important part of my job. Because I am very much like the old matron, that is what the old matron used to do. And people always like to see someone like that walking around. But I don't always have the time to do it. (Nurse manager in focus group)

Focus group discussions indicated that support to alleviate stress at work could be of a very practical nature. For example, access to mobile phones for district nurses visiting people in their own homes was seen as essential, but was not always provided. It was evident that some aspects of nursing were better supported than others. Children's nurses, for example, had more of a history of mutual support than some other nurses. Many people acknowledged the importance of informal support from team colleagues. In some specific working situations, other sources of support had become relatively institutionalised, e.g. from psychologists, social workers and hospital chaplains. Where this worked well, it was seen as a helpful means of supporting staff in stressful situations. Although we have insufficient data on this point to be sure, it is probable that this kind of support is more readily available to nurses in paediatric settings than those who care for adults. Support for staff who work alone in community settings may be particularly under-developed.

Literature on support at work yields further information on the impact of support on retaining staff. The 1998 study of Wai Chi Tai of staff in 42 dialysis facilities showed that supervisor support significantly influenced the likelihood of employee turnover, although other aspects of social support at work (co-worker support and work group support climate) did not affect turnover behaviour. The 16 per cent turnover rate for those who reported supervisor support was almost half that of the 27 per cent turnover

rate for those who perceived no support from their supervisor. Landstrom *et al.* (1989) reported that conflict between a hospital nurse and the nursing manager was the most common source of conflict (85 per cent) in the initial stage of turnover.

The need for more family-friendly working policies and practices

As we have seen, some nurses stayed in nursing (or in particular aspects of nursing) because it was compatible with family life and domestic responsibilities. Others endorsed this sentiment:

Chief executives have not given the greatest possible attention to family-friendly policies, but to things that they are performance managed on, e.g. waiting lists.

A chief executive agreed with that accusation:

I don't think it is very real at all. I think that people tick the box and say oh it's a good thing and we are now letting people come back to a job after they have got maternity leave, but actually ... people have dependants who aren't only children, there are school holidays, there is what happens when your child or elderly relative is sick, all those sort of things. I mean none of that has been thought through. People who only want to work evenings or only want to work term-times, on paper everyone says they are doing it, but actually you talk to people, who say – well I applied for a job-share or for a term-time job, or for Tuesday to Thursday, and I was told that is not convenient for the hospital.

The nurse whose statement follows would certainly have agreed with that chief executive.

I can't have a minute off to take my child to the doctors, and I literally have to plead to get half an hour off, and I daren't ever be coming in at 9.05 or go at 4.55.

There was a great deal of thoughtful awareness about the consequences for organisations of high levels of flexibility and a commitment to family-friendly policies, and occasionally there was a degree of resentment from those who did not have caring responsibilities. However, on the whole, the majority view from all directions was that the NHS needed to put family-friendly policies firmly in place if it was to be able to retain large numbers of its most experienced staff. However, family-friendly policies had to be more than mere rhetoric. Resources had to be made available so that these opportunities could be provided for staff. All of this confirms what the literature review demonstrated: of the 140,000 nurses, midwives and health visitors not working in the profession in England, it was found that nearly half were not working because they have domestic/family commitments. The single measure they identified as most likely to make the greatest difference in encouraging or enabling respondents to return was availability of part-time and flexible working hours or job-sharing (Stroud, 1999).

Better opportunities elsewhere to use transferable skills

Sometimes nurses leave nursing simply because they have transferable skills and wish to apply them elsewhere. Interviewees tended to see this as an inevitability to some extent, all the more so since nursing had moved to degree-level qualifications. A nurse manager said:

We have interviewed nurses who are finishing their degrees or diplomas and once they've got that degree, they say I am doing something else with it now.

This tendency may become all the more marked as nurses attain greater managerial responsibilities and realise the value that is put on their skills in other contexts.

For some nurses, realising the value and transferability of their skills and noting new opportunities to apply them is linked to a general sense of frustration.

I also think the skills you need to be ward sister are much like running a small business. There's far more opportunity out there for running businesses –

more personal reward than working on the ward with limited resources and staff who are frustrated with trying to get agency nurses dealing with complaints. We've got more skills than ward sisters did 20 years ago. (Ward sister)

All of the factors outlined above need to be considered as a whole if nurses are to be dissuaded from taking their talents elsewhere.

6. Gender issues and recruitment and retention of nurses

A woman's career?

Although both women and men contributed to this research (though there were few men in the focus groups), both genders largely accepted that nursing was likely to remain a predominantly female occupation. The historical predominance of women in nursing was seen as a factor in low pay and in the status of nursing. The assumed 'naturalness' of caring as a female attribute was also thought to have undermined access to professional development at times. However, many people commented that times were changing and nursing had to wake up to the impact of more choice and more opportunities for women in the workforce. This would certainly result in some women choosing alternatives to nursing, but it would also bolster the positive choice to nurse made by women who could, if they chose, pursue other career options. However, one person attributed some of the confusion about the nurse role to gender issues and the removal of gender stereotypes.

Part of the professionalisation of nursing was to try and get away from some of the gender stereotypes, to say that nurses could be managers and they could be leaders and they can work with intellectual challenges, and there's a career path for nurses. So a lot of the things that we were trying to do to sell nursing, to try and get away from that gender thing, yet it's left this core gap of caring, and caring is the core of nursing.

Celia Davies (1995) makes the point that although nurses may be applauded at the patient interface, they are viewed more ambivalently at policy level. Her view is that nursing is still regarded as women's work and is hence seen as low status, and this reverberates throughout the profession. This ambivalence is clearly echoed in the frustration expressed by nurses themselves. Bharj (1995) found in her research into the view of nursing as a career for Asian schoolgirls that both students and careers teachers viewed nursing as a low status profession. The majority of the participants

agreed that nursing was a 'terrible job' because it was 'messy work' and consisted of 'working long hours with limited career prospects'.

The dilemma that is captured by Susan Reverby (1987) in her account of the history of American nursing is that of being ordered to care in a society that does not value caring. Nurses are expected to uphold the values of a female identity in the face of a masculinity that is profoundly ambivalent about it, and in the face of institutions involved in that same masculinity. In general, in the NHS, as elsewhere, the more senior the post, the less likelihood of finding a woman in it. According to Hilary Graham (1983), caring is something that slips through the conceptual net offered by the academic disciplines of the social sciences. The commitment to care that nurses bring, because it is not at all well articulated or understood and because it is simultaneously romanticised and trivialised by others, can serve to lock nurses into a spiral of resentment and cut them off from co-workers. Corley and Mauksch (1988) found that the assumption by co-workers that nurses will care about the patient absolves others (particularly doctors) from identifying with the patient, and protects them from feelings of guilt and failure. This means that others can neglect their work, effectively 'dumping on' nurses who are unlikely to resist and who are thus placed in an unenviable position of responsibility without power.

Clearly the debate about how best to build and retain an effective nursing workforce is not gender-free. Policies and working practices need to be based around the needs and expectations of a workforce that is likely to remain largely female for some time to come. At the same time, there must be a thorough recognition that this is unlikely to be a workforce with limited ambitions for themselves as individuals or for the nursing profession as a whole.

7. Education, training and development

The importance of training and development

The education and training of nurses at all levels, and the opportunities for continuing professional development and career development were major concerns in interviews and in focus groups. In particular, opportunities for training and development were seen as crucial to both recruitment and retention.

It's a thing that comes up at interview all the time. When you're interviewing candidates, what training and development opportunities are there? Will I be able to go on a course? – classic interview question and I think you have to be able to give a positive response to that or you're not an attractive proposition for people. (Nurse manager)

It was also important for nurses to have the opportunity to apply the training to practice. A chief executive suggested that sometimes nurses undertook specialist training, for example in renal nursing, but when they returned, their role had not been properly thought out and they might still be 'plugging in the dialysis patients, and making the cups of tea, rather than nursing people who are in kidney failure'.

Similar misgivings were expressed by one interviewee who felt that inadequate thought had been given as to how to make the best use of nurses with degrees, though that was not so in all places.

Also, nursing was contrasted unfavourably with the medical profession in so far as it was more difficult within the grading system for a nurse to develop skills by changing fields within nursing. A nurse manager outlined the problem as follows:

Within nursing you've started with one speciality and worked your way up and you think you would like to branch out into another speciality in order to either enhance what you're currently doing or seek a change of direction. You

don't take into account that you may have worked yourself up to the top in urology, but if you come to work in a total different faculty, you're not going to be functioning at your best level in something that is totally new to you, and this is a dilemma for people to know then what grade to put you on. The medical staff don't, every time they go into different speciality, lose their money and start again.

Equal access to training and development opportunities

The literature alerts us to the existence of possible discrimination and unequal access to training opportunities. Beishon *et al.* (1995) report from a postal survey carried out among nurses and midwives that most minority ethnic, but not white, nursing and midwifery staff believed that racial discrimination operated in the NHS, particularly in the allocation of educational and training opportunities. This obviously results in these staff therefore becoming stuck and clustering in the jobs with lower grades and poorer status.

While nurses had nothing specific to say about education consortia, other interviewees made critical comments about them. The consortia were accused of 'being patchy and having a limited vision'. They were considered to be in need of people of appropriate seniority to lead them. They were thought to not spend enough on post-registration training, and to be not focused enough on primary care.

Leadership development

The need for leadership development was an important theme for nurses and their managers. One chief executive had developed a leadership development programme in her trust. Everyone at supervisory level was going on the leadership development programme and it had proved enormously beneficial for recruitment and retention, and in reducing sicknesses and absence from work. A focus group also highlighted the need for leadership development at ward manager level. Generally, it was accepted that more investment was needed in leadership development for nurses at all levels.

Many of the more senior nurses who took part in focus groups underlined the importance of development. They saw it as essential for the person who was being enabled to develop their skills, knowledge and confidence. Equally, they found it satisfying to be able to help other staff within their teams to enhance their abilities and opportunities. A staff nurse described her satisfaction at opening a journal and finding that someone she knew as a newly qualified nurse is now running their own unit. She found it satisfying to have had a stake in their career and influenced the kind of nurse they had become.

A nurse manager said:

I think as you get a bit more senior you don't always get more job satisfaction, mainly because you're not the frontline person. You get it indirectly, from seeing people who start off brand-new, and scared to death, progressing to competent people, who may end up far more competent than you are yourself at the moment or maybe ever were! That's really nice.

Others referred to the satisfaction of developing a service, which was an important aspect of personal development and team development even if a nurse moved away from one-to-one work with clients. Opportunities to be involved with audit and other quality projects were seen as important development opportunities, alongside more formal academic courses.

Time to reflect on practice

One of the important ingredients of development that was widely identified was time to reflect on practice. Pressures at work commonly made it difficult or even impossible to stand back and reflect on practice. Clinical supervision was acknowledged to be important, but was sometimes vulnerable because people were so busy.

Time to reflect on practice needed to be supported in a variety of ways, and examples were given of where this worked well. Preceptorship schemes, buddying, shadowing

and mentorship were all mentioned with enthusiasm. Increasing the access of nurses to specialist advice was also commended by one chief executive, as was the development of academic links. As well as supporting nurse development, this was seen as a powerful tool in making a trust a more attractive place for nurses to work.

Project 2000

Interviewees and focus groups had much to say on Project 2000 and its impact on nursing. Opinions were curiously polarised, and positive and negative views were spread across all kinds of staff, levels and settings. One chief executive described Project 2000 as 'a mistake'. Most of its critics, however, made more specific negative comments, of which the most common were:

- inappropriate balance between theoretical and practical
- too academic/too theoretical/too classroom-based
- too focused on acute care
- the status of nursing students and their level of bursaries are too low.

On the other hand, Project 2000 also attracted positive comments:

- encourages assertiveness
- encourages nurses to ask questions
- equips nurses for modern nursing
- contrasts favourably with former training programmes for nurses.

It was suggested that some of the apparent failings of the Project 2000 courses were actually the responsibility of the NHS. As one person crisply put it:

Some service people abdicated responsibility and said it's all down to higher education.

The literature on Project 2000 clearly outlines the impact of the largely supernumerary status of diploma students on the number of available 'pairs of hands'.

This reduction may be exacerbated by the reported difficulties of diploma students in adapting to the working situation once they have qualified. Charnley (1999) found that almost all participants in her study experienced feelings of stress associated with the sudden change in role and status. Many nurses described themselves as being 'shielded' as a student from the full breadth of the role in terms of time and number and type of tasks. The literature also tends to support some of the reservations of interviewees about the relevance of the more academic aspects of training. Failings in Project 2000 training have been described as 'practical skills illiteracy' (Macleod Clark *et al.* 1996).

Discussions about Project 2000 tended to be tinged with nostalgia for a golden era that may never have existed. Indeed, when older nurses reflected on their training, they did not look back on it as perfect. Nevertheless, debates about the changing face of nursing and the move towards graduate nurses delivering skilled care, care management and care planning while supervising much of the hands-on care delivered by health care assistants, sometimes laid all the blame and all the confusion at the feet of Project 2000. However, other aspects of the research data make this simplistic position unlikely to be correct. While the initial training of nurses is a crucial issue with immense bearing on recruitment, retention and the whole future of nursing, these issues must be seen alongside the many other complex issues that influence the nursing workforce's ability to do its job and its willingness to stay in post.

8. Organisational issues

Getting the basics right

Wai Chi Tai *et al.*'s research (1998) points clearly to the fact that health care and nursing managers have control over a significant number of the variables that impact on turnover – through job design, work environment, appropriate leadership, working practices, high levels of support, etc. – and that more concentrated effort should be made in these areas, rather than focusing on the external labour market or staff's individual characteristics. This would include a re-orientation toward retention rather than the current over-emphasis on recruitment. In confirmation of this approach, throughout the research a number of points were made about the organisational contexts within which nurses worked. Much dissatisfaction was attributed to organisations not being very good at listening to their staff and taking heed of what they said. This was seen as a basic requirement of a healthy organisation. Advice from a senior manager was:

Listen to staff and actually act on what you listen to. And what you will listen to isn't going to be rocket science. It is going to be – my hydrotherapy lift hoist hasn't worked for the last six months and no-one has fixed it for me.

But in practice, as one of the focus groups complained, the reality was:

... a lot of the time you are actually involved in something, but the final decisions are made for you. And they might listen to the localised level, but the deal is already done.

In the real world, nurses often felt that they were swamped by organisational and bureaucratic requirements. Although they accepted the need for paperwork to support risk assessment, health and safety, etc., they still felt that their essential functions were endangered by management needs at the expense of patients' needs.

There is much to be learned from the American experience. For example, a study was carried out by the American Nurses Association (McClure *et al.* 1983) in the USA between 1981 and 1983, when over 80 per cent of hospitals did not have adequate nursing staff and there were some 100,000 vacancies in the system. The study's aim was to identify a national sample of 'Magnet' hospitals, that is those that were able to attract and retain professional nurses. The researchers also wanted to identify the factors that seem to be associated with the hospitals' success in doing so. Nurses from 'Magnet' hospitals reported higher satisfaction on five job satisfaction factors:

- organisational structure
- professional practice
- management style
- quality of leadership
- professional development.

Nurses from 'Magnet' hospitals were three times more likely to be very satisfied with the management style. In most 'Magnet' hospitals, nurse directors were seen to occupy positions of parity with other top-level executives in the hospital. These nursing staff expected to participate in efforts to control costs. However, they also expected the director of nursing and other nursing leaders to have the administrative knowledge and power to prevent damaging cuts in the nursing budget and to assure that the required nursing staff and programmes for quality of care were in place. In these hospitals, responsibility was decentralised to the patient care units. Head nurses in collaboration with staff make decisions relating to organisational matters, such as scheduling, assignments, educational activities of staff and meeting the objectives of patient care, and thus have a high degree of control over their work.

Effective leadership and management

Nursing, like other disciplines in the NHS, can only flourish where there is effective management and competent leadership. There was wide agreement that management needed to be facilitative, empowering and good at listening to the workforce. In this, the chief executive was clearly important, but the director of nursing was also a key

figure. The chair of the board, other non-executives and executive directors were no less important. Moreover, effective leadership at ward level was critically important. Many people stressed the importance of ward sisters and staff nurses in making the organisation function effectively.

The role of the Region

The role of the Regional Offices of the NHS Executive provoked interesting discussion. Senior people at Regional level seemed to have a clear view of how and why they needed to support nursing. This clarity was not necessarily perceived so strongly at a local level. Indeed, it is evident that many nurses and managers working in the field feel that there is still a considerable gap between policy and practice. The suspicion borne of years of a perceived lack of resolve in supporting recruitment and retention issues for nurses will take time to diminish.

Organisational instability and insecurity

Some interviewees were disturbed by the history of organisational change, which was apparently not yet over. This had sometimes been an upheaval and had created insecurity about jobs and career development. One of the focus groups described the NHS as 'a political football'. Some described their concerns about an apparent tendency to ever-larger organisations. They did not regard this as conducive to team spirit, a sense of control or to retention of staff.

We have got a lovely atmosphere at our clinic because it is small, I have worked at bigger clinics and the district nurses don't really know the health visitors because one is over one side of the building and one is over the other, and that's it, they don't go out together, it is kept separate. Whereas we all go out together.

A ward manager made the point very strongly:

If we think things are bad and unmanageable and difficult enough to get a handle on and get someone to fix the broken door handle or get the lifts working now, imagine how much more difficult it would be if the Trust encompasses yet another local trust. It just seems that there is a megalomaniac somewhere who will not stop until the whole of the South East of England is one trust – with the Estates Department located in Kent! I feel we need to draw it all in and have a smaller area of responsibility and for everybody to know what the extent of their responsibility is – not just with the nursing fields but with everything else.

9. Conclusion: next steps

The material gathered in this research confirms and strengthens a number of key messages that have been made by a variety of sources over many years. The more this material is put together, the more puzzling are these questions:

- why has it taken so long for these messages to receive the attention that they are due?
- why are some problems relating to nurse recruitment and retention apparently so difficult to solve when they appear to be relatively simple?

There are a number of explanations that may shed some light on these questions, and some of the possible reasons are suggested by the data analysed in this research. Firstly, the extraordinary loyalty of nurses themselves may be a factor that has allowed the level of concern about tackling the problems that underlie recruitment and retention to be lower than it should have been. Although nurses have left nursing in significant numbers, many have stayed in spite of extreme difficulties and frustrations.

Secondly, for quite a long time, and until very recently, it was deeply unfashionable to attribute difficulties within the NHS to a shortage of resources – human or otherwise. Recent acknowledgements that the NHS is in need of additional funding on a year-on-year basis have begun to create a climate wherein fundamental issues about staffing levels and other resources can be openly considered. Thirdly, the constant organisational turbulence that has characterised the NHS at least since 1974 has possibly been a distraction in terms of addressing some of the most basic human resource issues. Although the pace and nature of organisational change has still not abated, workforce issues can no longer be pushed aside.

In addition, experience shows that it is insufficient to tackle problems relating to recruitment and retention in a piecemeal fashion, as has largely been the case up to now. All the research evidence points to an inter-relationship between quite different factors. If a nurse decides to leave nursing because of some frustration or dissatisfaction, typically it is rarely a single issue that has prompted the decision.

Rather, it is a matter of a last straw that tends to break the camel's back. Nursing staff become worn down by a remorseless stream of problems, which they are not empowered to solve. This lack of control is a major irritant and impedes nurses in their efforts to deliver a safe and effective service to patients.

The key messages from this report form a framework for going forward and building on the widely shared concern about the future of the nursing workforce in an integrated manner. They are as follows:

Listen to staff and empower them

Nursing staff, health care assistants and nurse managers often have clear ideas on how they could deliver services more effectively. At their best, these ideas are rooted in everyday experience of what contributes to better systems and better care. Involving staff can lead to higher quality and more appropriate services, just as involving patients can. Ways of listening to staff in order to empower them should be encouraged and developed at both trust level and unit level, to engage staff to use their experience and insights in order to make a difference. Allowing and encouraging responsibility for implementing change and improving services at a local level would make a difference to patients as well as addressing staff frustrations with existing barriers to improvements.

There are many examples of effective practice that have empowered the nursing workforce, and these have often been centred on enabling nurses to take more control of what they do by aligning power with responsibility. However, these examples and lessons are not as widely shared as they could be.

Do not rely on staff loyalty

The NHS is fortunate in having a largely committed and loyal workforce. However, generational changes in attitude and greater educational and employment opportunities mean that loyalty cannot be taken for granted. The NHS must scrutinise all aspects of its personnel practices and organisational structures in order to ensure

that it can compete with other occupations. This is particularly so in relation to other public service occupations.

More staff

More nursing staff and more support staff are necessary to deliver a safe and effective service. It is likely that the ability to recruit more staff would also help to stem the tide of staff who leave because of insupportable pressures.

Pay and conditions

More pay is widely seen as important, but it would not be enough to attract and retain staff in the absence of other benefits and facilities. Accommodation, leisure, transport and flexible employment practices are as essential as adequate financial remuneration.

Development for all

Nurses need to have good opportunities for developing their skills. However, this does not mean that developmental opportunities should be wholly geared towards 'high fliers'. For many, development is centred on opportunities to do a job safely and effectively and with increasing personal satisfaction. A comprehensive programme of professional development that allows maximum opportunity for development within nursing and other health care professions is an essential attribute of a healthy workforce.

Tackle discrimination

The NHS must be at the forefront of tackling all forms of discrimination, most notably racism. The experience of racism by black and minority ethnic nurses is a historic blot on the NHS, and is one that provides important lessons for the future.

An integrated approach

Above all, an integrated approach is needed to tackle all of these issues as part of a whole. Issues relating to workload, working conditions and the ability of nurses to do the job for which they were trained are inextricably bound together and influence one another. The approach to recruiting and retaining nurses in the NHS must be similarly holistic. Only a sustained commitment from government and local NHS management, and an appropriate investment of resources (time and money) can enable full use to be made of the wealth of material that is known about the problems and the possible solutions to nurse recruitment and retention.

Appendix

Methodology

This study used a qualitative methodology and is based on fieldwork carried out in London and the immediate environs between March and May 2000. Although these findings are not nationally representative in a statistical sense, they are consistent with other studies in this area. The interpretations of the data are believed by the authors to be coherent and consistent with the wider literature and in a general sense reflect the picture of nurse retention and recruitment nationally.

A total of 11 focus groups and 19 semi-structured interviews were carried out. The aim of the focus groups was to include within them all the different disciplines within the nursing profession. To achieve this, a purposive sample was used and the focus groups covered the following:

- health visitors, district nurses, school nurses and some specialist community nurses
- practice nurses and nurse practitioners working in the community
- specialist nurses, including paediatric, renal, intensive care, neuro-surgery nurses and A&E nurses
- acute, general and care of the elderly nurses
- nurses working in mental health and with people with learning disabilities
- non-professionally qualified staff working in support of the above professionally qualified groups
- nurses working for NHS Direct
- nurse returners.

The sample included people of different ethnicity, gender, experience, type of trust, etc. All the focus groups were recorded, transcribed in full and the findings analysed in detail. The facilitator explained the aim of the focus group and circulated a list of the topics we wished to cover. People were then encouraged to talk to one another, ask questions, exchange opinions and comment on each other's experiences and

points of views. All the quotations contained within the report are drawn from the transcriptions of either the focus groups or the structured interviews.

A purposive sample of key informants was identified for the semi-structured interviews. The purpose of these interviews was to provide a context for the data gathered from the focus groups. The data then represents a rich mix, from the perspectives of practising nurses from the different disciplines to those of policy-makers, civil servants, trades unions and professional bodies. Semi-structured interviews were held with people from the NHS Executive, the London Regional Office of the NHS Executive, the Royal College of Nursing (RCN), the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC), UNISON, Education Consortia, NHS trust chief executives, chief nurses and human resources directors, health authority chief executives and primary care group (PCG) chairs. Again all the interviews were recorded, fully transcribed and analysed in detail.

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